



# The impact of parental substance misuse on child development

**They do love you but they *have* to put that (drugs) first ... it's an illness really ... it's number one, the drug is – definitely. That's something I've definitely had to accept to understand anything. However badly you want yourself to be number one to them, it'll never happen.**

Young person, aged 20 (Kroll and Taylor, 2008)

**Sometimes she's a parent, but then sometimes when she needs to do what she has to do, she's not there.**

Young person, aged 17 (Houmoller et al, 2011)

## Key messages from research

The main impact of parental substance misuse (PSM) on child development can be summarised as follows:

- > In utero exposure to drugs and alcohol may affect bonding, health and development (short and long term).
- > PSM adversely affects attachment, family dynamics and relationships.
- > PSM significantly increases the risk of physical and emotional neglect.
- > PSM is implicated in behavioural and mental health problems in children and young people.
- > PSM often undermines school performance and academic attainment.
- > PSM can erode self-esteem, self-worth and confidence.
- > PSM reduces levels of safety and oversight – inside and outside the home.
- > PSM can provide a problematic model for problem-solving.
- > There are a range of protective factors that can promote resilience and reduce risk.

## Introduction

**This briefing examines the degree to which PSM can affect children's physical and emotional welfare at a range of levels. Whilst there is no suggestion that all children of parents who misuse substances are automatically going to experience developmental problems, this type of behaviour can affect the extent to which children's needs, across the developmental domain, are met.**

While it is important not to pathologise or label children it is equally important to identify those who are at risk and need help and support (Cleaver et al, 2011). It is important to note that this is a complex area of practice and this briefing can only provide an overview. It is designed to be used alongside judgement, consultation with other professionals, supervision and training.

It is estimated that two million children and young people in the UK are affected by PSM (Manning et al, 2009). Manning et al offer a more detailed picture of the types of parental drinking and the relevant estimated numbers of parents in each category. They estimate that there are around 300,000 children living with a 'harmful' drinking parent, where alcohol misuse is defined as having consequences for parental physical and mental health, but with much higher figures for 'binge' or 'hazardous' drinking patterns.

Forrester (2012) suggests that one million children reside with a parent with an 'alcohol problem'. Estimates for drug misusing parents indicate that 335,000 children live in the UK with a drug dependent parent (Manning et al, 2009).

Figures linking PSM to child protection intervention vary from between 20 per cent where there was a referral to children's services to 60 per cent at the child protection stage (Cleaver et al, 2011). Forrester's (2000) sample of 50 families found that 52 per cent of these were on the CP register due to PSM. Devaney's (2008) study of child protection reports in Northern Ireland found that substance misuse by at least one adult was the primary factor in registration. Brandon et al's (2012) review for 2009-2011 found that substance misuse was mentioned in 42 per cent of families in serious case reviews involving a child's death or serious injury.

For the purpose of this briefing 'misuse' is defined as use that leads to harm (social, physical and psychological) both to the user and others in their orbit (Scoda, 1997). Such problematic or harmful behaviour does not necessarily imply (or rely on) addiction or dependence, although it may well do so (Forrester and Harwin, 2011). At the same time it is important to distinguish between different levels for both drug and alcohol use and their respective impacts (for example Forrester, 2012).

It is well established that PSM is a significant feature of social welfare professionals' caseloads – with neglect and emotional and physical abuse the most common concerns for children who are subject to child protection plans. It is also one of the 'toxic trio', often co-existing with domestic violence and mental health problems (Forrester and Harwin, 2011; Brandon et al, 2010).

Cleaver et al (2011) talk about the 'multiplicative' impact of combined factors which significantly increase the risk of harm to children and Brandon et al (2012) observe that, in serious case reviews, '...it is more common for these features to exist in combination than singly'. Research by Nair et al (1997; 2003) also suggests that there are specific risk factors that can work together with particularly deleterious consequences and that 'disruption in care was highest when mothers were young, there were other children in foster care, heroin use was frequent and mothers reported depressive symptoms' (Nair et al, 1997).

PSM also has a significant impact on the wider family/kinship network and is linked to other social problems; notably criminal activities, poverty and social exclusion. The link between substance misuse and negative outcomes is complicated by various psycho-social factors resulting in a 'web of disadvantage' which can be difficult to unpick (Forrester and Harwin, 2006; Velleman and Orford, 2001; Kroll and Taylor, 2003).

The substance use may have an impact on adult behaviour in general, on parenting in particular and on parent/child interaction. Whether one or both parents or carers are using/drinking will also be a significant factor. The effects on children will depend on their characteristics, personalities,

coping mechanisms and outside support systems. Family functioning and environmental factors will also be significant.

The effects on children of any type of behaviour to which they are exposed will be influenced by their chronological age, stage of development, degree of vulnerability or resilience and the risks that may be involved. What needs to be borne in mind are the protective factors in the individual, the family and the community, as well as robust professional support, that might sustain and support children and offset negative consequences posed by these risks. These are outlined at the end of this briefing.

This frontline briefing begins with a consideration of the impact of substance misuse on the unborn child. The seven dimensions of the child development domain in 'The Framework for the Assessment of Children in Need and their Families' (Department of Health, 2000) will then be considered in relation to the possible impact upon them of parental substance misuse.

## The impact of substance misuse on the unborn child

There is considerable research to suggest that alcohol and drug use, depending on its frequency and severity, can have an adverse impact on the health and development of the growing baby – who is most vulnerable in the first twelve weeks of pregnancy (Cleaver et al, 2011; Forrester, 2012; Hepburn, 2007). The type of substance, the stage of pregnancy, the way the substance is used or taken, the extent of the substance use and its duration, both over time and in terms of intensity, are all significant.

Risks common to both drug and alcohol misuse include increased risk of miscarriage, likelihood of premature birth, reduced birth weight, smaller head circumference at birth and an increased risk of cot death (Forrester, 2012). Although it is generally agreed that the more alcohol that is consumed the greater the impact on the unborn child, even this has to be qualified to some degree. Regular moderate use of substances is often less harmful than 'bingeing', as the sudden arrival of the substance in the baby's system followed by

the subsequent withdrawal can place him/her at more risk (Ford and Hepburn, 1997; Hepburn, 2007).

Many people who use misuse drugs and/or alcohol may also be involved in a range of other risky behaviours that may place them and their unborn babies in jeopardy. Smoking cannabis, often ignored if other drugs seen as more dangerous are also used, inevitably involves nicotine, itself a high risk drug in pregnancy – particularly as 'spliffs' or joints are generally not filtered, increasing the nicotine's toxicity (Forrester, 2012). The combination of substances, together with the mother's diet, engagement with ante-natal services and general health can therefore be a critical factor in foetal health and either mitigate or complicate the potential harm that can be caused.

## Specific risks and conditions associated with PSM

The main issues to consider are:

Illegal drug use in pregnancy

- > Neonatal Abstinence Syndrome
- > HIV and Hepatitis

Alcohol use in pregnancy

- > Foetal Alcohol Spectrum Disorders (FASD) and Foetal Alcohol Syndrome (FAS)

### Neonatal Abstinence Syndrome (NAS)

This term refers to the effects of drug withdrawal symptoms on babies exposed to substances in utero (Rayns et al, 2011).

Babies born physically dependent on opiates such as heroin develop symptoms between one and three days after birth, although this can sometimes be delayed. Symptomology is related to drug type and degree of exposure, with poly drug use altering the pattern of withdrawal (Johnson et al, 2003).

Treatment includes aiding withdrawal and specialised feeding. Short term effects include withdrawal symptoms, irritability, gastrointestinal problems and poor weight gain (Drugscope, 2005).

Research in relation to long term developmental outcomes is inconclusive, with little evidence that

NAS is associated with long term conditions apart from a possible link with some problems of vision (Hunt, 2008; Forrester, 2012) and mild cognitive problems in pre-school children (Johnson et al, 2003). Good post-natal provision can help regain weight deficiency and increase the probability that developmental milestones are met (Cleaver et al, 2011).

In relation to cocaine exposure there is some evidence linking it to enduring problems in attention and concentration, although the role of environmental enrichment plays a critical role in reducing these (Rayns et al, 2011).

Sudden infant death syndrome is between five and ten times more likely to occur in babies who have been exposed to cocaine and is also seen to increase the risk of premature birth or miscarriage due to restriction of the blood flow to the placenta. These babies may have many of the symptoms associated with NAS as a result of this restriction rather than actual withdrawal. In utero exposure to opiates, particularly methadone, increases this risk (Johnson et al, 2003).

### HIV and Hepatitis

HIV and Hepatitis B and C are all risks associated with the use of contaminated drug paraphernalia. In relation to HIV, which can be transmitted during pregnancy, delivery or breastfeeding, risks can be significantly prevented or reduced by drug treatment and/or caesarean section (Forrester, 2012; Cleaver et al, 2011).

In relation to Hepatitis B, whilst it is rare for it to cross the placenta, risk of transmission at delivery is between 20 per cent and 90 per cent, although immunisation is effective (Forrester, 2012). In relation to Hepatitis C (where figures suggest almost 50 per cent of drug users are affected) infection from the mother is also rare, at about four per cent, although multiple virus infection increases this risk (Cleaver et al, 2011).

### Foetal Alcohol Spectrum Disorders and Foetal Alcohol Syndrome

Alcohol is potentially the most harmful substance in terms of children's development as it affects

brain development at a critical time in the evolving foetal central nervous system (Forrester, 2012; Rayns et al, 2013). This potentially leads to three broad categories of symptoms – deficient growth or height, distinctive facial or physical characteristics and dysfunction of the central nervous system – potentially resulting in a range of biological, cognitive and behavioural difficulties (Cleaver et al, 2011).

There is a range of potentially adverse effects resulting from pre-natal exposure to alcohol. These include different types of physical, behavioural and intellectual abnormalities or difficulties. The term used to encompass these effects is 'Foetal Alcohol Spectrum Disorder' (FASD). Diagnosis enables a child to be assigned to one set of FASD categories (Horgan et al, 2011). These include Foetal Alcohol Syndrome (FAS), seen to be the most severe condition (Rayns et al, 2011). This is a complicated and evolving area of knowledge and both diagnosis and treatment can be difficult to establish. This emphasises the importance of seeking expert opinion from specialist midwives, health visitors and doctors and of effective inter-agency collaboration and protocols at an early stage (for example Kroll and Taylor, 2010). Forrester's concise (2011) text offers a very helpful chapter on this topic.

### The impact of PSM on health

**Babies born with withdrawal symptoms – high pitched crying, disturbed sleep patterns, breathing problems, feeding problems, vomiting and diarrhoea – can be hard to care for, with implications for bonding and attachment. Problems that flow from this may also predispose children to maltreatment (Kroll and Taylor, 2003). Children's health may be placed at risk if their environment is unsafe in some way – for example syringes, pills or bottles are too accessible. Accidental ingestion of methadone or other drugs is extremely dangerous (sometimes fatal) and some parents may give drugs to children to quieten them (Cleaver et al, 2011). Methadone may be kept in reach of children and is particularly tempting to try due to its attractive colour.**

Being left alone or unsupervised while parents are intoxicated or under the influence of drugs potentially places children at risk and, when a

parent's need for the substance becomes the primary focus, children may be left with unsuitable carers while drugs or alcohol are obtained (Barnard, 2007; Kroll and Taylor, 2008).

Fear of official intervention and discovery of the substance misuse if, for example, the child is unwell and medical attention is sought, might also constitute a factor in child health and may make parents less assiduous in following any medical advice given (Cleaver et al, 2011). Parents may neglect their own and their children's physical care, and levels of hygiene and cleanliness may suffer. Routine health checks may be missed.

If family resources are stretched due to drink or drug misuse, health may be further undermined by poverty.

Children may exhibit a range of psychosomatic responses to the anxieties of living with substance misusing parents – including stomach aches, headaches, bed wetting and sleep problems. Parents' capacity to anticipate the particular dangers presented by inquisitive children requiring especial vigilance may be blunted (Barnard, 2007). There are likely to be particular problems where children have special needs (Taylor, 2008).

Physical and mental health needs may not get picked up and young people going through puberty and adolescence may lack the support and understanding that they may require to cope with the physical and emotional changes they are experiencing, placing them at increased risk on a number of fronts.

Since substance misuse can sometimes be accompanied by violence in the home, the physical risks to children and young people may increase, especially during mid to late adolescence – when they might engage with or challenge parents' behaviour, express views, complain or become involved in parental quarrels (Onyskiw, 2003).

The fear of constant arguments, actual physical violence or the threat of it, either to a parent (usually the mother) or to themselves, or at times fear of sexual abuse may also undermine well-being and health (Taylor and Kroll, 2003). Children may also fear for their own safety, particularly if a non-drinking/using parent is unable to offer protection

and if the substance misusing parent prone to violence is left in sole charge of the children (Cleaver et al, 2011).

## The impact of PSM on education and cognitive ability

**The major impact here relates to the level of stimulation offered to the developing child and the impact on concentration and attainment.**

Children of parents with chronic substance problems are likely to have more problems at school in terms of learning difficulties, reading problems, poor concentration and generally low performance, linked with limited parental involvement (Velleman and Orford, 2001; Cleaver et al, 2011).

Substance misusing mothers have been shown to be less responsive to the child's signals, less willing to involve themselves in the meaningful play that is so crucial to educational and cognitive development in babies and be potentially more likely to respond in a manner that is curt rather than facilitative (Bays, 1990; Kandel, 1990).

This lack of attentiveness may result from parents' pre-occupations with their own anxieties or feelings, or the impact of drugs or withdrawal from drugs, causing hyperactivity or impatience:

*You want people to hurry up ... kids can't and you can't be bothered sitting down and talking to them like you are supposed to.*

(Klee et al, 1998)

This can result in what Cleaver et al (2011) term 'difficult cycles of relating' and longer term conflictual interactions between children and parents.

Inconsistency, neglect and an impoverished environment are also key considerations in terms of stimulation, as is a chaotic lifestyle and the capacity to respond appropriately in order to stimulate the developing child. The motivation and energy to deal with the demands and challenges of an inquisitive and alert child can be adversely affected by the stresses and structural pressures that either precipitate substance misuse or are the result of it (Klee et al, 1998; Harbin and Murphy, 2000).

Maintaining contact with schools and teachers and following through with strategies to assist with attendance, completion of and involvement in homework and boundary setting for behaviour may also be compromised and children may lack an appropriately assertive champion to enable them to battle with the education system (Cleaver et al, 2007). Shame, embarrassment and the stigma attached to substance misuse may also cause children to worry about their parents being seen by teachers as well as by their peers. Schooling may be derailed by numerous moves of house, influenced by problematic changes in circumstances related to substance misuse.

Children are more likely to have problems at school such as learning difficulties, disruptive behaviour, interpersonal problems and higher rates of absenteeism, with a significant proportion experiencing serious academic difficulties (Covell and Howe, 2009; Hogan and Higgins, 2001). Whether this is due to the earlier impact of in utero exposure or the emotional effects of parents' behaviour and the impact on the family is hard to establish (Alison, 2000). Stress and/or distraction about what might be occurring at home may take its toll, as this quote illustrates:

*He has poor concentration, and does not have many friends at school. He is very agitated in class and cannot sit still: he cannot concentrate and is constantly talking.*

Teacher speaking about a pupil (Taylor, 2008)

Children may experience mockery and bullying, resulting in truancy, or indeed become bullies themselves, as a defence (Taylor, 2008; Kroll and Taylor, 2008). The obvious implications for educational attainment and the acquisition of qualifications may have consequences for long term life chances (Lakey, 2001). Young people may start missing school in order to care for a parent who may be unwell, look after younger brothers or sisters, and protect family members from the violent consequences of substance misuse or monitor drinking or drug taking.

For many children, however, school can act as a safe haven, where they can develop away from problems at home :

*Even though I was having problems at home I didn't let it show in school. I'd still come in and do my work and act like a normal kid ... I didn't say anything.*

Young person, aged 18 (Houmoller et al, 2011)

## The impact of PSM on emotional and behavioural development

**Parents' preoccupation with the substance, to the exclusion of other priorities, will have a range of consequences for children's sense of emotional security. An unavailable, preoccupied or emotionally, psychologically and physically detached parent will find it difficult to keep children in mind or put them first. Changes in mood and behaviour, together with inconsistent responses and lack of empathy, will make life uncertain and anxiety-provoking at the very least (Egeland, 2009; Cleaver et al, 2011).**

There are obvious implications for attachment since, if your primary attachment is to a substance, this will affect your capacity to attach to others (Kroll and Taylor, 2003) and PSM has been linked to the development of insecure, disorganised attachment patterns (Howe, 2005). As the quote at the beginning of the briefing makes clear, the main impact on children is a strong sense of not coming first, as well as feeling unloved and unwanted.

Children of alcohol misusing parents can suffer higher rates of separation from, and loss of, parents due to imprisonment, hospitalisation, random absences and the child's removal from home for various reasons (Robinson and Rhoden, 1998). A similar picture emerges from some studies of children of drug misusing parents (Hogan, 1997; Barnard, 2007) further compounded by children's awareness that drugs can cause death (Barnard and Barlow, 2003).

When parents' behaviour is unusual, inconsistent, worrying or frightening, small children find it hard to put their fears and anxieties into words and these therefore manifest themselves in ways akin to the signs of post traumatic stress disorder such as rocking, problems with sleeping and bed wetting (Juliana and Goodman, 1997). Lack of routines can increase distress and uncertainty:



*...there was no continuity in my parenting if you like ... I couldn't remember anything that I'd said to them. So they would say 'you said I could yesterday' and I wouldn't remember ... so I told them off for coming home late or not doing something ... I couldn't parent.*

Parent (Holland et al, 2013)

When children view their parents as untrustworthy or powerless they may react by either withdrawing or trying to please (Cleaver et al, 2011). Children can also lose all respect for parents whose behaviour is embarrassing, or by alcohol induced displays of maudlin affection (Laybourn et al, 1996). Children may become clingy, withdrawn and unnaturally quiet. Alternatively, children may react by developing conduct disorders and behaviour that is out of control (Cleaver et al, 1999; Brooks and Rice, 1997). The desire to retreat is strong and escape into fantasy and make believe is not uncommon (Kroll and Taylor, 2008). Children encountering adults exhibiting disturbing behaviour are likely to experience anxiety.

Research suggests that children of parents who misuse substances show higher levels of aggressive, non-compliant, disruptive or anti-social behaviour – although this is generally linked to a combination of parental problems rather than substance misuse alone (Cleaver et al, 2011).

Girls and boys generally react differently to parental problems, with boys externalising and girls internalising their distress. In relation to parental drinking problems, however, *both* boys and girls tend to react by acting out – an interesting departure from the norm (Velleman and Orford, 2001). In Kroll and Taylor's sample, both boys and girls had problems with anger linked to managing the strong feelings engendered by parents' drug using behaviour:

*...when I get angry I have the ability to do things to people. I'm scared of one day what I might do to someone and that's all from seeing things from being around my parents.*

13-year-old (Kroll and Taylor, 2008)

Emotional and behavioural development can be significantly affected by the pressure to grow up fast and take on adult responsibilities. As a consequence, bits of childhood can be lost. It is

by no means the case that all children with a substance-misusing parent become carers – often there is another parent who is substance free or other people in the social network that can help. However, when caring responsibilities do fall to a young person, this can often cause conflict or the child may assume adult roles too soon – with consequences for normal childhood activities, roles and development:

*I feel that I have got a lot of responsibility ... 'cos ... it was always me that coped with everything and looked after three children ... It's kinda like I had to turn into a mother ... often I have to drop plans.*

21-year-old, looking back at her childhood (Taylor, 2008)

Young people are often torn between their desire to care and the fact that their own needs may be subjugated to those of the parent and are therefore not being met. This can lead to feelings of guilt and resentment. By the same token, the concerns for the parent may become so all-consuming that the young people deny that they have any needs or feelings, so that this conflict can be avoided (Aldridge and Becker, 1993).

Young adults may continue to feel that they are in some way to blame for their parents' difficulties and feel responsible for what has happened. Feelings of worthlessness, powerlessness and a sense of despair and hopelessness about the future can lead to emotional problems, increased risk of suicidal behaviour and vulnerability to peer group pressure and anti-social acts (Cleaver et al, 2011). However, both self harm and the risk of conduct disorders are far more strongly correlated with an array of co-existing parental problems and can be mitigated by factors that foster resilience (Velleman and Orford, 2001).

Children in the same family can also react very differently to the same set of circumstances:

*We all coped differently ... I coped by believing everything my mother said was right ... my dad was bad. My brother coped by rebelling but he might have rebelled anyway ... My sister just kept herself to herself and studied incessantly.*

Young adult (Laybourn et al, 1996; Cleaver et al, 2011)

## The impact of PSM on identity and social presentation

*Drugs came first! You chose drugs over me!*

Child respondent (Kroll and Taylor, 2008)

If, as already indicated, parents are unavailable to provide positive reinforcement of who and what you are, celebrate your skills and express confidence in your potential, or are inconsistent in their responses, it is easy for children to feel rejected, uncertain and undermined. The child who may, in fact, be loved but has a parent or parents unable to show it may come to see her/himself as unlovable with obvious implications for his/her internal working model (Howe et al, 1999). As we have already seen, some children can also experience guilt that they are in some way to blame and that they must be responsible in some way for their parents' behaviour.

Others, however, see the drinking problem like an illness rather than connected with the way they behave – making it easier to cope with the consequences, including parents' inability to change (Laybourn et al, 1996; Bancroft, 2004; Gorin, 2004). Children also try different coping responses at different ages, for example 'emotion' focused approaches replacing 'problem' solving strategies that had not altered problem drinking (Laybourn, 1996). Much depends on the parents' capacity to provide reassurance that the substance problem was about them and not about the child.

In the process of constructing a clear identity a perennial concern for young people is that they will turn out like the parent who has the problem (ChildLine, 1997; Laybourn et al, 1996). The link between PSM and childhood transmission is complex and most offspring do not become problem drinkers or drug users (Velleman, 1993; Cleaver, 2011). However, there is research evidence to suggest that parental dependence does increase the likelihood of offspring use, as it increases susceptibility to peer influences (Li et al, 2002).

Some children view their parents' substance use as a deterrent:

*I don't want to turn out that way ...  
I'm not following what my mum done.*

14-year-old (Kroll and Taylor, 2008)

Some children express fears about 'catching' drug or alcohol misuse from their parents. For other children and young people, however, their use appears to be a way of connecting with an emotionally absent parent, inhabiting the same space and thereby achieving some kind of closeness and identification (Kroll and Taylor, 2008). For others, still, of course, this type of parental behaviour provides a problematic model for problem-solving, with research suggesting children develop a similar coping strategy as that of their parents to deal with difficult feelings or problems (Sheehan et al, 1988).

Parents' substance related behaviour – or fear of it – will cause shame and embarrassment as children's desire to be ordinary and like everyone else is strong. This will also lead to fears that they too will be seen in a negative light:

*There goes the junkie's kid – bet she'll turn out just the same.*

Child (Kroll and Taylor, 2008)

## The impact of PSM on family and social relationships

*I want to be able to be like a normal mother and be able to get her ready in the morning ... instead of getting up and thinking 'oh no, where am I going to get the next hit from?' before I can change her or do anything like that.*

Mother (Barnard, 2007)

*We'd park him in front of the box (television), and go into the bedroom, close the door, barricade the bloody door ... and use ... He'd call through the door and we'd go 'yeah, yeah hold on'.*

Parent (Houmoller et al, 2011)

The impact in this area is very similar to the effect on emotional and behavioural development, as both dimensions have, at their centre, issues of attachment, security and trust. In addition, substance misuse affects 'the shape of the family and its everyday rhythms due to its impact on rituals and daily functioning' (Kroll and Taylor, 2003). Celebrations, family gatherings, festivals and outings are all potentially under threat with the potential for disruption and disappointment. Even ordinary routines can be prone to upset due

**to unreliable, forgetful parents who are otherwise preoccupied, often by the 'demands of supply' – when substances are to be obtained and how this is to be funded. Substance misuse can also significantly affect both family dynamics and the relationships between adults, with both periods of use and withdrawal/hangover playing their part.**

The atmosphere of secrecy and denial that often characterises families where substance use is a problem can result in the substance becoming the 'central organising principle' of the family, with family members operating around it and in relation to it (Brown, 1988; Robinson and Rhoden, 1998). From the child's point of view a 'don't talk, don't tell' rule is imposed. If challenged, the child's perceptions of the realities in the family are called into question. Here, we encounter 'the elephant in the living room' – a huge, significant presence that no child would ignore but which the parents are determined to pretend is not there (Kroll and Taylor, 2003).

A gap opens up between what children know and see and what they are told to believe. This results in loss of confidence in their own perceptions, as they are drawn into a world of denial. Barnard and Barlow (2003) describe children's situation as like a 'world of mirrors' where children's distorted reality affects not only their ability to disclose but also their ability to 'know' – a pre-requisite for disclosure. In Kroll and Taylor's (2008) sample, young people became aware of something they came to learn was parental drug use at an early age, as an awareness of something 'odd' going on evolved into a clear sense of what this was.

Houmoller et al found that, whilst parents invested in mainly unsuccessful strategies to conceal their substance misuse, young people invested in the opposite – 'looking for clues and trying to interpret what they mean' and that young people's shifting perception of their parents' behaviour changes over time as a result of their contrasting experience outside the home as well as what went on within it (Houmoller et al, 2011). These insights are significant, as children in a range of studies have identified the importance of professionals making attempts to understand their world and how they view it (Houmoller et al, 2011).

When children start to question and challenge previously accepted family norms children's feelings of rejection and response to parental attitudes can lead to dramatic changes in the family dynamic.

As already indicated, additional risks relate to the dangers of copying substance using behaviour, either as simple imitative behaviour in small children, as a problem solver or as a means of escape for young people (Aldridge, 2000). If violence is also a feature, young men may copy abusive behaviour in their own relationships (Moffitt, 1993). Being exposed to unsuitable adults who may be part of the adults' substance sub culture may also present a range of risks, particularly if criminal activity is involved (Hogan, 1997; McKeganey et al, 2001). By the same token, as the capacity for empathy evolves, children develop more awareness of a parent's need for care or help and feel they have to respond accordingly (Brisby et al, 1997).

In terms of socialisation, children of substance misusing parents may have been subject to bullying or stigma, or their experiences in the home may have given them less opportunities to develop the problem-solving or mediating skills necessary for sustaining friendships (Holt et al, 2008). However, research suggests that approachable, trustworthy professionals willing to listen may help children open up and talk about difficulties and can enable children to break down the walls of secrecy and denial which may be negatively affecting their relationships (Daniel et al, 2009, in Cleaver et al, 2011).

Awareness of the fact that the family is visible to the outside world has particular consequences for the children of substance misusing parents 'who may feel under pressure to avoid or minimise contact with the outside world which might bring drinking and its shameful associations to the attention of others' (Laybourn et al, 1996). Parents' anxiety or fear of censure may result in them distancing themselves and prevent children from mixing, so that they miss out on the benefits of opportunities to socialise.

The potential for the embarrassing and the unexpected make young people, understandably, wary of allowing others to see what is happening

in their family. These factors have consequences in terms of outside friendships – with implications for social support – and can lead to the danger of increasing isolation (Barnard and Barlow, 2003). Shutting oneself away, withdrawing emotionally or putting headphones on and keeping them there might come to feel like the safest options:

*When my mum was drinking ... there was nothing for me to do except sit in my room, play loud music and bother the neighbours.*

16-year-old (Taylor, 2008)

Other responses might include spending more and more time away from home, not necessarily in the right company, with the attendant risks that this may involve (Velleman and Orford, 1999). Young people may also just leave home in order to escape, on the basis that anywhere, including the streets, would be better. Indeed, the most common reason for running away amongst young people was the neglect they experienced as a result of PSM and the incidence increases where there is also domestic violence (Wade and Biehal, 1998).

Homelessness leads to poorer outcomes in relation to future education and employment (Quilgars et al, 2008). Research suggests that young carers in general have significantly lower educational attainment at GCSE level than their peers and are more likely than the national average to be NEETs (not in education, employment or training) between the ages of 16 and 19 (Children's Society, 2013).

## The impact of PSM on self care skills

The main risks here relate to the temptation to allow even small children increasing responsibilities in relation to household tasks, child care and parent care, depending on the nature of the support systems available. Parents' inconsistent behaviour and the children's need for some control might also lead to children becoming co-parents or simply parenting their parents (Robinson and Rhoden, 1998). Young people and adolescents may neglect their own needs and concern, and a sense of duty and responsibility may lead to the belief that

levels of vigilance are required which may then affect school attendance and restrict social life.

A variety of other opportunities – leaving home to go to university perhaps – may feel too dangerous to risk (Cleaver et al, 2011).

## What might help? Resilience and protective factors

As indicated in the introduction, developmental risks are subject to possible mediating influences, where protective factors that foster resilience can offset negative consequences. Adamson and Templeton offer a useful definition, describing a protective factor as 'a factor or process which reduces or prevents the impact of a risk factor, while a resilience factor or process is something which supports a child to avoid the harms associated with a risky environment' (Adamson and Templeton, 2011). A key factor here is that resilience is better viewed as a process of interaction between an individual and their social contact (for example, family) as opposed to a fixed trait or single factor.

Forrester and Harwin (2011) use the example of a non-using parent/partner. This *may* act as a protective factor but it will depend on the partner's capacity to avoid the stresses from this relationship that may inhibit their ability to provide a warm response to the child (Eiden et al, 2004). Adamson and Templeton (2011) also make the point that protective factors and processes may have different impacts at different times, so that what may be significant for a child at one age will be different for those at another.

Mindful of these contingencies, and drawing on the work of ACMD (2003), Luthar (2003), Velleman and Templeton (2007), Velleman and Orford (2001), Cleaver et al (2011), Adamson and Templeton (2011), Moe et al (2007), Kroll and Taylor (2003) and Forrester and Harwin (2011), the following is a list of protective characteristics in individual children, their families and their communities that foster resilience.

**Individual protective characteristics in children that foster resilience include:**

- > Secure attachment
- > Strong self-esteem
- > Positively regarded temperament
- > Cognitive competence, good problem-solving skills
- > Absence of neurobiological problems
- > Absence of early loss and trauma
- > Social understanding, awareness and empathy
- > Internal locus of control – belief in own internal resources and that child can influence circumstances/achieve change
- > Goal directedness
- > Ability to use adults as resources, often including a supportive and trusting relationship with an adult in either the extended family or a friend's family
- > Spiritual or religious faith
- > Good verbal skills
- > Good sense of humour
- > Managing a balance of supporting parents and looking after themselves
- > Ability to plan and respond at times of transition
- > Previous experience of achievement or success.

**Familial characteristics include:**

- > Absence of violence
- > Effective management of any parental mental health problems
- > Availability of at least one stable, nurturing caretaker
- > Existing family rituals and structured family activities
- > Low parental tension and minimal family discord
- > High parental self-esteem
- > Consistently enforced family rules within a framework of well-balanced discipline
- > Adequate economic status
- > Treatment for substance misuse and attempts to abstain

- > Openness and good communication between parents and children
- > Acknowledgment of the substance misuse problem and its effects in the home
- > Strategies/action to minimise impact of substance misuse on children
- > Putting children first.

**Community characteristics include:**

- > Positive, nurturing school experiences
- > Availability of supportive adults to serve as role models and care givers
- > Cultural connection, value and identity
- > Socially rich environment
- > Community members able to give of themselves, who will notice children and parents in distress or difficulty
- > Community resources (such as child care, health care, good education, leisure facilities and transport)
- > Positive achievement outside the home environment
- > Supportive friendships with whom it is possible to discuss difficulties at home.



> This list can also be found on the chart accompanying this briefing. This is available at [www.rip.org.uk/frontline](http://www.rip.org.uk/frontline).

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