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

Its six key messages are:

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

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

Further copies of this report, together with the Executive Summary,
can be obtained from prolog.uk.com Telephone: 0870 241 4680 Fax: 0870 241 4786.
The report and Executive Summary are also available on
the national drugs strategy website – www.drugs.gov.uk
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BUILDING A SAFE, JUST AND TOLERANT SOCIETY

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Hidden Harm Responding to the needs of children of problem drug users Advisory Council on the Misuse of Drugs June 2003

Hidden Harm

Responding to the needs of children of problem drug users



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

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Chapter 5

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

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

Its terms of reference were to:

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

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

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

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

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

Method of working

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

Summary and recommendations

Summary and recommendations

Introduction

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

Chapter 1 Estimates of the scale of the problem

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

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

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

Recommendations

1. All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them.

2. Whether a client or patient has dependent children and where they are living should be included as standard elements in the National Drug Misuse Treatment System in England and Wales and in the Drug Misuse Databases in Scotland and Northern Ireland and should be recorded in the same way to allow comparisons between regions.

Chapter 2 The impact of parental problem drug use on children

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

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

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

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

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

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

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

Recommendations

3. Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish relationships between maternal problem drug use and congenital and developmental abnormalities in the child.

4. Studies should be urgently carried out to assess the true incidence of transmission of hepatitis C between infected female drug users and their babies during pregnancy, birth and infancy.

5. A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from conception to adolescence. It should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere, and the evaluation of interventions aimed at improving their health and well-being in both the short and the long term.

Chapter 3 The voices of children and their parents

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

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

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

Recommendations

6. The voices of the children of problem drug users should be heard and listened to.

7. Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.

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

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

Specialist drug agencies

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

Maternity units

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

Social work services

Responding agencies had an average of about 2,000 new cases of children in need and 143 cases on the child protection register in the previous year. On average, parental problem drug or alcohol use featured in a quarter of cases of children on the child protection register. Over 80% of agencies inquired about drug and alcohol problems in the mother and father; 70% had specific staff for dealing with substance use issues but only 40% had a protocol for decision-making for children of substance users; 65% provided training in managing families with substance use problems. 64% had formal joint arrangements for working with other agencies in child protection cases involving parental drug use. Only 43% reported providing specific services for problem drug using parents and their dependent children. Liaison with general practitioners was relatively infrequent.

Recommendations

8. The Department of Health and the devolved executives should ensure that all maternity units and social service children and family teams routinely record problem drug or alcohol use by a pregnant mother or a child's parents in a way that respects privacy and confidentiality but both enables accurate assessment of the individual or family and permits consistent evaluation of and comparisons between services.

9. The National Treatment Agency and the devolved executives should ensure that all specialist drug and alcohol services ask about and record the number, age and whereabouts of all their clients' children in a consistent manner.

Chapter 5 The legal framework and child protection arrangements

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

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

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

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

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

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

Recommendation

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

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

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

England

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

Wales

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

Scotland

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

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

Recommendations

11. Reducing the harm to children as a result of parental drug use should be a main objective of the UK's drug strategies.

12. The Government should ensure that the National Children's Service Framework and equivalent strategic arrangements in Wales, Scotland and Northern Ireland, identify children of problem drug users as a large group with special needs that require specific actions by health, education and social services.

13. The National Treatment Agency, the Welsh Assembly Government and the Scottish Executive should ensure that services for adult substance misusers identify and record the existence of clients' dependent children and contribute actively to meeting their needs either directly or through referral to or liaison with other appropriate services, including those in the non-statutory sector. This should include protocols that set out arrangements between drug and alcohol services and child protection services.

14. Whenever possible, the relevant Government departments should ensure there are mechanisms in place to evaluate the extent to which the many initiatives outlined in this chapter benefit vulnerable children, including the children of problem drug users.

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

Access to and coordination of services

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

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

Recommendations

15. All Drug Action Teams or equivalent bodies should ensure that safeguarding and promoting the interests of the children of problem drug users is an essential part of their area strategy for reducing drug-related harm and that this is translated into effective, integrated, multi-agency service provision.

16. All Drug Action Teams or equivalent bodies should have cross-representation with the relevant children's services planning teams in their area.

17. Drug misuse services, maternity services and children's health and social care services in each area should forge links that will enable them to respond in a co-ordinated way to the needs of the children of problem drug users.

Maternity services

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

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

Recommendations

18. Every maternity unit should ensure that it provides a service that is accessible to and non-judgemental of pregnant problem drug users and able to offer high quality care aimed at minimising the impact of the mother's drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.

19. Pregnant female drug users should be routinely tested, with their informed consent, for HIV, hepatitis B and hepatitis C, and appropriate clinical management provided including hepatitis B immunisation for all babies of drug injectors.

20. Every maternity unit should have effective links with primary health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

Primary care

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

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

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

Recommendations

21. Primary Care Trusts or the equivalent health authorities in Wales, Scotland and Northern Ireland should have clear arrangements for ensuring that the children of problem drug or alcohol users in their area are able to benefit fully from appropriate services including those for the prevention, diagnosis and treatment of blood-borne virus infections.

22. Primary care teams providing services for problem drug users should ensure that the health and well-being of their children are also being met, in partnership with the school health service, children and family teams and other services as appropriate.

23. Training programmes on the management of problem drug use by primary care staff should include information about the importance of recognising and meeting the health care needs of the children of problem drug users.

Contraception and planned pregnancy

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

Recommendations

24. All general practitioners who have problem drug users as patients should take steps to ensure they have access to appropriate contraceptive and family planning advice and management. This should include information about and access to emergency contraception and termination of pregnancy services.

25. Contraceptive services should be provided through specialist drug agencies including methadone clinics and needle exchanges. Preferably these should be linked to specialist family planning services able to advise on and administer long-acting injectable contraceptives, contraceptive coils and implants.

Early years education and schools

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

Recommendations

26. All early years education services and schools should have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee when concerns arise about the impact on a child of parental problem drug or alcohol use.

27. All schools should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users.

28. Gaining a broad understanding of the impact of parental problem drug or alcohol use on children should be an objective of general teacher training and continuous professional development.

Social work children and family services

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

Recommendations

29. All social services departments should aim to achieve the following in their work with the children of problem drug users:

- An integrated approach, based on a common assessment framework, by professionals on the ground including social workers, health visitors and GPs, nursery staff and teachers, child and adolescent mental health services.
- Adequate staffing of children and family services in relation to assessed need.
- Appropriate training of children and family service staff in relation to problem drug and alcohol use.
- A co-ordinated range of resources capable of providing real support to families with drug problems, directed both at assisting parents and protecting and helping children.
- Sufficient provision of foster care and respite care suitable for children of problem drug users when their remaining at home is unsafe.
- Efficient arrangements for adoption when this is considered the best option.
- Residential care facilities that provide a genuinely caring environment for those children for whom this is the only realistic option.

30. The Government should continue to explore all practical avenues for attracting and retaining staff in the field of child protection.

31. The new Social Care Councils for England, Wales, Scotland and Northern Ireland should ensure that all social care workers receive pre-qualification and in-service training that addresses the potential harm to children of parental substance misuse and what practical steps can be taken to reduce it. Consideration should be given to the inclusion of such training as a prerequisite for registration by the appropriate professional bodies.

Fostering, residential care and adoption

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

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

Recommendations

32. Residential care for the children of problem drug users should be considered as the option of last resort.

33. The range of options for supporting the children of problem drug users should be broadened to include: day fostering; the provision of appropriate education, training and support for foster parents; and robust arrangements to enable suitable willing relatives to obtain formal status as foster parents.

34. Where fostering or adoption of a child of problem drug users is being seriously considered, the responsible authorities should recognise the need for rapid evidence-based decision-making, particularly in the case of very young children whose development may be irreparably compromised over a short period of time.

Specialist drug and alcohol services

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

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

Recommendations

35. Drug and alcohol agencies should recognise that they have a responsibility towards the dependent children of their clients and aim to provide accessible and effective support for parents and their children, either directly or through good links with other relevant services.

36. The training of staff in drug and alcohol agencies should include a specific focus on learning how to assess and meet the needs of clients as parents and their children.

Specialist paediatric and child and adolescent mental health services

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

Recommendations

37. The possible role of parental drug or alcohol misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose.

38. Child and adolescent mental health services should routinely explore the possibility of parental drug or alcohol misuse.

39. Acquiring the ability to explore parental substance misuse should be a routine part of training for professionals working in child and adolescent mental health services.

Specialist children's charities and other non-statutory organisations

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

Recommendations

40. Given the size and seriousness of the problem, all non-statutory organisations dedicated to helping children or problem drug or alcohol users should carefully consider whether they could help meet the needs of the children of problem drug or alcohol users.

41. Drug Action Teams should explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area.

42. Agencies committed to helping the children of problem drug or alcohol users should form a national association to help catalyse the development of this important area of work.

Police

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

Recommendation

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

Courts and prisons

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

Recommendations

44. When custody of a female problem drug user is being considered, court services should ensure that the decision fully takes into account the safety and well-being of any dependent children she may have. This may have training implications for sentencers.

45. The potential of Drug Courts and Drug Treatment and Testing Orders to provide non-custodial sentences for problem drug users with children should be explored.

46. All women's prisons should ensure they have facilities that enable pregnant female drug users to receive antenatal care and treatment of drug dependence of the same standard that would be expected in the community.

47. All female prisoners should have access to a suitable environment for visits by their children. In addition, where it is considered to be in the infant's best interests to remain with his or her mother, consideration should be given by the prison to allowing the infant to do so in a mother and baby unit or other suitable accommodation.

48. Women's prisons should ensure they have effective aftercare arrangements to enable appropriate support to be provided after release for female problem drug users with children.

Chapter 8 Conclusions

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

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

Chapter 1

Estimates of the scale of the problem

Chapter 1 Estimates of the scale of the problem

Key findings

Parents among problem drug users accessing treatment in England and Wales

1. A five-year dataset from English and Welsh drug misuse treatment services had information on over 300,000 problem drug users accessing treatment during 1996–2000. There were parenthood data on 221,000 (71%) of whom 95,000 (43%) had dependent children, including 53% of the women and 40% of the men.

2. Of those with dependent children, 69% were fathers and 31% were mothers, both with an average of just over two children each. **This represents just under one dependent child (under 16 years) for every problem drug user accessing treatment.**

3. The annual number of both parents and non-parents using services more than doubled in the study period.

4. The proportion of service users with dependent children increased from 39% to 45% over the five-year period.

5. Only 46% had their children living with them; 54% had children living elsewhere (usually with other family members or friends) including 9% whose children were in care. The proportion of parents not living with their children increased from 51% in 1996 to 57% in 2000.

6. Mothers were far more likely (64%) than fathers (37%) to live with their children.

7. Seventeen per cent of all the 15–19-year-olds and 22% of the female 15–19-year-olds had dependent children.

Relationships between parenthood and risk factors

8. Non-parents and parents living with their children had on average a lower number of risk factors than parents whose children lived elsewhere. Parents living with their children were the least likely to be sharing injecting equipment, to be using stimulants regularly or to have unstable accommodation. However, many still had multiple problems.

9. The likelihood that parents would be living with their children steadily diminished as the number of risk indicators increased. Of those with no risk factors, 65% lived with their children, compared with 28% with three risk factors and only 9% with six or more.

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

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

Estimates of numbers of children of problem drug users in Scotland

11. Combining data from three separate data sources, we estimate there are 41,000–59,000 children of problem drug users in Scotland. **This represents 4–6% of all children under 16.**

12. There are an estimated 10,000–19,000 children in Scotland *living* with a problem drug-using parent.

Aims of the chapter

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

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

Sources of data

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

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

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

England and Wales

1.5 The full data set for the five years 1996–2000 was obtained from 11 of the 12 regional database centres in England and Wales. Data from the South West of England were not available due to technical problems. The figures presented here are likely to be a 11% underestimate, as this is the average proportion of records contributed by the South West database over the five-year period. To avoid double counting, only one presentation by each individual in any one year was included. Individuals starting treatment episodes in different years were included in each year (18% of users were represented in subsequent years) for the analysis of trends and in order to reflect changes in personal circumstances, especially with regard to children. Analyses were re-run excluding repeaters to ensure that exclusion of double counting between years would not have yielded different findings.

Dependent children

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

Missing data

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

Sample description

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

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

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

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

1.11 Parents and non-parents did not differ much in their social profiles (Table1.3). Both groups were overwhelmingly white. A larger proportion of parents lived in private or council rented accommodation (70% vs 56%), whereas non-parents were more likely to own their home (23% vs 16%). Non-parents were also slightly more likely to live in unstable or other accommodation.

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

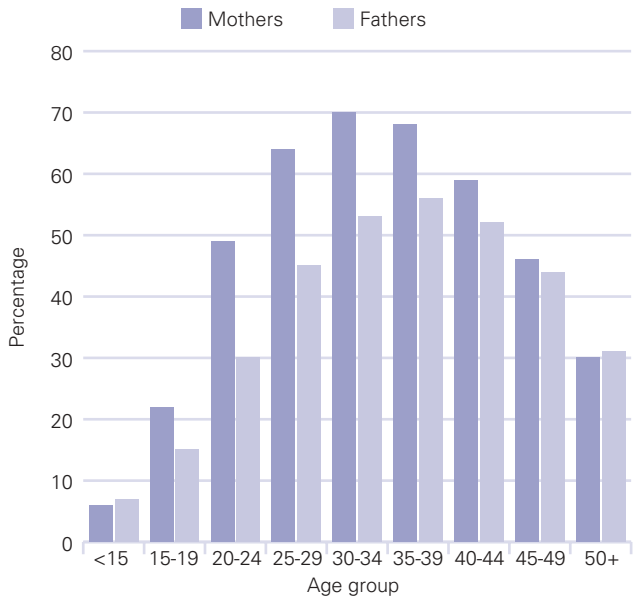

Table 1.1: Number and percentage of problem drug-using parents

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

Table 1.2: Parenthood by gender

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

Table 1.3: Client profile

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

Where the children live

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

Risk profile

1.13 Following a review of the literature, a risk profile was created using eight possible risk indicators recorded in the database. Four drug-related risk factors were chosen as indicators of severe and potentially chaotic drug use and four social risk factors as indicators of potential social insecurity.

Drug use risk factors:

a) daily heroin use

b) daily alcohol use with the use of illicit drugs

c) regular stimulant use

d) sharing of injecting equipment.

Social risk factors:

a) unstable accommodation

b) living alone or with strangers

c) living with another drug user

d) criminal justice involvement.

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

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

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

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

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

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

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

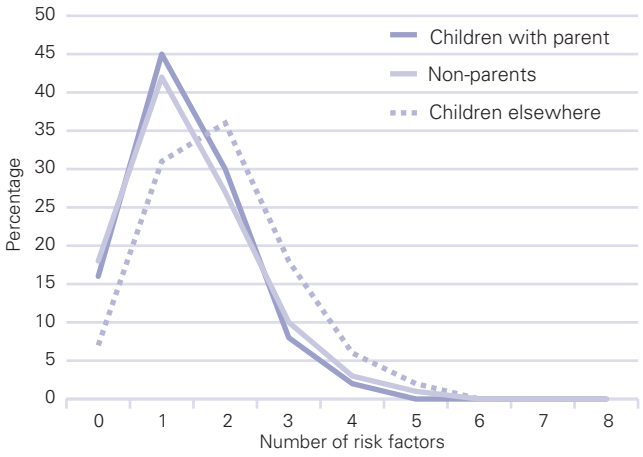

Figure 1.3: Proportion of parents living with their children according to number of risk factors present

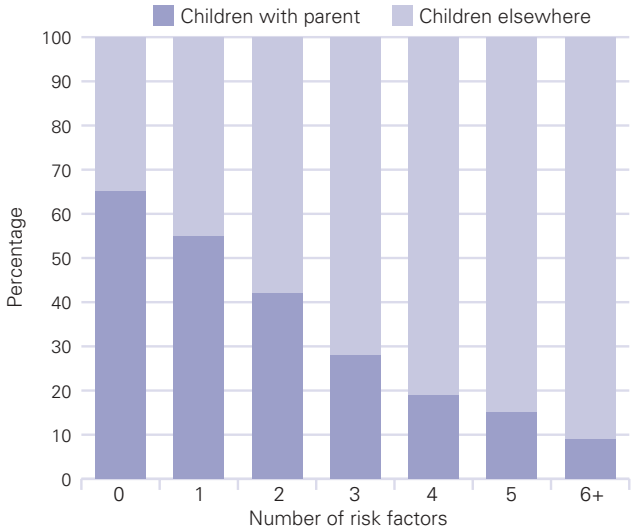

Figure 1.4: Parenthood and individual risk factors

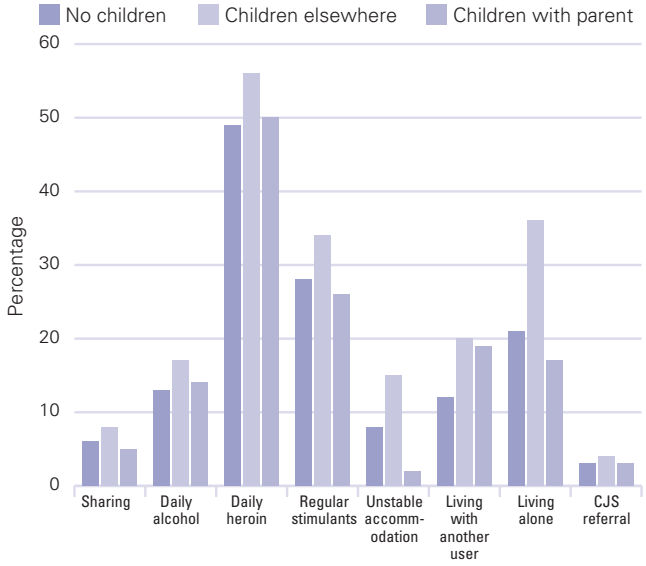

Table 1.5: Trends in prevalence of risk factors

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

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

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

Estimating the numbers of children affected by parental problem drug use[1]

England and Wales

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

The five-year estimate

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

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

The one-year census estimate

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

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

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

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

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

Scotland

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

The prevalence study

1.26 The prevalence study applied capture-recapture methods to provide prevalence estimates for problem drug use in Scotland in 2000. Problem drug use was defined as the use of opiates and benzodiazepines. The study used data on problem drug users from the following sources: SDMD (data on new attenders at drug agencies and new treatment episodes with general practitioners), the police (Misuse of Drugs Act) and Social Enquiry Reports.

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

Drug Outcome Research in Scotland

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

Scottish Drug Misuse Database

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

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

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

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

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

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

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

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

1.35 The available data do not permit the calculation of a single estimate of the number of children of problem drug users. This is because *both* parents of an unknown number of children will be problem drug users. Simply adding the two estimates in the above paragraph will result in an unknown amount of double counting. **We therefore conclude that between 40,800 and 58,700 children in Scotland have a parent who is a problem drug user.** The minimum estimate would arise if all drug-using mothers were joint parents with a drug-using father, and the maximum if all drug-using mothers and all drug-using fathers were joint parents with non-drug users. **Based on population estimates for 2000, this represents about 4–6% of the 1 million children under 16 in Scotland.**

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

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

Discussion

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

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

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

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

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

Recommendations

1. All drug treatment agencies should record an agreed minimum consistent set of data about the children of clients presenting to them.

2. Whether a client or patient has dependent children and where they are living should be included as standard elements in the National Drug Misuse Treatment System in England and Wales and in the Drug Misuse Databases in Scotland and Northern Ireland and should be recorded in the same way to allow comparisons between regions.

Other recommendations about research follow Chapter 2.

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Chapter 2

The impact of parental problem drug use on children

Chapter 2 The impact of parental problem drug use on children

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

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

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

Growth and development

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

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

Table 2.1 Common features of problem drug use

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

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

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

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

Legal
Arrest and imprisonment
Outstanding warrants and fines
Probationary orders

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

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

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

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

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

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

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

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

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

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

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

Conception to birth

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

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

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

Heroin and other opiates

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

Cocaine and amphetamines

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

Benzodiazepines

2.14 Most of the published research on drug-exposed babies is from the United States where benzodiazepine misuse is uncommon. There is thus little evidence to indicate whether or not there are long-term consequences from fetal exposure to high doses of benzodiazepines. There is some evidence from animal experiments that fetal exposure to benzodiazepines may have a pronounced effect on subsequent adult responses to stressful stimuli[10]. Neonatal abstinence syndrome is considered in 2.31.

Tobacco and cannabis

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

Alcohol

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

Blood-borne viruses

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

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

Maternal nutrition and general health

2.19 Poor maternal nutrition may have significant long-term consequences for the health of the unborn child. Over the past decade, evidence has mounted that a mother's general health and nutritional status during pregnancy have a profound effect on the susceptibility of the child to a wide range of diseases in later life, often decades later[20]. Specifically, a maternal diet that is low in green vegetables may result in folate deficiency, increasing the risk of neural tube defects in the baby. Problem drug use is often associated with poor diet, typically high in sugar and low in high-quality protein, fruit and vegetables[21]. Whilst there appear to have been no published studies of the diet of pregnant problem drug users, it is reasonable to assume that in many cases their diet and nutritional status are sub-optimal.

Violence

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

Antenatal care

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

Conclusions

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

From birth onwards

2.23 Table 2.2 summarises the main features of normal growth and development from birth to adolescence across four key dimensions. It emphasises the multi-faceted nature of growing up and in particular the importance of regularity and consistency. Table 2.3 highlights some of the ways in which parental drug use can interfere with the child's development in these domains, either directly or indirectly. It can be seen that its impact is potentially global and can affect every aspect of the child's upbringing. How an individual child is affected will of course vary enormously, depending on numerous factors. The following sections summarise the research and experiential evidence available to the Inquiry – both of the damage that may be caused and of the factors that may help to limit this. Chapter 3 will describe some aspects of parental drug use from the perspective of the children themselves. Chapters 4 and 5 will provide evidence of the large number of children that social work services across the UK are encountering, where parental drug use is a major contributory factor to abuse or neglect.

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

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

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

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

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

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

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

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

Similarities to impact of mental health and alcohol problems

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

Separation and death

2.25 As shown in Chapter 1, many children of problem drug users are not living with their biological parents. The separation can take place at birth or at some time thereafter and may be temporary or permanent. The impact on the child of serious chronic parental illness such as HIV or hepatitis B or C, or admission to hospital for overdose or other drug use-related emergencies, may also be considerable. Imprisonment or treatment at a residential rehabilitation centre are other common causes for enforced separation. A high proportion of chaotic female drug users may quickly lose custody of their child. For example, during the past decade around 30 female problem drug users gave birth annually at the University College Hospital in London. Many were heavy users of opiates, cocaine and alcohol. On average, around seven mothers did not go home with their child and a further eight or nine no longer had their child by the end of their first year[24]. A study of the lifetime experiences of 188 children raised by 70 methadone-maintained parents in the US indicated high levels of lifetime separation. In all, 4% of the children were placed in adoptive care, 9% had been in foster care and 1% had been placed in a residential care unit at some point in their lives[25]. The children spent significant periods of time being cared for by people other than their mothers. Mostly they were with relatives (43%) or their other parent (36%). However, 7% reported that their children were cared for by friends, 6% reported that they were left with no one and 4% did not know who watched their children when they were absent. Among 171 women attending services for problem drug users in Glasgow, all of whom had had at least one child, only 35% were still living with their child[11]. The annual death rate among problem drug users is around 1–2% – mainly due to overdose, accidental or non-accidental injury, or, in some parts of the country, HIV infection[26]. Losing a parent through separation or death is therefore a much more common experience for the children of problem drug users than for other children.

Teenage pregnancy

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

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

Resilience factors

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

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

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

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

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

Birth to two years

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

Neonatal abstinence syndrome

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

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

Other physical health problems

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

Neglect and abuse

2.33 Problem drug use can contribute to neglect and/or physical, psychological or sexual abuse of children from the earliest age[38, 39]. Drug dependency is a chronic relapsing condition, typically marked by dramatic swings between relative stability and chaos. During times of chaos, children become especially vulnerable, as meeting their physical, social and emotional needs conflicts with the parent's need to meet the demands of their drug habit[40]. Specific examples of how the child may be affected are many: when intoxicated, parents may fail to hear their child's cries or notice it is unwell; they may accidentally smother it when unconscious due to drugs; they may leave the child unattended when seeking money or drugs; they may provide it with inadequate food, warmth or clothing due to insufficient resources or inclination. As the infant becomes more mobile and inquisitive, so the risk of accidents increases (see Box 2.1). Chapter 5 includes data from recent case reviews in London and Scotland showing that parental problem drug use is one of the most frequent causes of child abuse and neglect.

Box 2.1: Fatal consequences of neglect

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

Developmental problems

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

Parenting skills and styles

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

Resilience factors

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

3–4 years

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

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

5–9 years

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

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

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

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

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

10–14 years

2.43 Interviews with the children of drug users indicate that children's understanding of their parents' drug problems typically falls into place around the age of 10–12 (see Chapter 3). Children at this age may be cautious about exposing family life to outside scrutiny and therefore friendships may be restricted and social isolation severe. Those children who have taken a role as a carer may feel stigmatised and undervalued. If parental drug use diverts money away from household items such as clothes, adolescents may find it difficult to keep up appearances and friendships may be further jeopardised. Due to parental emotional unavailability, the children of problem drug users are more likely to be left to cope alone with the physical changes of puberty. The persistent impact of parental problems leads to a higher likelihood of emotional disturbance and behavioural disorders including bullying and offending[25]. Due to poor parental supervision and role modelling and low self-esteem, there is a high risk of experimentation with smoking, drinking and drugs. Substance misuse at an early age is strongly associated with both parental drug use and associating with a delinquent or drug-using subculture[50]. Taking the same road to problem drug use as their parents is thus a real possibility, completing a tragic inheritance of wasted potential.

2.44 Educational under-performance remains likely, due to poor school attendance, home preparation and concentration at school. Kolar and colleagues[25] found 41% of problem drug-using parents had a child who had repeated a year at school, 19% who had truanted and 30% who had been suspended from school at an average age of 12 years. Sowder and Burt51 reported similar problems as well as lower IQ scores and perceptual motor performance than control children from the same neighbourhood.

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

15 and over

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

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

Children who no longer live with their parents

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

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

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

Weighing the research evidence

2.51 To anyone familiar with the hundreds of studies of problem drug users that have been conducted in the UK, it comes as a shock to discover that virtually none has focused on their children. We believe this is both due to a lack of awareness of the problem by researchers and policy makers and because carrying out research on the children of problem drug users is extremely difficult. The few published studies that exist are mainly from the United States, where patterns of drug use and the social context may be very different from the UK. For example, the prevalence of cocaine use may be higher and the ethnic mix different. Not all the findings may therefore be relevant to the UK. They also only give a very partial view of reality. Most feature parents (usually mothers) in a treatment programme who have agreed to be interviewed. Consequently, they are unlikely to involve the most chaotic and non-compliant parents whose children may be more at risk. In addition, the capacity of the studies to reveal exactly what is happening to the child is very limited. Most are largely dependent upon the parents' versions of events, backed up by assessment and examination of the children, usually at one point in time or over a short period. The opportunity to observe what goes on at home day after day and week after week is not available. Because a child's development depends so much on what occurs over months and years in the home situation, these are serious shortcomings. Furthermore, the majority of the studies focus on pregnancy and the early stages of childhood and on those children who continue to stay with at least one parent. There is precious little about older children or those who no longer live with one or both biological parents. Attention has also tended to focus on mothers who misuse drugs and there has been virtually no research on the role of fathers who misuse drugs[54].

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

Recommendations

3. Problem drug or alcohol use by pregnant women should be routinely recorded at the antenatal clinic and these data linked to those on stillbirths, congenital abnormalities in the newborn, and subsequent developmental abnormalities in the child. This would enable epidemiological studies to be carried out to establish relationships between maternal problem drug use and congenital and developmental abnormalities in the child.

4. Studies should be urgently carried out to assess the true incidence of transmission of hepatitis C between infected female drug users and their babies during pregnancy, birth and infancy.

5. A programme of research should be developed in the UK to examine the impact of parental problem drug use on children at all life stages from birth to adolescence. It should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere and the evaluation of interventions aimed at improving their health and well-being in both the short and the long term.

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Chapter 3

The voices of children and their parents

Chapter 3 The voices of children and their parents

Introduction

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

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

Disrupted households

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

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

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

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

3.5 This now recovering parent powerfully conveyed the predominance of drugs in her and her son's life at that time[3].

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

3.6 This mother in a study of drug-using parents in Dublin[4] noted the financial drain that drugs were prior to her stabilising on methadone:

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

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

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

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

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

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

Exposure to parental drug use

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

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

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

3.10 The children and young people interviewed in the Glasgow study indicated that they had known about their parents drug problem long before their parents thought they did[1].

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

Exposure to criminality

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

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

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

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

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

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

Education

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

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

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

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

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

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

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

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

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

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

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

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

Young carers

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

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

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

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

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

Being there

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

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

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

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

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

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

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

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

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

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

Living with stigma and fear

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

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

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

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

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

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

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

Conclusion

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

Recommendations

6. The voices of the children of problem drug users should be heard and listened to.

7. Work is required to develop means of enabling the children of problem drug users safely to express their thoughts and feelings about their circumstances.

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