European Monitoring Centre
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Responses to the needs of children of people who use drugs

Background paper commissioned by the EMCDDA for
Health and social responses to drug problems: a European guide

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> *'My father he, he passed when I was only a child. it was suicide …. He had mental problems, drug problems, cocaine and alcohol …. Me mother was an alcoholic and in the mix cocaine but mostly an alcoholic all her life … I started heroin at 13 ... I was just getting up seeing me ma drunk so just going smoking weed and making sure me brothers got something to eat and got them to school …. I never had a parent there to tell me no …. My eldest brother, …, he never touched drugs, …, he has always been there for me, he has never let me down, he's all been my support, I see him as my father, that's the only father figure I had in my life growing up.'*
>
> (John, excerpt from Comiskey and Galligan, 2017)

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Introduction

In September 2019 The General Assembly of the United Nations marked the thirtieth anniversary of the adoption of the UN Convention on the Rights of the Child (United Nations General Assembly, 1989). This is an international treaty that recognises the human rights of children. It establishes in international law that States must ensure that all children, without discrimination: benefit from special protection measures and assistance; have access to services such as education and healthcare; can develop their personalities, abilities and talents to the fullest potential; grow up in an environment of happiness, love and understanding; and are informed about and participate in, achieving their rights in an accessible and active manner. The thirtieth anniversary celebrated the milestones of the Convention in transforming the lives of children and recognised the challenges posed in the 21st century to achieving these rights. Similarly, the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006), which adopts a broad categorisation of persons with disabilities, reaffirms that all persons with any type of disability, including those who may have a psychiatric condition such as substance use disorder and who may be parents, must enjoy the full range of human rights and fundamental freedoms as an individual and within their families. The previous international Covenant on Economic, Social and Cultural Rights (United Nations, 1966) provides further protection and recognises the right of both adults and children to the enjoyment of the highest attainable standard of physical and mental health. Finally, the Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1979) re-affirms women's rights to non-discrimination in education, employment and economic and social activities, and protects them against stigma and other forms of discrimination.

Despite these recognitions, the experience of children of parents who use drugs originally became widely known as 'Hidden Harm' (Advisory Council on the Misuse of Drugs (ACMD), 2003). The term encompasses the two key features of that experience, firstly that these children are often not known to the relevant services and, secondly, that they may suffer harm in a number of ways as a result of compromised parenting. The definition of this term has expanded to include harms to children as a result of parental alcohol use and the use of non-illicit drugs (Tusla and HSE, 2019a; The Scottish Executive, 2013). It is also recognised (Horgan, 2011) that parents and care givers may use more than one substance, and while the literature highlights that there exist important substance-specific effects, the primary aim for most interventions is to address the more general non-substance-specific needs of children. In addition, the literature also considers both problematic and non-problematic use of substances. Problematic use is defined according to ACMD (2003) in the first Hidden Harm report as the use of a substance that results in serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for both the person who uses and those around them. Within this paper the focus is on problematic use, and the term use refers to problematic use; where a reference refers to non-problematic use this is highlighted for the reader.

While the literature on alcohol and other licit drug use overlaps and is often combined with the literature on illicit drug use, the aim of this background paper is to provide an overview of the available evidence on responses to the needs of children of people who primarily use illicit and licit drugs, excluding alcohol, and whose use is problematic. Where the evidence solely relates to alcohol use this is highlighted.

The objectives of this background paper are to:

- identify the main issues of concern with respect to children of people who use drugs in Europe;
- describe the different response options available and their effectiveness;
- provide an overview of the European response to the needs of these children, including case study examples; and
- explore the likely future developments, opportunities and challenges in this field, as well as the implications for drug policy and practice.

The UN Convention defines a 'child' as a person below the age of 18, unless the relevant laws recognise an earlier age of majority. For this background paper the same definition was used. Although not all drug use by a parent will impact on a child, it is recognised that for some children the effect of their parent's drug use continues from their infancy into their adult lives, and for this reason it is appropriate to use a child development framework to identify issues of concern for children at varying ages and stages of their development (Horgan, 2011). In this paper we first present the main issues of concern for children according to their developmental stage. We then address various response options and review their effectiveness. This is followed by a presentation of specific case studies, looking at two responses adopted by EU countries and one initiative from the United Kingdom. The paper ends with a discussion of possible future developments, challenges and opportunities.

Identifying the Main Issues of Concern

While many parents who use drugs do so in moderation and don't present an increased risk of harm to their children, it is acknowledged that some parents and care givers and who use substances such as alcohol and/or drugs can have chaotic, unpredictable lifestyles and may find it difficult to provide their children with a safe environment and clear boundaries (Cleaver et al., 2011). This is also reiterated by Lipari and Van Horn (2017), who state that many children living with a parent who has a substance use disorder related to alcohol or drugs will not experience abuse or neglect although they can be at increased risk of child maltreatment and social services involvement compared to other children.

In quantifying the prevalence of the problem within the United States, Lipari and Van Horn (2017), using data from the combined 2009 to 2014 National Surveys on Drug Use and Health, reported that

approximately 1 in 8 children (8.7 million or 12.5 %) aged 17 or younger lived in households with at least one parent who had a substance use disorder (SUD) in the past year. Within the United Kingdom, the Advisory Council on the Misuse of Drugs (2003) originally estimated that in England and Wales there were between 200 000 and 300 000 children living in a situation where one or both parents had a serious drug problem. This represented about 2–3 % of children under 16. They also estimated that there was one dependent child (under 16 years of age) for every person using drugs and accessing treatment. Similar local estimates were provided in Ireland, where Galligan and Comiskey (2019) also estimated that there was approximately one child for every person known to a drug treatment service. Varying levels of risk depending on the substances used were highlighted by Kuppens et al. (2019), who in their meta-analysis revealed a statistically significant, small detriment to child well-being for parental substance abuse over time (r = .15). However, further analyses demonstrated that the effect was more pronounced for parental drug use (r = .25), compared with alcohol use (r = .13), tobacco use (r = .13) and alcohol use disorder (r = .14).

Velleman and Templeton (2016) note that risks can be increased in cases where, for example, a child is exposed to multiple issues; lives with two parents who use drugs problematically; has to cope with a number of particularly serious problems; and experiences significant disruption to the family. However, they also observe that there is evidence to show that children can grow up in many varied and difficult circumstances without developing significant problems, and in such cases children can demonstrate good outcomes. This is also reiterated in the Scottish Government's (2018) national drug and alcohol strategy, which adopts a whole family approach and recognises, in item 22, that children living with a parent or guardian with alcohol and/or drug use issues are not always at risk of harm.

Larson et al. (2019) have expressed concern over the lack of research on the long-term risks to children during pregnancy. They highlight the emerging literature revealing an association between the exposure of neonates to opioids in utero and longer-term adverse neurocognitive, behavioural and developmental outcomes. The authors also note that many adverse consequences may not be apparent in the neonatal period, but may become more pronounced as children develop and reach pre-school and school age. The article further underscores that the adverse developmental outcomes for children who are prenatally exposed to substances, and in particular opioids, are well documented and are likely to be the result of a combination of factors, not just biological and environmental but also genetic, and so, given the co-occurrence of these risk factors, it is important to support parents and children through screening and early identification, as well as ensuring access to appropriate treatment, care coordination, and other measures. Recognising that attributing causality is difficult in such a highly complex system, with a myriad of genetic and other variables, Larson et al. (2019) suggest that prevention is essential and that children have the greatest potential for success when their mothers are healthy and supported.

Using a child development framework, the risks to children can be described according to their age and stage of development. Furthermore, a child's development can be explored across four domains: physical health; cognitive ability; relationships; and emotional and behavioural development.

Birth to Pre-school

The *World drug report* (UNODC, 2018), in Booklet 5 on women, provides a succinct summary of some of the physical effects of opioids, cocaine and cannabis use on newborn infants, which can include neonatal abstinence syndrome (NAS), low birth weight and premature birth. According to Finnegan (2013), the symptoms for newborn babies with NAS may include mild tremors, irritability, fever, excessive weight loss and seizures, while the severity and timing of these symptoms can vary. Klaman et al. (2017) provide a targeted review of the treatment of opiate use disorder among women who are pregnant or are parenting and conclude that increased medication levels may be needed with advancing pregnancy, and are not associated with more severe NAS. Furthermore, NAS appears to be generally less severe following prenatal exposure to buprenorphine versus methadone. Cataldo et al. (2019) have produced a literature review specifically looking at the impact on mother–infant interactions for women with a diagnosis of a substance use disorder and who have children under the age of three. Using a biological, psychological and social model to explore these interactions, the authors conclude that there is a significant research gap regarding the physiological impact of drug use on mothering and that the analysis to date has focused more on child neglect.

According to ACMD (2003), further risks to infants include the transmission of infectious diseases and losing the benefits of breastfeeding, with rates of breastfeeding among women who use drugs recognised as low. Klaman et al. (2017) note that, postnatally, breastfeeding is seen as beneficial for the infant where women are maintained on a stable dose of opioid agonist medication. In terms of HIV and breastfeeding, Esaú (2020), in a summary of the World Health Organization guidelines, highlights that if mothers with HIV are receiving effective antiretroviral therapy (ART) then the level of virus in their blood can be suppressed to undetectable levels and the risk of transmission of HIV during a vaginal birth could be reduced to <1 %. Furthermore, according to Esaú (2020), with maternal ART and six months' exclusive breastfeeding (meaning that the baby receives no foods and liquids except breast milk, not even water) the risk of postpartum transmission of the virus could also be reduced to virtually zero. However, Esaú (2020), also notes that within the United States, where mothers have access to clean water and replacement milk, breastfeeding among mothers with HIV and in receipt of treatment is not recommended.

Finally, in terms of physical well-being, ACMD (2003) highlights that if a parent who uses drugs is experiencing a chaotic phase in their substance use, babies and infants are at an increased risk of neglect or abuse in terms of their physical, social or emotional needs.

With regard to cognitive and educational risks, Cleaver at al. (2011) found that children's cognitive development and learning may be delayed because fear and anxiety prevents them from exploring

their environment. This review highlights that young children need to gain a sense of security and the confidence to explore their environment. Parents who are preoccupied with their own problems or who are emotionally unavailable can impact on their children's sense of emotional security and may evoke feelings of separation anxiety. Inconsistency and a lack of routine increase a child's sense of insecurity and fearfulness, and may result in infants becoming clingy and fearful.

Language development may also suffer due to a lack of stimulation and encouragement; and parental disorganisation may mean that children fail to regularly attend pre-school facilities. Furthermore, emotional and behavioural development may be delayed due to trauma and stress experienced by the child. Some children may display symptoms of post-traumatic stress disorder, particularly if a parent's behaviour is erratic or frightening. A child may also learn inappropriate behaviour responses if they are witnessing domestic violence.

The impact of the exposure of children of all ages to trauma has been recognised in relation to what have become known as 'Adverse Childhood Experiences' or ACEs. These are significant traumatic events in the life of a child and the term is used to describe all types of abuse, neglect and other potentially traumatic experiences that happen to people under the age of 18. ACEs have been linked to risky health behaviours, chronic health conditions, low life potential and early death. As the number of ACEs increases, so does the risk for these outcomes (Centres for Disease Control and Prevention, 2019). Asmussen et al.'s (2020) report surveys the evidence relating to the prevalence, impact and treatment of ACEs; the extent to which ACEs should provide the basis for frontline practice and service design; and the known level of effectiveness and value of ACE-related approaches, such as routine enquiry and trauma-informed care. While recognising the importance of ACE research, the authors also highlight the limitations in the current evidence base and caution against so-called 'quick fixes' to prevent adversity or to help people overcome it. Current estimates of the prevalence of ACEs are imprecise, and reliable data on the prevalence of childhood adversity and wider risk factors remain lacking.

School-Aged Children from 5 to 14 Years

In their systematic review of the literature on children of parents with substance use disorder, Peleg-Oren and Teichman (2006) examined the relevant findings from studies that focused on school-age children whose parents used alcohol and other, illicit, drugs. These studies, which were scientifically designed with control groups, and used reliable and valid instruments, found that these children exhibited a range of emotional, cognitive, behavioural and social problems. In the UK, the Advisory Council on the Misuse of Drugs conducted a national inquiry on the prevalence and impact of parental substance use (ACMD, 2003). Combining the work of a team of independent researchers who reviewed the international literature with the input of expert practitioners from an education sub-group, a primary care sub-group and a group of non-statutory agencies, and including a number of oral presentations, the ACMD delivered its findings across varying domains using a child development

framework. Cleaver et al.'s book (2011) provides an international literature review of children's needs and parenting capacity with respect to parents dealing with mental illness, disability, substance use and domestic violence, including details pertaining to the child development framework and the various domains.

In terms of physical health, school-going children whose parents have drug problems may miss physical and dental checks and may not be registered with a general practitioner. Older school children may not experience parental support during puberty and may be at risk of taking up smoking and drinking at an earlier age. In terms of educational and cognitive development, children may demonstrate poorer school performance and increased absences due to an unstable home environment and the possible need to take care of younger siblings. These children are also at risk of higher levels of school exclusion, while with respect to relationships and identity, they may suffer from poor self-image and low self-esteem, and have restricted friendships due to circumstances in the home. Finally, in terms of emotional and behavioural problems, young boys may exhibit anti-social behaviour, and, as they grow older, are more likely to be involved in criminal activity. Girls may have greater levels of depression and anxiety. Both boys and girls may exhibit emotional disturbance and conduct disorders, for example bullying and sexual abuse are more common in this group of children (ACMD, 2003; Peleg-Oren and Teichman, 2006; Cleaver et al., 2011).

Adolescents Aged 15 Years and Older

In terms of health and well-being, adolescents with parents who use drugs problematically are at an increased risk of experimenting with smoking, drinking and drug use. This may in turn increase their risk of poor health due to harm suffered as a result of early substance use. They may also experience problems related to sexual relationships and teenage parenthood, while a lack of educational attainment may affect their long-term life chances. The lack of a suitable role model may impact upon their relationships and sense of personal identity. Cleaver et al. (2011) highlight the increased risk of self-blame, guilt and suicide among these young people. Furthermore, adolescents in this group are also at an increased risk of committing conduct disorders and crime, while young males may take on an aggressive and abusive role in intimate relationships. Both young women and men may dress inappropriately and isolate themselves from other young people and adults. Isolation can also result from taking on a caring role for a parent or siblings.

In their qualitative research working directly with the voices of children aged 15 years and older, Backett-Milburn et al. (2008) noted how older children of parents who use substances had to deal with the spatial, financial and social constraints of living in disadvantaged circumstances, and often had to 'get by' without being able to rely on parents to look after them. In 2010 the EMCDDA also published a thematic paper including the voices of children, parents and service providers from across the then 14 European Member States. Quotations from children were sourced from research interviews conducted between 1997 and 2010 with children under 18 years of age and some young adults

recalling their childhoods. From their research the EMCDDA (2010) found a number of areas of concern for these older children, including the challenges of living with harmful parental drug taking; being separated from parents; and experiences related to drug consumption as well as the interventions intended to address drug use.

Summarising Potential Risks to Children and Gaps in the Research

In a recent rapid evidence assessment of the literature on parental non-dependent substance use, McGovern et al. (2018) examined both health and psychological impacts on children aged from birth to 20 years. Health impacts included direct health impacts for the child (e.g., those brought about by accidental ingestion or exposure to the substance or contaminated environments) and indirect health impacts (e.g., health service usage, physical injury or death). Psychological impacts included both internalising and externalising behaviours. They reviewed eight papers of varying quality, covering a range of child ages. The results corroborated the reviews of Peleg-Oren and Teichman (2006), ACMD (2003) and Cleaver et al. (2011). In Table 1 we provide a brief summary of potential impacts across the four key domains according to the child's development.

Table 1. Summary of domains of potential impact on a child across its developmental stages, as a result of parental substance use (adapted and summarised from Cleaver (2011) with additional input from Peleg-Oren and Teichman (2006) and ACMD (2003) and corroborated by and McGovern et al. (2018))

Age in years	Health and well-being	Education and cognitive ability	Relationships and personal identity	Emotional and behavioural development
0 to 4	Poor hygiene and diet. Missed immunisations, and health and dental checks. Safety risks due to inadequate supervision. Physical violence.	Lack of stimulation due to parental preoccupation with drugs and own problems. Irregular or no attendance at pre-school.	Separation from one or both biological parents. Problems with attachment in relation to parents or care givers. May be expected to take on excessive responsibility.	Emotional insecurity due to unstable parental behaviour and absence. Hyperactivity, inattention, impulsivity, aggression, depression and anxiety all more common. Continued fear of separation. Inappropriate learned response due to witnessing violence, theft and adult sexual behaviour.

5 to 14	School medicals missed. Dental checks missed. Poor support in puberty. Early smoking, drinking and drug use more likely.	Poor school attendance, preparation and concentration due to parental problems and unstable home situation. Continued poor academic performance, especially if looking after siblings, and increased risk of school exclusion.	Restricted friendships. May be expected to take on excessive responsibility for parents or siblings. Poor self-image and low self-esteem.	More antisocial acts by boys, and higher levels of depression, anxiety and withdrawal among girls. Emotional disturbance and conduct disorders, for example bullying and sexual abuse, are more common. Higher risk of offending and criminality.
15+	Increased risk of problem drug and alcohol use, pregnancy and sexually transmitted diseases.	Lack of educational attainment may affect long-term quality of life.	Lack of appropriate role models.	Greater likelihood of self-blame or guilt, increased risk of suicide.

There is a considerable gap in terms of research on older children of parents who use drugs (ACMD, 2003; Tusla and HSE, 2019a). So far, little attention has been focused on older children or young adults, on children who no longer live with one or both of their parents, or on the role of fathers who use drugs. To date the emphasis has been on pregnancy, early childhood and early childhood interventions. In the next section we explore the evidence on interventions, different response options and their effectiveness within a range of relevant settings.

Different Response Options and their Effectiveness

The prevalence of children of parents who use drugs and the potential impacts across all ages implies that interventions and prevention must be targeted across the span of childhood, from pre- and postnatal to young adulthood. Furthermore, Comiskey (2019) has highlighted that recent research has challenged the belief that parental drug use necessarily has life-long implications for children. Peleg-Oren and Teichman (2006) present an alternative view on outcomes, with their review finding that the availability of support systems had a significant and positive effect on children's development as they entered adulthood. These support systems could be located within the extended family or in the community and can act by having a positive influence on the child's ability to cope with the trauma experienced within their families. Horgan (2011) reiterates this and recognises that the heterogeneous

outcomes observed in children stem from their personal attributes as well as their degree of exposure to protective or resilience-building factors.

In their longitudinal study of 65 children of parents with problem alcohol use, Werner and Johnson (2004) followed the children and adults over a period of 30 years. Both children and adults were either interviewed or responded to survey questionnaires. When the children were 18 years old, they were personally interviewed about the quality of family life they had experienced in adolescence. In the follow-up study, when the participants were now aged 31 and 32, a structured interview assessed their perception of the major stressors and supports they had encountered while growing up in a family with problem alcohol use. They were asked about school, work and their relationships with adults inside and outside of the home. The interview included a number of questions about who had helped them most in dealing with the difficulties and stresses in their lives and the kind of help that had proved beneficial. The data showed that individuals who coped effectively with the trauma of growing up in an alcoholic family and who became competent adults utilised a significantly larger number of sources of support in their childhood and youth than those who exhibited coping problems by the age of 32.

Prevention approaches vary greatly, and range from those that target society as a whole and are referred to as environmental prevention programmes, to interventions focusing on at-risk individuals and known as indicated prevention programmes. The settings in which these programmes are carried out can also vary from school to family to community settings. Similarly, the target of the programme can be the parents, the child, the family or a combination of these parties. Bröning et al. (2012) conducted a comprehensive and systematic review to identify and summarise evaluations of selective preventive interventions for children and adolescents from substance-affected families. The interventions reviewed were aimed at reducing the risk of the children from these families developing their own substance-related or other mental disorders. From their review Bröning et al. identified nine eligible programmes within 13 studies and a list of these is provided in Table 2.

Table 2. Listing of programmes reviewed by Bröning et al. (2012) by setting and significant outcomes

Setting	Programme	Outcomes
School programmes	1. Stress Management and Alcohol Awareness Program (SMAAP)	1. Improved programme knowledge, emotion-focused coping, problem-solving ability and social competency
	2. Friends in Need	2. Reduced physical aggression for the intervention group, no other significant treatment effects

	3. School Based Support Group (SBSG)	3. Improved addiction-related knowledge, improved coping strategies and social integration (females only); increased medical complaints and diminished social integration (males only); qualitative findings: improvement of social behaviour, school performance, coping strategies and knowledge on programme content.
	4. Children Having Opportunities in Courage, Esteem and Success (CHOICES))	4. Increased self-esteem, increased social skills and attitude towards substance use improved; improvement in isolation, loneliness, coping strategies and knowledge on programme content; improvement in attitudes, school performance and social behaviour
Community programme	1. Teen Club	1. Went to school for a significantly longer time period; had a better chance of getting a job; fewer depressive symptoms; fewer pregnancies; higher frequency of alcohol consumption; high programme contentedness; decreased risky behaviour
Family programmes	1. Focus on Families (FOF)	1. Hardly any differences between study and control group children; improved family behaviour; significant improvements for the parents in the areas of parenting skills, drug use, deviant peers, and family management; reduced risk of developing substance use problems (only males)
	2. Strengthening Families Program (SFP)	2. Reduction of Oppositional Defiant Disorder symptoms in the study group compared to the controls from the parents' perception
	3. Family Competence Program (FCP)	3. Significant improvement in family involvement, communication and family rules, family satisfaction and organization, and relationships between parents and children; parenting behaviours and relationships between parents improved; children: problem behaviours were reduced, social skills and programme-related knowledge improved

	4. Safe Haven Program	4. High drug use group: improvement of externalizing/internalizing problem behaviours; low drug use group: fewer school problems; total sample: improved family cohesion, less parental drug use

With the exception of one programme conducted in Spain and another one with partial sampling in Canada, all the programmes and their evaluation were conducted in the United States. Studies varied in programme format, structure, content and participants. They also differed in outcome measures, results and study design quality. Programme duration was generally between 8 and 14 weeks, with weekly sessions of approximately 90 minutes. Group sizes usually ranged from 8 to 12 children. While programme content varied, common themes of coping with emotions, problem solving, education on drugs and addiction, and improving family relations were evident.

In the school-based initiatives, parents (the substance using parent and his/her spouse) were not involved in the programme. Family-based programmes differed in the attention given to children, parents and family sessions. Outcomes measured included knowledge, self-worth, coping and social behaviour. Individual personal attributes, such as emotion regulation, depression, health behaviours, substance use, school attachment and performance, family and/or social relationships, were also included. Details of the nine programmes and their outcomes are available in Bröning et al. (2012).

The review found that there was preliminary evidence for the effectiveness of a number of programmes and that effective interventions displayed the following features:

- they involved children as well as parents;
- they involved family skills training components; and
- their duration was sufficient and over 10 weeks.

It also revealed that outcomes close to the intervention, such as programme-related knowledge, coping-skills and family relations, showed better results than more distal outcomes, such as self-worth and substance-use initiation. Reasons postulated for the latter finding were the comparatively young age of participants and the lack of longitudinal data. This gap in the data was repeatedly identified in additional later reviews, as discussed below.

McGovern et al.'s review (2018) studied the evidence on trials of psychological and social interventions for dependent and non-dependent substance-using parents. The authors reported on 33 trials of varying quality, with a focus on those aimed at reducing parental substance use. The participants in the trials were mostly mothers, with few trials including fathers. While the interventions had overlapping components, they could be broadly described as: individual alcohol and/or drug treatment programmes focusing on the substance misuse needs of the parent; parenting skills training

programmes; family-centred interventions; and peer support programmes. The review revealed mixed results. However, in terms of effective programme features, the authors found that **intensive case management** and **family-level interventions** seemed to offer the most promise, with the limitation that the outcomes measured were at the parent, as opposed to the child, level.

Usher, McShane and Dwyer (2015) also conducted a realist review, but unlike McGovern et al. they focused on family-based interventions for children and young people. They wished to evaluate programmes that employ family disease and family prevention model theories and their effectiveness for children of parents who use substances. In a family disease model, addiction is viewed as a family disease, whereby the entire family is affected by one person's substance dependency. Children living in this environment are thus considered to be in need of specific intervention within a family context in order to disrupt the cycle of addiction, and the programmes attempt to break down existing patterns by providing family members with education and knowledge. The family prevention model views addiction as one of many risk factors that characterise dysfunctional families. Improving the family environment is seen as key to reducing risk factors, and interventions target issues of risk and resiliency. The authors included studies where participants were aged between 6 and 18 years and had a parent who used substances. The parent had to attend the programme with the child, and these sessions were delivered in a group setting and were family-based. Seven programmes across 30 studies were reviewed in the light of their theoretical backgrounds. A wide range of outcomes were reported, and, as was also noted by Bröning et al. (2012) as a limitation, most outcomes were measured shortly after the completion of the programme so that evidence of programme fidelity was not always apparent. The categories of outcomes were summarised as child behavioural changes; child emotional changes; parenting; relapse prevention; and family cohesion.

Three features were identified as fundamental to generating positive programme outcomes, namely:
- creating opportunities for positive parent–child interactions;
- supportive peer-to-peer relationships; and
- (addiction) knowledge is power.

Usher et al. (2015) concluded that family prevention-based programmes appear to be effective when they encourage positive parent–child interactions, facilitate peer relationships and are attuned to client engagement. Trust was also found to be a key mechanism in establishing programme engagement and promoting the development of peer relationships and opportunities for positive parent–child interactions.

Calhoun, Conner, Miller and Messina (2015) conducted a systematic review of randomised control trials that examined the outcomes for children affected by parental substance abuse. Inclusion criteria were evidence-based randomised control trials (RCTs) of interventions directed either at parents with a substance use problem or children with at least one parent with a substance use problem. Four trials were identified for inclusion; all were family-based interventions for children aged 2 to 16 years, but only one explored child outcomes. The programmes evaluated were Parents under Pressure

(PUP), Focus on Families (FOF), Behavioural Couples Therapy, and Parent Skills with Behavioural Couples Therapy. The findings from the review suggested that the features of interventions that may be effective in reducing problems in children affected by parental substance use included:

- a focus on improving parenting practices; and
- a focus on family functioning.

However, as in other studies, the review found that further research utilising rigorous methodologies is needed in order to identify other successful interventions which can improve the outcomes of these children long after the programme has ended.

Synthesising results across the reviews, it can be seen that one feature that was identified in potentially effective interventions was sufficient programme duration. Bröning et al. (2012) suggested that programmes should last longer than 10 weeks. Furthermore, to enhance the evidence for longer-term success, outcomes must be measured some considerable time after the completion of these programmes. This recommendation for longer-term monitoring of distal outcomes is supported by the work of Werner and Johnson (2004), who by following up children over a 30-year period provided evidence on the long-term positive outcomes of providing additional wider supports for children of parents with problem alcohol use. A second feature of effective prevention interventions was captured in the finding that programmes which included both the child and the parent, as well as those which involved family functioning/skills/parenting training, were found to be more successful. This result also reflects the wider literature on parent and child interventions. According to McGilloway et al. (2014), there is strong evidence to show that parenting interventions which aim to improve parent–child relationships are effective in tackling behavioural disorders in childhood, as well as improving parenting skills, parent mental health and sibling adjustment. Finally, a third feature of effective programmes was encouraging engagement with trust, within the context of supportive peer-to-peer relationships and addiction knowledge. An ongoing repository of effective prevention programmes has been developed by the European Monitoring Centre for Drugs and Drug Addiction. The Xchange registry provides access to evaluated manualised interventions for which European studies have demonstrated beneficial outcomes.

The European Response and Case Studies

In 2013 the European Union recognised the importance of supporting child well-being, protecting the rights of the child, combating social exclusion and discrimination, and promoting social justice and the protection of all children. In response to this recognition, the European Union produced its Recommendation for Investing in Children (European Union, 2013). This document advocated investing in children and breaking the cycle of disadvantage. As a consequence of this recommendation the European Platform for Investing in Children (EPIC) was developed (https://ec.europa.eu/social/main.jsp?catId=1246&langId=en). This online platform serves as a tool for

Member States to monitor activities resulting from the recommendation. EPIC is an evidence-based platform containing information that can help children and their families. It provides a repository for policy and services, comprising country profiles, a collection of evidence-based practices, a social innovation repository and a user registry on practices being implemented across Europe. As part of the EPIC remit, Davies, Janta and Gardner (2019) provided a review of positive parenting interventions for specific settings and age groups. The review focused primarily on child outcomes from early childhood to adolescence, and covered the age range from birth to 18 years. The authors acknowledged that research with current adults on their past exposure as children to experiences such as substance abuse has identified strong correlations between childhood adversity and many of the leading causes of death and illness now observed in adulthood. While children of parents who use drugs were not always specifically highlighted within the reviews of the interventions, the authors succeeded in producing a graded list of evidence-based interventions being implemented across Europe that address some of the impacts observed within the literature on children of parents who use drugs. However, the authors urge caution and clearly state that questions still remain about the effectiveness of parenting interventions across different settings and populations.

Beyond the development and provision of specific programmes, also important is a systems approach that ensures appropriate interventions are available to support and meet the needs of children with parents with drug problems across the different age ranges and in various circumstances. Examples of different system approaches are presented below as case studies. Within Ireland a series of government policies with planned and monitored actions have been developed across a number of Ministries to address the challenge posed by children of parents who use drugs. Within these actions, evidence-based parenting programmes may be introduced. In the Netherlands, rather than taking a policy approach, a series of evidence-based parenting programmes have been introduced, targeted at specific vulnerable communities and groups. In the United Kingdom the justice system has introduced specific family drug courts that coordinate the provision of individualised interventions to support parents who are at risk of losing the care of their children. These courts have been evaluated and shown to produce a range of positive outcomes as well as being cost-effective (Harwin et al., 2014).

Case Study: Policy Response in Ireland

Galligan (2020) provides a detailed historical perspective, from 2010 to the present day, on the Irish policy response to the children of parents who use substances, including looking at how both the substance use policy and the policy for children have worked together to tackle this challenge. The experience of children living with, and affected by, parental problem alcohol and other drug use has become widely known as Hidden Harm. In 2014, 'Hidden Harm' was prioritised as a theme within, 'Better Outcomes Brighter Futures: The National Policy Framework for Children and Young People (2014-2020)' by the Department of Children & Youth Affairs. In 2017 the new drug strategy, 'Reducing

Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland, 2017-2025', identified both the national agency responsible for the welfare of children, Tusla, and the national agency in charge of healthcare, The Health Service Executive (HSE), as joint lead agencies, with the help of additional partners, in the implementation of the following actions:

- Action 1.2.5 Improve supports for young people at risk of early substance use;
- Action 1.3.9 Mitigate the risk and reduce the impact of parental substance misuse on babies and young children – Hidden Harm;
- Action 2.1.17 Further strengthen services to support families affected by substance misuse;
- Action 2.1.22 Expand the range, availability and geographical spread of problem drug and alcohol services for those under the age of 18.

In early 2019 three key publications in relation to Hidden Harm were produced. These were the *Hidden Harm, strategic statement*, the *Hidden harm, practice guide* and an information leaflet for frontline workers entitled *Opening our eyes to Hidden Harm* (Tusla and HSE 2019a, 2019b, 2019c). It is not expected that drug and alcohol service staff will become specialists in child welfare and protection, nor that child service staff will become expert in drug and alcohol treatment, rather, that all staff and relevant frontline workers, from teachers to sports coaches to youth workers, GPs and families, will develop a deeper understanding of, and improved joint practice on, Hidden Harm. The HSE and Tusla recently completed a further project to develop an online learning resource on the topic of Hidden Harm.

Case Study: Parenting Programmes in the Netherlands

The original Dutch 1995 white paper 'Drug policy: continuity and change' outlined four major objectives: (i) to prevent drug use and treat and rehabilitate drug users; (ii) to reduce harm to users; (iii) to diminish the public nuisance caused by drug users; and (iv) to combat the production and trafficking of drugs. Policy since the 1995 white paper has been articulated in a series of specific topic papers, and an evaluation of the original policy was undertaken in 2009 (Trimbos, 2009). This evaluation noted that when exploring prevention and harm reduction objectives the degree of focus on vulnerable groups varied over time and that there were currently other interventions in operation, targeting, for example, young people inside and outside the social scene, young people in institutions, children of parents who use drugs, and young people with mild mental disabilities.

This change in focus is reflected in the European Platform for Investing in Children. According to Davies, Janta and Gardner (2019), the Netherlands have implemented a series of parenting programmes that have been identified as examples of best practice. These programmes have included the Incredible Years programme, the Parent Management Training Oregon programme and the Triple P programme. These three initiatives have been designed to be implemented with children and young people across their development stages, from early childhood (0–5 years), middle childhood (ages 6–9), pre-adolescence (ages 10–12) and adolescence (ages 13–18). The outcomes

these programmes target include the promotion of positive parenting, treating child behavioural problems, and reducing or preventing harsh or abusive parenting. Programme settings include the individual-based interventions within homes, group settings and media-based online environments. However, as we saw above, many of these programmes, while recognised as best practice given their sustainability and transferability of impact, still require additional longitudinal research on the broader range of outcomes when implemented with children and young people whose parents use substances.

Case Study: Family Drug and Alcohol Courts in the United Kingdom

The safeguarding of children whose parents have drug problems is an important concern, and in severe cases these children may be removed from their families and taken into the care of the state. However, breaking up families can have negative consequences for both the parents and children, so alternatives that still ensure the safety of the child are preferable. One such example, from the United Kingdom, is what is known as a Family Drug and Alcohol Court (FDAC). This is a court which aims to provide an alternative way of safeguarding children whose parents have drug problems by supporting the parents to overcome substance misuse and other challenges, instead of removing the children from their care. A focus on strengths-based models is recommended as appropriate for families, and the FDAC recognises that parents will often have other difficulties as well, including mental health problems and experiences of domestic abuse. The court works with the family to solve the problems that have brought the parent to court. To do this, the same judge reviews the case every fortnight in an informal hearing with each parent. Parents who join the FDAC programme are given what is called 'a trial for change'. This is a period in which they work on interventions agreed in a personalised plan, which the team, family and other professionals come up with together. Parents are asked to work closely with the FDAC team and other services. Towards the end of proceedings, the team make a recommendation to the court on whether the parent can safely care for their child. Further details are available at https://fdac.org.uk/. This approach has been shown to reduce parental substance use and result in fewer children being taken into care (Harwin et al., 2014).

Future Developments, Challenges and Opportunities

The term 'Hidden Harm' recognises two key features: firstly, that children are often hidden, silenced and unknown to the relevant services; and secondly that they may suffer harm in a number of ways as a result of compromised parenting. The notion of silenced children is articulated within the German national strategy on drug and addiction policy (Drug Commissioner of the Federal Government, 2012), and the reason for this silence is rightly identified as anxiety over the consequences of speaking out along with the fear of stigma. It is this stigma which is one of the greatest challenges facing both families and those responsible for the design, delivery and effective implementation of

policy. In his review of the literature, Lloyd (2013) explains that stigma is a long-lasting mark of social disgrace that has a profound effect on interactions between the stigmatised and the unstigmatised, and can be a significant barrier to recovery. Finnegan (2013), in her summary of factors that help women who use substances during pregnancy to protect themselves and their babies, included stigma-reducing services and noted that the stigma associated with substance use in pregnant women presents a significant barrier to their accessing treatment. Children articulated their experiences of social isolation and stigma as part of their lives in EMCDDA (2010), and the need for non-stigmatising supportive services for parents and children was also expressed. Addressing stigma is a fundamental paradigm shift that must be undertaken, starting with policy leadership.

A further challenge is the lack of knowledge across Europe regarding the prevalence of the Hidden Harm within communities and countries. It is well established (ACMD, 2003) that for planning purposes, prevalence estimation is an essential first step. Finally, as Hidden Harm is known to be repeated across the generations, investment in longitudinal research, monitoring the sustainability of inter-generational outcomes following interventions, is essential for conducting cost-benefit analyses.

Fortunately, stigma has started to be addressed in the language of policy and practice. This change is being driven by community services and interventions run by people who use drugs (Citywide, 2018; Harrod et al., 2018). Communities are also addressing the scale of the challenge within their regions, and one example of local prevalence estimation is provided by Galligan and Comiskey (2019). The European-wide Treatment Demand Indicator Protocol 3.0 is also a potential resource for estimating the scale of the challenge in terms of parents in receipt of substance use treatment and whether and how they live with their children (EMCDDA, 2012). Items 7 and 8 of the protocol relate to the domestic arrangements of people in treatment. Item 7 asks with whom the person is living and responses include an option to list partners and children. Item 8 assesses if those in treatment have children and enquires into the living conditions of the person and the children. Children in this item include those of all ages, both biological and not biological.

The modification of the protocol to include the addition of these questions is a resource that has yet to be fully realised. A modification in the protocol of the European-wide ESPAD study offers a possible direct opportunity to ask young people not only about their substance use but also about use in their family context, and results from this modification should be available in future reports. (ESPAD Group, 2016).

However, in spite of these opportunities for monitoring the scale of the problem, the challenge still remains of evaluating the longer-term outcomes for parents who use drugs and their children. The gap between what stakeholders need for planning and what researchers identify as important has been addressed by Ferri at al. (2015). Wiessing et al. (2017) call for improved outcome monitoring for people in receipt of drug treatments but they fail to prioritise the measurement of long-term outcomes for children of parents who use drugs.

We also need to take advantage of the possible future opportunities from disruptive innovation, big data, virtual reality, mhealth and wearable technology resources. 'Big data' is the term used to describe large volumes of varying types of data that are currently available to organisations. These data may be captured from individual computer use, mobile phone networks, city street cameras, banking services, shop loyalty cards or insurance and healthcare systems. The Scientific Committee of the European Monitoring Centre for Drugs and Drug Addiction in their *Addiction* editorial (Comiskey et al., 2020) have highlighted the opportunities this data can potentially offer. However, the challenge, as well as the opportunity, that big data presents is to analyse and harness the insights it offers to provide better policy and services for people who use drugs, their families and their communities.

In terms of mhealth and ehealth, according to Davies, Janta and Gardner (2019), early studies evaluating online parenting programmes have indicated that interventions delivered in this way have shown promising results and have the potential to enable wider access for parents, children and young people. There is a need to carry out innovative large-scale pilot studies to test interventions that use these technologies.

The future of Hidden Harm need not reflect the past; children no longer need to be silenced nor parents shamed and stigmatised. Innovative, strengths-based policy and practice is possible given adequate leadership, resourcing and research.

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