

“Looking Beyond Risk”
Parental Substance Misuse:
Scoping Study

Substance Misuse Research

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EXECUTIVE SUMMARY

Introduction

Parental substance misuse can result in a considerable number of negative effects on the family. However, it is incredibly hard to calculate how many children and other family members might be affected. There is also growing evidence that some children appear to be more resilient than others to the negative impact of parental substance misuse. There is a need to investigate how these general statements relate to parental substance misuse across Scotland, a topic that has been given priority status by the Scottish Executive, and other key organisations. There is also a need to ensure that recent national and international literature and policy initiatives inform research, practice and policy across Scotland. Thus, the Scottish Executive (Substance Misuse Research Team) commissioned this scoping review which was undertaken during 2005. The key aims of this review were to scope how much literature there is on the topic of parental substance misuse, and then to further scope the literature to summarise key themes and gaps arising from the literature, to collate knowledge and evidence on effective practice, and to identify priorities for future work.

Undertaking the review

The international literature, from 1990 to summer 2005, was comprehensively searched for relevant articles (this included published work and 'grey' literature), with the bulk of the searching focused on major electronic databases. We initially found over 4,000 references, but that was reduced to the current total of approximately 2,600 through screening and removal of duplicates. All references accessed were in the English language. The majority were from the USA and were journal articles. Quantitative work and basic exploratory work (i.e. impact on or risks for children) dominated the literature. About 40 references related specifically to Scotland, and these were mainly journal articles and reports, including relevant policy documents.

Given the number of references identified, and that this was a scoping review, as opposed to a full literature review, we further examined the literature on two levels. Firstly, we used a checklist to review and count the references across a wide range of topic areas (corresponding to key objectives of the review). Several thousand references were screened in this way; duplicates and irrelevant references were removed from the database. Secondly, we reviewed key areas (corresponding to key objectives of the review and agreed following discussion with the Advisory Group) in more detail, by looking at approximately 40 selected abstracts for each area (or all abstracts if there was a limited number to choose from) and whole articles, chapters and reports in some cases. The areas thus reviewed were: Prevalence; Child Protection / Domestic Violence; Resilience; Pregnancy / Motherhood; Fathers; Children's views; Mental Health; and Interventions / Service provision.

Findings

It is clear that there has been a great deal of research into many aspects of the lives of parents who misuse substances and the impact on their families. The impact of, and risks associated with, parental substance misuse appears to have been well mapped. Accumulation of risk associated with certain factors, such as domestic violence, marital break-up, unemployment, deprivation etc., have been highlighted. Particular risks associated with pregnancy, motherhood and parenting have been emphasised. However, it should be highlighted that, despite the dominant focus on negative impact, there are studies that found no evidence of heightened risk for children stemming from parental substance misuse alone. Following on from this, a philosophical shift in the literature towards resilience is

occurring and this has clear potential when applied to children, and other family members, affected by (parental) substance misuse. This shift allows those delivering services to identify and promote resilience factors and processes in families affected by substance misuse. There is growing evidence that a range of services and interventions for children and families is developing, but there is a need for continued expansion of such responses, and for their rigorous evaluation, with both service development and delivery incorporating the views of, and outcomes for, children. The key gaps in the literature included the following: children's views (particularly in relation to impact, resilience factors, service needs, or views on existing service provision), fathers, siblings, service needs, service provision, mental health, rurality and ethnicity. These are key areas where future attention should be directed. This work must consider the gender and age of children. It is also clear that it is often the problems that are associated with or arise from (parental) substance misuse that can have a greater negative impact on the family than the misuse per se, and hence there is a need to view parental substance misuse as part of a far wider, multi-dimensional, picture. Finally, clear and methodologically sound attempts to measure and validate the numbers of children and families affected by substance misuse are severely lacking.

There are a number of recommendations about priorities for future work and for effective practice resulting from the findings of this review. Whilst many gaps have been identified in our review, it is to Scotland's credit that Scottish research and literature has often been part of a minority literature to address such gaps. We sincerely hope that further work in Scotland can continue to be innovative in this way, using this scoping review as a step in the right direction.

Recommendations

Identification of priorities for future research in this area:

1. Identify the most appropriate methodologies with which to estimate prevalence, and the definitions with which to work.
2. Estimate the prevalence, nationally and locally, of children (and other family members) affected by parental substance misuse, and of associated costs.
3. Future research, evaluation and service development should include, where possible and appropriate, the views and needs of children, both to map their experiences but also to establish their particular service and support needs.
4. Conduct further research on the experiences and needs of particular groups of children. For example, siblings, those living in rural areas, those from black and minority ethnic groups, those who have a parent who has died or is in prison as a result of substance misuse, those living in care, and children living with domestic violence or parental mental health problems, and children who have been exposed to alcohol or drugs in utero.
5. Conduct further research on the views, needs, roles and responsibilities of others central to parental substance misuse, particularly fathers and grandparents.
6. Ensure that the development and introduction of new services and interventions are properly and fully evaluated.
7. Undertake a review of 'what works' in relation to child protection, especially with overlapping issues of substance misuse, and of domestic violence.

Some of the recommendations could be partially met by further, more focused reviews of the evidence. In other cases, further exploratory or evaluative work is needed on a larger scale.

On effective practice:

Commissioners and providers of services in Scotland should:

8. Increase service delivery to the children and families of those affected by (parental) substance misuse, involving a range of service and intervention options. This includes services and teams that respond to the particular needs of pregnant mothers and their neo-nates, as well as services that more holistically meet the needs of children and families together.
9. Commission service provision that takes account of the broader context of substance use and parenting including involvement of the wider family.
10. Recognise and respond to local need where this differs from national need and national priorities.
11. Ensure that services are provided more holistically, focusing on all aspects of parenting, substance misuse and co-existing issues (such as domestic violence, mental health problems, or women who are pregnant and where children might have been exposed to drugs or alcohol in utero).
12. Reflect the equal importance of promoting resilience and reducing risk in the development of interventions and services for children affected by parental substance misuse.
13. Investigate how addiction services, and child and adult services could best be integrated and encouraged to work together.
14. Organisationally, ensure that joint working protocols, and information sharing procedures, are in place.
15. Ensure that professionals in all services are well supported through managers and supervisors who have been trained in working with substance users and their families.
16. Improve qualifying and post qualifying social work training to ensure that it includes training on alcohol and drug use and how this relates to working with children and families. The training of child and family social workers should be a priority; the role of adult social workers was not a focus of this review and would need further investigation.
17. Take steps to develop the means by which data about child-related issues can be collected and collated from clients of services within Scotland whose primary problem is alcohol misuse.
18. Establish a database and directory of services that respond to the needs of children and families.

BACKGROUND

Substance misuse is currently seen as problematic within Scotland. Findings from the most recent survey of attitudes (2004) towards drinking and smoking in Scotland indicate that nearly two thirds of 1,600 interviewed thought that drinking was a major part of life, yet 46% felt that alcohol caused more harm than drugs. This survey showed that there were particular concerns arising from binge-drinking, drinking by young people and alcohol-related crime. Another national opinion survey of 1,001 adults (2004) found that 96% thought that drug misuse was a serious problem, and 69% a very serious problem. There are about 5 million people in Scotland, about 20% of whom are aged 16 and under. It is extremely hard to calculate how many people might be affected by substance misuse in the family (this will be further discussed in the prevalence section of this report). However, it has been estimated that there are millions of affected family members in the UK (this includes children).

Parental substance misuse can result in a considerable number of negative effects on the family (both children, and other family members such as grandparents), as well as on the parents themselves. Co-existing mental health problems and/or domestic violence can be additional problems faced by this group of families. Substance misuse (particularly alcohol) contributes significantly to the number of children and families on social work caseloads (Forrester & Harwin, 2004). Families may cope differently with parental substance misuse as a result of a number of variables, for example, ethnicity, geographical location (urban versus rural), social class, and age / development of child. There is also growing evidence that some children appear to be more resilient to the negative impact of parental substance misuse.

However, the needs of family members have largely been neglected within an historical focus on the treatment of those individuals with the alcohol or drug problem (see Orford et al., 2005 for a review). Family members including children can be hard to engage with, because they feel too ashamed about their situation, are used to keeping the substance misuse a secret, or simply do not know where to go for help or what to do if help is available to them. Professionals, either specialists working in the addiction field or generic staff working in children and family services, schools or primary care for example, can feel uncertain, and lack training and confidence in how to respond to the needs of children and families of substance misusers.

Political attention (and therefore resources) has been similarly focused towards the individual alcohol or drug misuser, although the impact of substance misuse on the family, and the needs of family members, has in recent years been slowly climbing up the political agenda, within a broader recognition of the importance of working in a more holistic and systemic way. Policy initiatives (either UK-wide, such as Hidden Harm (ACMD, 2003), or specific to Scotland such as Tackling Drugs in Scotland: Action in Partnership (Scottish Executive, 1999), the Scottish Plan for Action on Alcohol Problems (Scottish Executive, 2002), Getting our Priorities Right (Scottish Executive, 2003), and It's Everyone's Job to Make Sure I'm Alright (Scottish Executive, 2002) set the agenda for research, practice and policy within Scotland. Research and service development has also been on the increase, and there is a range of research and evaluation projects, and service developments in this area, that are indicative of the potential for supporting children and families affected by substance misuse (Copello et al., 2005; Williams, 2005).

However, there is still evidence that the needs of children and families are often sidelined. A recent profile of all 840 studies published in Addiction Abstracts

1994-2001 (Short, Stevens & Crome, 2005) made no reference to research and practice with children and families. The Alcohol Manifesto for Scotland (Griesbach D et al., 2005) has as part of its vision a desire to see, "fewer families break-up and have children taken into care because of parental drinking", yet its ten proposals for change are of a general nature and do not specifically mention children and families. A report from the Registrar General for Scotland concludes that the number of drug-related deaths has increased by 12% to 356 in 2004; yet the needs of bereaved family members are not mentioned (Registrar General for Scotland, 2004). Similarly, a review of residential detoxification and rehabilitation services makes little mention of the provision of services to pregnant clients and mothers, or children and families, but it is unclear if this reflects a realistic lack of services in this sector to children and families (Griesbach D et al., 2004).

The death of 11 week old Caleb Ness in Edinburgh in 2001, however, prompted discussion and movement across Scotland in the area of substance misuse and the family, with particular regard to the role of social services and the wider issue of inter-agency working. As Caleb was the subject of Child Protection procedures at the time of his death (his mother was a long-term heroin addict and his father had a criminal history of drug-related offences), a formal inquiry was commissioned and completed (O'Brien, Hammond & McKinnon, 2003). The inquiry concluded that no one person could be scapegoated, but that blame should be shared amongst a range of professionals and organisations, at every level. Communication (intra- and inter-agency) and contextual and historical assessment (including risk assessment) of the family were particular areas of concern highlighted by the inquiry. Concerns were also raised about the CPCC (Child Protection Case Conference) process. Whilst many of the conclusions and recommendations made were not new, the report triggered a great deal of debate and activity (for example, at least three areas of Scotland have produced child protection guidelines that consider how to work with children in families with problem substance use), and it is hoped that further improvements will be made and such devastating consequences avoided in the future.

The scoping review: aims and objectives

The key aims were to:

- 1) Undertake a comprehensive literature search to scope how much work has been done on the topic of parental substance misuse.
- 2) According to the amount of literature identified, adopt an appropriate methodology to further scope the literature, to identify key themes and gaps, focusing in particular on evidence of effective practice, and the identification of priorities for future work.

The objectives were to focus on the following areas of the literature:

- 1) The impact of parental substance misuse on i) children, ii) other family members and iii) the parents themselves.
- 2) The needs of these three groups.
- 3) Evidence of the direct views and experiences of these groups.
- 4) Effective interventions in this area.
- 5) Service needs and service provision, with a specific focus on Scotland.
- 6) Consideration of the issues of risk and resilience.
- 7) Incidence and prevalence.

METHODOLOGY

This is a summary of our methodology (see also the Discussion section in this report for thoughts on the search process, its benefits, challenges and limitations). The searching was restricted to between 1990 and summer 2005. We identified the key resources to search, devised a search strategy and conducted the comprehensive, international literature search. Identified references were imported or entered into a computer-based library software package, Reference Manager.

The bulk of the searching focused on major electronic databases. Librarian support at the University of Bath advised us to focus on PsychInfo, Web of Science, EMBASE and PubMed (Medline). We employed a dual strategy, to ensure maximum coverage, combining use of 'free-text' terms with pre-determined MeSH headings (where appropriate). CINAHL and SIGLE were also searched in this way. Computer-based searches, or 'eyeballing' of reference lists and abstracts, were also undertaken. These included: Addiction Abstracts (from 2001), the Cochrane Collaboration, the Campbell Collaboration, ETOH, the National Research Register, Project CORK, Drug Misuse Information Scotland, Caredata, and publications lists of the UK Drug Strategy Directorate Publication List, the CDMR (Centre for Drug Misuse Research in Glasgow) and Bancroft and colleagues. Additionally, the Scottish Executive's Substance Misuse Research Team provided a reference list from its database, together with a collation of further thoughts and suggestions from the Advisory Group. E-mails were sent to individuals suggested by the Advisory Group, including to the DAT Association for Scotland, and to the ENCARE network (European network for children affected by risky environments within the family). In addition, one of the research team (LT) was testing the search strategy for another project, a systematic review, and anything new to arise from this was included. The research team also subscribe to various journals and news alert services (for example, Daily Dose, NSPCC, Drink and Drug News) and were therefore aware of any newly released, relevant, literature.

It is important to highlight that the core aim of the review was to scope the literature base on the topic of parental substance misuse, rather than undertake a systematic or comprehensive in-depth literature review of all that we identified. The amount of literature identified would thus influence how we proceeded to summarise themes and gaps within that literature. In this case, given the time available to us for the review, and that our comprehensive literature search identified several thousand articles, it was not possible for us to review the literature in depth. After discussion with the Advisory Group, it was agreed that we would scope at a broader level, as opposed to using strict quality assessment criteria that would have meant we read a very small amount of the literature in more detail. We therefore employed the following three level strategy:

Scoping Level One: To quantitatively scope the database in relation to the study objectives, we divided a printed, paper copy of the database contents (titles and abstracts) between the four of us and used a checklist to tally the references, corresponding to the key objectives of the study and areas of importance agreed following discussion with the study Advisory Group (for example, impact, domestic violence, risk, resilience). Several thousand references were screened in this way (Table One). This process allowed us to screen for relevance, remove duplicates and references that were not relevant to the objectives of the review, and to identify areas for more detailed review.

Scoping Level Two: Given the large number of relevant references that remained in the database following level one, and the time available to us, we felt

that it would be most useful to review in more detail a selection of key areas identified in the study objectives, with the agreement of the study's Advisory Group. We decided at this stage not to look at Risks and Impact, as the literature search in both areas had resulted in a large number of references. The research team felt judged that it was unlikely that many news areas for future research would therefore be identified on these subjects. We thus selected seven areas for further review, as it seemed likely that reviewing these areas would lead to both more information on effective practice, and priorities for future work. A selection of abstracts (or all abstracts if there was a limited number to choose from) were selected and reviewed, and a short report was written on each topic. The seven areas were:

- 1) Child Protection and Domestic Violence.
- 2) Resilience.
- 3) Pregnancy, Motherhood and FASD (fetal alcohol spectrum disorder).
- 4) Service needs.
- 5) Fathers¹.
- 6) Parental mental health.
- 7) Children's views.

Scoping Level Three: In discussion with the Advisory Group, two areas were identified as warranting more detailed review. The two areas were Prevalence and Interventions. This entailed reviewing a larger number of abstracts as well as selected full articles and reports.

In order to ensure a good spread of literature in the selection of abstracts, articles and reports for more detailed review, we attempted to use the following criteria when identifying abstracts and literature for review under scoping levels two and three: Scottish work; not all USA work (though this was very hard, given the limited amount of non-US literature); more recent work; reviews, systematic reviews or meta-analyses; a range of study designs and methodologies (RCT, intervention, evaluation and qualitative); and a split between alcohol and drugs. However, given the time available and the amount of literature identified, a lesser emphasis was placed on quality analysis and an in-depth review of the data and a greater emphasis placed on continuing to scope the literature. The themes and gaps that we have identified, and the recommendations that we make, allow for detailed literature reviews on particular issues to be conducted, based on this broader scoping review. This would also allow for confirmation of the findings that we have reviewed and the conclusions that we have made from scoping such a large amount of literature.

¹ Fathers was not initially identified as key objective for review, but our initial scoping plus discussions with the Advisory Group led to the decision to include it.

TABLE ONE – QUANTITATIVE SUMMARY OF DATABASE REFERENCES	
Impact	
Parents	345
Younger children	1203
Adult children	574
Other family members	159
Needs	
Parents	40
Younger children	88
Adult children	11
Other family members	27
Views	
Parents	129
Younger children	168
Adult children	73
Other family members	21
Interventions	687
Parents	249
Younger children	220
Adult children	88
Other family members	130
Risk	569
Prevention	86
Ethnicity	91
Resilience	190
Pregnancy, motherhood and FASD	433
Child Protection	159
Domestic violence	59
Mental health	141
Service needs and provision	310
Scotland	48
Incidence and prevalence	71

FINDINGS

Our initial work resulted in over 10,000 titles or abstracts which might have been relevant. After removing duplicates and others that proved non-relevant, including those identified through the Level One scoping exercise, and the subsequent more detailed review at Levels Two and Three, we have approximately 2,600 entries in the Reference Manager database. Key criteria for the exclusion of entries from the database (unless an overlap with the overall aim and objectives of the scoping study could be identified) included: literature that pre-dated 1990; biochemical and pharmacological research into substance misuse; the genetics of substance misuse; substance misuse by adolescents (unless this related to use as an effect of parents' misuse, and we have retained material that confirms that early or problematic substance use is a risk factor resulting from having a substance misusing parent); literature related to the general areas of prevention of substance use/misuse in young people; domestic violence (if solely related to inter-spouse violence with no mention of children or family issues); interventions (again if child or family issues were not mentioned) and smoking.

All references are in the English language (even with foreign journals, where the title and/or abstract are published in English). The majority are from the USA. Quantitative work and basic exploratory work (i.e. on the impact on, or risks for, children) dominate. Over half of the entries are journal articles, though this includes abstracts from the USA resource Dissertation Abstracts International, with a further 135 book chapters, 60 reports and 40 books. About 40 references, mainly journal articles and reports relate specifically to Scotland.

It was immediately apparent that there is a very considerable amount of material looking at impact and risk, whilst resilience and interventions are growing areas. Child protection and domestic violence are two highly relevant and overlapping areas of literature and these themes feature strongly in much of the literature, particularly the literature relating to child protection. Similarly, pregnancy, motherhood and fetal alcohol spectrum disorder were large areas. It was apparent that there was a lack of literature focusing on children's views, the father's role in parenting, service needs, service provision, mental health and ethnicity. There is a need for further work in these areas to establish how they may impact upon parental substance misuse and its impact on children and families.

The following sections contain the reports of the topics reviewed at levels two and three. Apart from the topic of fathers, which reviewed just over 100 abstracts, approximately 30-60 abstracts were reviewed for each topic. For the most part, literature tended to be American, published journal articles and based on quantitative work. Particular exceptions to this are highlighted in the sections that follow. Many of the points to emerge from the review of the service needs literature was felt to mirror other topics reviewed, and so this literature was integrated throughout the report (including the Discussion). Similarly, we read through the Scottish specific references, and evidence and ideas contained within them were integrated into the appropriate section of the report, or into the discussion and recommendations sections.

Overall, the literature rarely differentiated between the substance misused by parents in terms of impact or need; this issue is explored in more detail in the discussion (see particularly p37).

PREVALENCE

There is a dearth of literature that examines the prevalence of parental substance use at a general population level. Prevalence information usually comes at the start of articles, by way of background, and is rarely detailed enough to trigger further discussion. Estimates of the number of family members affected by someone else's substance misuse are rare: it is much more common for papers to estimate the prevalence of substance misuse more generally.

Prevalence estimates can be calculated from national survey data, from smaller samples of specific populations or by considering the measurement of problems faced by children and families of substance misusers. However, the majority of this work is American. Gomby & Shiono (1991) reviewed USA work that focus specifically on newborns. They discussed how prevalence calculations might be over- or underestimates, thus highlighting some of the key challenges and issues to consider.

Hidden Harm (2003) estimates that there are up to 60,000 children under 16 years old in Scotland who have a parent with a drug problem (approximately 5% of the total population group for this age). Further estimates indicate that 10,000-20,000 children live with a drug-using parent whilst the number of babies born to drug-misusing mothers rose to nearly 18 per 1,000 in 2000 ('It's Everyone's Job to Make Sure I'm Alright', 2003). 'Getting our Priorities Right' (2002) estimated that there are 40,000-60,000 children in Scotland affected by parental drug use and that 19% of the 10,798 adults reported to the Scottish Drug Misuse Database in 2001/2002 were living with dependent children.

At present, the method used by the ACMD in calculating the figure for Hidden Harm is the best estimate available for numbers of children affected by drug misuse in Scotland, where figures for substance misusing parents were calculated by using a method combining a number of sources: 1) the prevalence results reported by Hay et al. (2001), 2) the Drug Outcome Research in Scotland (DORIS) figures and 3) SDMD figures. The latter two figures are based on new contacts known to treatment services only and are therefore limited. However, Hay et al. (2001) developed a hidden population model to attempt to estimate the people not in touch with services. Data sources were treatment contacts (SDMD), drug related hospital admissions, police contacts and social work/social enquiry records and were identified by Council area or by postcode. This enabled figures to be re-calculated based on NHS Board area, DAAT areas and police force areas.

Pavis (2004) has highlighted variations in prevalence across areas / NHS regions and thus emphasised the importance of localised prevalence estimates when considering service delivery for those misusing substances, and their families. As an example of such a local calculation, Murray and Hogarth (2003) estimated that *"there are an estimated 1,306 children and young people affected by substance misuse within the family"* in the Borders region. This is 1.2% of the overall population of 109,270 at the time of the study. Limitations to this work are that it covers (some) illegal drugs only, focused on adults in direct contact with services, and did not employ a standard methodology for estimating prevalence; thus such calculations are certain to be underestimates. Hay, Gannon & McKeganey (2005) have done work on estimating the number of children affected by parental substance misuse in Glasgow, deriving an estimate of 6,142 such children (5.5% of the under 16 population), with slightly more living with at least one parent with an alcohol problem than with a drug problem. In both cases it is more likely that the father has the alcohol or drug problem.

For alcohol, the most recent and widely cited figures are found in the Plan for Action on Alcohol Problems, which indicates that 80,000-100,000 children in Scotland are affected by parental alcohol use. The 2005 Alcohol Manifesto (Alcohol Focus Scotland) also reports a figure of 100,000 children living with a parent with an alcohol problem. However, there may be particular problems in calculating estimates of numbers of children affected by alcohol misuse. First, the hidden population may be much greater and thus estimates based on treatment services are likely to be underestimates. Secondly, particular attention has to be paid to terminology and whether estimates relate to dependence, problem drinking, binge-drinking, and how these terms are defined.

Hidden Harm (2003) also reported that, on average, 25% of children on child protection registers were there because of parental alcohol or drug use. Other estimates of substance use in families in contact with social workers are much higher, ranging from 20-78% depending on sample size and point of contact with social services (see Forrester & Harwin, 2004; Hayden 2004). Figures for Scotland for 2004-2005 state that over 12,000 children were looked after, with 2,157 on the CPR at 31st March 2005 (Scottish Executive, 2005).

Conclusions and recommendations

It is clear that there are broad estimates of the numbers of children affected by parental substance misuse across Scotland, and that taking alcohol and drugs misuse together these figures probably exceed 150,000. This is in line with the widely held belief that substance misuse (particularly alcohol) affects many people, and that children are a group most likely to be affected. However, commentary on these documents, and on calculating prevalence in general, suggests that these figures are likely to be underestimates. There is a dearth of specific knowledge (as opposed to generalised estimates) in this area, with a need for clearer national and local data, and estimates drawn from the most reliable methodologies in order to drive forward Scottish policy in this area. However, the availability of data, and the best method for making such calculations, remains unclear. Work by the EMCDDA (Frischer et al., 2001) has tested various methods for estimating problematic drug misuse prevalence in Great Britain. The work of Hay et al. (2005, 2001) in Glasgow is important and further consideration should be given to the application of their capture-recapture methodology (which can include calculations of the 'hidden' population, rather than limiting data solely to information contained within health, police and social services databases). Some work has been done to test the suitability of capture-recapture methodologies to the alcohol population (Corrao, Bagnardi, Vittadini & Favilli, 2000) but, as alcohol is a legal substance, existing information systems and data collection processes relating to alcohol misuse are unlikely to support the ready application of such methodologies. Further work to explore potential methods to calculate prevalence in relation to alcohol misuse would therefore be particularly useful.

Work on prevalence must consider its definitions of substance misuse (e.g. alcohol or drugs, which drugs, what is defined as misuse) and who is being counted (e.g. all family members, just children, age restrictions). The definition of parental substance use needs to include both mother's and father's use. Given that around a fifth of the Scottish population live in rural areas (and 6% of those in remote rural areas), having clearer prevalence estimates by area would further help define where adapted practice and policy approaches are needed.

The Scottish Executive response to Hidden Harm (2005) does not make specific recommendations relating to estimating prevalence. However, there are clear recommendations that the Scottish Drug Misuse Database (SDMD) collect data on the children of those included in the database. This is a recommendation that

has already been acted upon, with the decision that workers will be asked to collect information during initial assessment on the number of dependent children of the client (biological or those who they care for 'as a parent'); ages of these children; whether the client's children live with them or not; and whether the client or their partner is pregnant. At follow-up (usually 3 and 12 months), and at discharge, this information will again be collected. Workers will also be asked to record whether the client is receiving an intervention related to their children; and which type of organisation is providing the child orientated intervention. Whilst this is an important step, it remains to be seen how this change operates in practice. No information will be collected on the identified needs of the children or risks to them. Whilst we understand that a conscious decision was made not to collect information on risk at a national level, because data processing times would not help protect children, we recommend that these data continue to be collected at a local level by drug (and alcohol) treatment workers. Additionally, as the Scottish Drug Misuse Database is not designed to collect information about clients with solely an alcohol problem, alternative methods of collecting data on child-related issues from clients of services whose primary presenting problem is alcohol should be explored.

It is still the case, therefore, that further prevalence work is needed, both nationally and locally across Scotland, to understand the numbers of family members affected by alcohol or drug problems. Issues of methodology and definition, along with consideration of hidden, non-clinical populations, are vital.

CHILD PROTECTION AND DOMESTIC VIOLENCE

The clear message from the literature on these subjects was that problematic substance use has a negative impact on parenting skills and parental attention to the child. In particular the literature identified the heightened risk to children of all forms of abuse where one or more parents were using substances problematically. It also identified how parents with substance problems often had histories themselves of child abuse and neglect. However, it is important to note that the literature focuses on maternal (as opposed to paternal) substance misuse.

An important finding was the co-existence of domestic violence as a key factor in the environments of parents with substance problems, and how the combination of both factors increased the negative impact in all areas: the child's development, their experiences in adolescence, relationships and parenting abilities as adults, and prediction of adolescent psychopathology, perpetrating child abuse, developing substance problems, or perpetrating or suffering domestic violence in adulthood. Experiences of domestic violence and sexual abuse were also highlighted among women in treatment and in prison populations. Suffering domestic violence was also identified as a risk factor for the mother, with some studies suggesting it increased her punitive response towards their children.

A number of studies highlighted how parental substance use, as a single factor, is not solely responsible for increased risks of child abuse. Environmental factors including poverty, social isolation, and lack of family or community involvement increased the risk of harm to children and/or the removal of children from parental care. A related issue was the perception by parents (usually mothers) that substance use treatment would help them to keep custody of the child but at the same time they feared that approaching treatment services might prompt child protection procedures. This fed in to recommendations by a number of studies that services needed to assess and address the holistic needs of parents

and children. They suggested treatment not only needed to accommodate children but that supplementary services concurrently addressing non-substance specific needs demonstrated better outcomes for parenting and children and reduction in child abuse.

Within the broader group of substance using parents there was a range of specific parenting sub-sample populations. These included pregnant women, women in prison, and adult children of substance using parents who were now parents themselves. Pregnancy, in particular, was seen as an opportunity for risk assessment and intervention; with childbirth and children being both a motivator and demotivator for help seeking (see separate section on this topic for more detail). Some articles raised questions about mandatory assessment and/or testing of babies born to substance using mothers.

In relation to service provision and professional intervention, several studies identified social workers as needing better knowledge and support in order to address substance use within their child protection role. The failings of the child protection structures and staff to address substance use were raised in various forms, from lack of knowledge of social workers to the separation of child and adult services leaving gaps in service provision (within Scotland this was a clearly identified finding to emerge from the Caleb Ness Inquiry). One study showed that where there were good relationships between social worker and parent the outcome for the children was better. Some literature identifies guidance for existing services and describes models of service provision that are addressing parental substance use and its impact on children and families.

Some studies found differences in relation to the types of harm children suffered depending on the gender of the child and the gender of the parent with the problem, namely, how parental substance abuse and/or parental domestic violence impacted upon girls and boys differently. The impact on boys tended to manifest itself through externalised behaviours, such as increased aggression, whereas girls internalised the negative effects and were more prone to withdrawal and mental ill health. However, further work in this area is needed. Similarly, some studies paid particular attention to emotional neglect and abuse and identified how this had an equally negative impact on children and young people as the more commonly identified physical and sexual abuse. This supports some of the reports of parents being 'absent' during their childhood as a result of substance use. However, these categories are unlikely to be mutually exclusive and therefore the methodology needs further exploration.

One of the positives identified by adult children was the need for their own parenting to be different and to act as the role models of what parenting should be, rather than what their own parents presented. Finally, some articles looked at how grandmothers were often involved in taking care of children as a result of parental drug use and subsequent child neglect. They also identified the need for greater support for grandmothers who had to return to child rearing in later life.

There was very little evidence of qualitative work, nor of studies examining the views of parents and children. One study (Richter & Bammer, 2000) outlined the strategies mothers took to reduce the harm to their children when they were using and this could form the basis for a more positive and strength-based approach to developing services and interventions.

Some literature identified the need for, or recommendations about, tools to assess or support childcare professionals in their assessment of and intervention with parents using substances. Similarly, there was literature describing service initiatives that focus specifically on intervening with parents or families when

children are at risk. However, there appears to be an absence of a review of 'what works' in relation to child protection. This may be filled to some degree with the completion of an ongoing project on this subject by Hedy Cleaver in the UK (2005). This work addresses both substance use and domestic violence, and includes service user and provider perspectives.

One study looked at social services responses in cases of both domestic violence and parental substance misuse (Cleaver et al., 2005) and found that social worker plans and training were more likely to cover domestic violence than parental substance misuse. Links between domestic violence and substance misuse were rarely made; awareness by managers of local services for domestic violence or substance misuse varied between and within authorities. Furthermore, working relationships between adult and children's services, particularly housing and substance misuse services, were generally poor. Three quarters of initial assessments indicated that parenting capacity was negatively affected and children had unmet developmental needs; yet few initial assessments resulted in a referral to services for domestic violence or parental substance misuse. Greater focus should be given to improving information sharing and collaborative working between services for domestic violence and substance misuse, and children's services. Agreed, robust protocols and procedures should ensure that timescales and ethical considerations do not hamper joint-working.

Many of the abstracts finished by stating they had implications for policy and service provision but these were not explicit in the abstracts. Scotland is quite advanced in developing such guidance, stemming largely from Getting our Priorities Right (2003) and the Caleb Ness Inquiry. At least three areas of Scotland, Edinburgh and the Lothians (2005), the North East of Scotland and the Borders (2004) have produced child protection guidelines that consider how to work with children in families with problem substance use.

Conclusions

It is clear that:

- Problematic substance use can have a seriously negative impact on parenting skills and parental attention to the child, with a corresponding impact on many areas of the child's life.
- Co-existing domestic violence usually increased the negative impact in all areas, both in terms of its impact on the mothers' ability to parent and the children's outcomes.
- There are common intergenerational continuities in this area with parents with substance problems often having histories themselves of child abuse and neglect.
- Many other factors besides parental substance use are important in determining the impact on children, including the environmental factors of poverty, social isolation, and lack of family or community involvement.
- There are many suggestions that interventions need to be holistic and integrated, and that these lead to better outcomes for both parents and children.

Key recommendations:

- Undertake further research on fathers, both in terms of their role as substance misusing parents and as non-using partners to substance misusing mothers.
- Undertake further research on fathers as perpetrators of substance-related domestic abuse and the father's responsibility for parenting in this context.
- Undertake further research or more detailed reviews on differences in harm children suffer, depending on their gender, the gender of the parent with the problem, and the substance misused.

- Develop a focus on more qualitative work, work that examines the views of parents and of children, and work which focuses on positive, resilient and strength-based approaches (for example, the strategies mothers take to reduce the harm to their children when they are using).
- Undertake a review of 'What Works' in relation to child protection, especially with overlapping issues of substance misuse, and of domestic violence.
- Ensure that services are provided more holistically, focusing on all aspects of parenting, substance misuse and domestic violence, and on interventions to help children in these situations; and in an integrated form so that child and adult services are not divided.
- Improve qualifying and post qualifying social work training to ensure that it includes training on alcohol and drug use and how this relates to working with children and families. The training of child and family social workers should be a priority; the role of adult social workers was not a focus of this review and would need further investigation.

RESILIENCE

The majority of abstracts looked at resilience or coping with parental alcohol problems. Many studies used qualitative methods, but did focus primarily on exploratory work. Few studies used resilience or coping information to develop and evaluate interventions to increase resilience.

Many studies demonstrated that 'ACOA's' (adult children of alcoholics) do not have more problems (unemployment, difficulties at work or education, or in relationships, different personality profiles, etc.) compared with non-ACOA's. In fact, many studies started from a realisation that the older research and clinical literature which portrayed the 'COA' or 'ACOA' populations as homogeneous and ordained to negative outcomes was incorrect. Much of the research undertaken in the past 15 years has instead demonstrated that this population is very heterogeneous, and that there is no pre-ordination for negative outcomes. Instead, these children seem to have a wide range of coping behaviours and resilience features. Some children and young adults do demonstrate negative outcomes which seem related to their negative childhood experiences (family conflict, inconsistent parenting practices, etc.) whilst others seem more protected and resilient, which seems related to such factors as support from a non-problem parent, or intact family rituals (Gogineni, 1995). A number of studies within this set of abstracts (for example: Leahy, 1997, Harris, 1999, Hogan 2000) have shown that although adults who were the children of problem drinkers report (as compared to control groups) very disturbed early family environments, they score no differently to control samples on measures of current adult functioning (see also Velleman & Orford, 1999).

Coping

A number of studies examined coping strategies, comparing these children or young adults with control groups. Amongst the reported findings were that children of substance misusing parents used emotion-focused coping strategies at all ages whereas adolescents tended to also discuss problem-focused strategies (Amond-Berry, 2000). Females tended to discuss using more passive and internally referenced coping strategies whilst males tended to discuss using more aggressive and externally referenced coping strategies (Amond-Berry, 2000). Devine & Braithwaite (1993) showed that although 'parental alcoholism' contributed to children adopting the 'acting out' and 'placator' roles and was the sole predictor of the adoption of the 'responsible child' role, the adoption of these 'survival roles' appears to be as much a response to family disorganization as to 'parental alcoholism'. Pilowsky et al. (2004) showed that more resilient children

of injecting drug users were less likely to use internalising and externalising avoidance coping strategies but it is unclear (from the abstract) how coping was defined or what coping strategies were used instead.

Resilience

Many studies have shown that there are highly resilient individuals who are young adult children of problem drinking parents, although these studies also show that significant numbers are not functioning as competently as young adults from other non-problem backgrounds.

Resilient children seem to be remarkably similar to children from non-substance misusing families. Mohr (2000) found that they did not differ on any measure from others without substance misusing parents who did not develop substance misuse. Similarly, Gordon (1995) showed that few differences were identified in any of the variables they examined (for example, measures of security of attachment, use of alcohol, affective characteristics, disturbances of the self, interpersonal functioning, psychological symptomatology, family environment, and coping styles), *"suggesting that not all ACOAs suffer long term consequences of growing up with an alcoholic parent"*. They did show that their 'ACOA' sample had a more "avoidantly attached" attachment style, which they suggest may have served to protect these individuals from the deleterious effects of parental 'alcoholism'.

A number of studies have shown that, contrary to expectations, maternal attachment, security of attachment and quality of maternal parenting do not always operate in the hypothesized protective manner (Curran & Chassin, 1996; Gordon, 1995; Mohr, 2000). Some work (Cavell et al., 2002; Hill et al., 1992) reports on the positive influence of positive family relationships and dynamics.

Pilowsky et al. (2004) showed that the level of actual support received by resilient and non-resilient children did not differ significantly, but that perceived support was greater among resilient children. The work of Chandy et al. (1993, 1995, 1996) identified protective factors which included less worry about abuse from parents, the perception that school personnel cared about them, positive parental expectations, rating self as generally healthy, and religion.

One way that many children from this background demonstrate their resilience is by the professions they enter: there were a number of studies reporting adults who were children of substance misusers now successfully engaged in careers as therapists, social workers, medical students or doctors (e.g. Coombes & Anderson, 2000). Such papers often make the point that the adversity experienced by such children is sometimes transferred into a positive outcome, in a way similar to that reported within the 'Post-Traumatic Growth' literature.

Risk

Although these abstracts were chosen to focus on resilience, a number also examined risk. Some of their conclusions were that: the number of problem drinkers in the household was the strongest predictor of adolescent substance misuse (Mohr, 2000); that family conflict predicts adult alcohol problems in 'ACOAs' (Gogineni, 1995); that dysfunctional family processes lead to greater negative impact on childhood self esteem than parental substance misuse itself (Godsall, 1995).

Interventions

Significantly, there were very few studies that took any of these findings on resilience, coping or risk and translated them into interventions to test out whether it was possible to alter these potentially predictive relationships. A

number of studies presented 'frameworks' to help develop such interventions, or made suggestions of what these interventions might look like, without actually testing them (e.g. Begun & Zweben, 1990). Mylant et al's. (2002) work proposed that mental health professionals teach core resiliency factors to promote healthy behaviours for this vulnerable population. Finkelstein et al. (2005) and Arman & McNair (2000) described their group focused interventions but no results or evaluative data were available or presented.

One of the two sets of studies that did provide and then monitor the effects of an intervention is Catalano et al's. (1997, 1999, 2002) 'Focus on Families' programme. This approach combines parent skills training and home-based management services to reduce parents' risk for relapse to substance misuse and children's risk for the development of problems with substance use while enhancing protection. In 2002 they summarised all the results of their intervention: parents in methadone treatment can be successfully engaged, and will participate in intensive family interventions; the risk- and protective-focused intervention increased parent relapse prevention skills; the intervention had effects on reducing parents' drug use, domestic conflict, and deviant peer networks, increased the number of family rules and meetings and influenced parental coping. However, little data is available that focuses on the children.

Aktan et al. (1996) evaluated the effectiveness of the Safe Haven Program, a family skills training program for African-American families where one parent is a substance abuser. The evaluation was conducted on 88 substance-using and non-using parents and 88 children (aged 6-12 yrs), and they showed that the program was effective in increasing parenting efficacy and behaviours toward children, improving the children's risk and protective factors and behaviours, and supporting treatment reductions in the parent and family illegal substance use.

Conclusions and recommendations

These studies demonstrate that many children will grow to be resilient, although many will remain at risk. However, there is still a considerable lack of clarity over what many of the resilience factors are which determine these positive outcomes, and whether the factors which relate to resilience in this area are similar to or different from those factors which have been shown to be effective in more general resilience research. It is also the case that very few interventions have been developed to alter the social dynamics within families such that protective factors are increased and risk factors are reduced. Newman (2004) summarises key points and key messages related to resilience in the early years, middle childhood and adolescence / early adulthood. There may be ideas here that can inform research, practice and policy. This is a major area for further research.

PREGNANCY AND MOTHERHOOD

This was not a specific area listed in the original objectives for the scoping review, yet it emerged as an important area in which a lot of work had been undertaken.

The majority of the work in this area has focused on alcohol and cocaine. Many studies appeared to take as their starting point a clear understanding that pre- and postnatal alcohol or drug misuse can have serious negative effects on babies and their subsequent development. There is quite a lot of work specifically on fetal alcohol spectrum disorder but little that we found on neonatal abstinence syndrome. Ornoy et al. (1996) reinforce the point that there is considerable evidence that the use of 'drugs' or 'alcohol' alone is not the important issue: it is the type of drug or alcohol, the amount taken at any one time, the number of times this amount is taken, and the stage of pregnancy at which this occurs, as

well as a host of other, environmental, factors, which determine what, if any, negative impact substance misuse may have on a baby. As one example, and of relevance to the current national focus on binge-drinking trends, is a study that indicates a particular foetal risk if the mother binge-drinks, but the abstract is unclear on what constitutes a binge (Maier & West, 2001).

Many of the abstracts focused particularly on the impact of substance misuse on parenting (which usually means mothering), and on the mother-child interaction. However, very little of this work looked at the child's perspective, although one qualitative study reported on research with young mothers whose own mothers had misused substances. These young mothers demonstrated the long-term impact of maternal substance use and its impact on their own role as mothers, and wished to parent their own children differently. Linked to this is how becoming a parent (i.e. a mother) when also a substance misuser can act as either a catalyst or a barrier to seeking help or treatment: being a substance misuser can either motivate or stop women accessing pre-natal care, and becoming a (prospective) parent can either motivate or stop women accessing substance misuse treatment services. Many women are fearful (see also the Child Protection Section earlier in this report), that approaching treatment services may prompt child protection procedures.

The need for services to assist pregnant substance users is being increasingly recognised. Where work has focused on treatment services for women, positive outcomes have been demonstrated. These services are usually residential and sometimes accommodate the children. However, these outcomes relate mainly to the mother with few child-related outcomes reported. Additionally, few studies presented the views of the children. Some qualitative work has shown that, whilst women are aware of the risks of being a parent who is also a substance misuser, many women argue that they are still able to be good parents. It is the case that these views challenge traditional stereotypes of parenthood and mothering and such a challenge is appropriate; however, these mother's views do not appear to have been confirmed by additional work with children and others that might show whether or not substance misusing parents are still able to be good parents (see also Taylor, 1993 who conducted an ethnographic study with over 50 female injecting drug users in Glasgow).

It has been suggested that pregnant substance users could benefit from being managed using a shared care approach, involving obstetric services in conjunction with a substance misuse agency. Obstetric goals need to take account of pharmacological treatments, but should also shift towards a public health perspective, characterised by treating pregnant and postpartum substance misusers, protecting at-risk fetuses and children, and strengthening broken families. There is a need to educate pregnant women around alcohol, and the involvement of important people in mothers' social networks may be key to reducing substance misuse during pregnancy. Many studies have concluded that there need to be both women-specific and parenting components in existing treatment programs, where pregnant women who are substance misusers can benefit from comprehensive, family-centred treatment services and receive useful parenting advice. The benefits of specialist teams that treat addicted mothers and their babies have been demonstrated (Day et al., 2003), though there is a need for further work in this area with a view to developing more such services.

Many of the abstracts reviewed discussed fetal alcohol spectrum disorder. FASD covers the complete range of alcohol-related harm experienced by babies of mothers who drink during pregnancy. Children who have FASD are characterised by pre- and post-natal growth deficiency, distinctive facial features and moderate to severe learning difficulties and behaviour problems caused by central nervous

system impairment. Families caring for children who have disorders associated with FASD have a particular and high need for support programmes and services. Higher rates of mortality and child custody disputes are particular issues. Problems regarding provision of services for FASD include: (1) lack of appropriate standards of care; (2) limited availability of programmes or services specific to FASD; (3) lack of clarity over what is most effective: a need for programme evaluations in this area; and (4) concomitant problems in the care giving environment. There is a need for services and programmes directed at FASD, and more research is needed to clarify and define the needs.

One study (Richter & Bammer, 2000), modelled directly from qualitative work with heroin-using females, describes a hierarchy of strategies that these mothers use to reduce harm to their children from maternal substance misuse. This hierarchy is:

1. Stop using;
2. Go into treatment;
3. Maintain stable small habit;
4. Shield children from drug-related activities;
5. Keep home environment stable, safe and secure;
6. Stay out of jail; and
7. Place with a caregiver and maintain as active a parental role as possible.

It would be interesting to see how useful such a hierarchy might be to working with families in Scotland and to what extent it might be possible to adapt such a model to the stepped provision of services. However, the work of McKeganey, Barnard and colleagues suggests that the process of keeping children shielded from drug-related activities and its negative impacts is by no means straightforward, so this issue would need to be carefully considered. Some work in Scotland has been done to specifically consider the clinical management of pregnant substance users (Scottish Borders region inter-agency children protection guidelines, 2004).

Conclusions and recommendations

- Becoming pregnant or being a mother whilst simultaneously misusing substances can be a barrier to accessing ante- or post-natal care, providing good parenting, and accessing substance misuse treatment. However, there is evidence that if treatment is accessed, this may be a good time to offer help, and that outcomes can be positive. A drawback is that the evidence on which this statement is based is largely from the USA, generally concerns residential treatment that is expensive, and has not adequately looked at experiences of and outcomes for children. Further work is needed to explore the extent to which these problems are mirrored in the UK / Scotland.
- A lack of attention to children, and other family members (particularly fathers - see Fathers section for more detail), is clear and addressing this must therefore be a recommendation for future work.
- Linked to the research on resilience is the identification of the importance of attending to protective and resilience factors and processes at all stages of the life cycle, including ante-, pre- and post-natally. Newman (2004) summarises key points and key messages related to resilience in the early years, middle childhood and adolescence / early adulthood. There may be ideas here that can inform research, practice and policy.

FATHERS²

The literature in the database about fathers fell into three main categories.

- Level one: the impact on children of having a substance-misusing (primarily 'alcoholic') father. The majority of abstracts fell into this category.
- Level two: the impact of substance misuse (again primarily alcohol) on the father-child relationship and/or father characteristics / behaviours that mediate the impact of substance misuse on their children.
- Level three: the impact of substance misuse on fathers and fathering, exploring fathers' views and concerns and the fathering role. There were few abstracts here.

Level One

Several impacts for children of having a substance misusing (mainly alcohol) father were identified – their own substance use, psychopathology and psychiatric disorder, physical health, personality characteristics, psychosocial adjustment, adult attachment, cognitive functioning, school attainment or adjustment, behaviour conduct, risk and resilience factors. A small number of abstracts also looked at genetic transmission of addictive behaviours between substance-misusing fathers and their offspring. A small number of studies explored the differential findings associated with drug misuse and alcohol misuse (e.g. Cooke et al., 2004; Kelley & Fals-Stewart, 2004). Both found that children of drug misusing fathers were at greater risk than alcohol misusing fathers of negative behaviours, psychosocial impairment and lifetime psychiatric disorder.

Level Two

The literature suggests a complex pathway between paternal substance misuse and unfavourable outcomes for children. Some studies focussed on the negative impact of substance misuse on various aspects of fathering (Das Eiden et al., 2002; Das Eiden & Leonard, 2000; Dumka & Roosa, 1995; Brooks et al, 1998), whilst others look at mediating factors (e.g. family structure or paternal warmth) that may reduce the negative impact of (paternal) substance misuse on children. Some studies explored differences depending on whether fathers, mothers or both parents are substance misusers. Finally a number of studies focussed on the impact of substance misuse not only on the children, but also the (usually non substance-misusing) mothers in these families (e.g. Frank et al, 2002; Fisher, 1998; Das Eiden & Leonard, 1999), and report negative psychological and physical outcomes associated with the fathers' substance misuse. These are all factors to take into account when considering intervention and service delivery.

Few abstracts made direct reference to paternal responsibility, and the importance of father-child relationships, and there appears to be a general sense that mother-child relationships are much more significant (Cavell et al., 2002; Tweed & Ryff, 1996). However, Tarter et al. (2001) take a unique angle, reporting the finding that children living with both parents have better outcomes, in terms of conduct problems and own substance misuse, than those whose fathers were absent – even when the father is misusing substances. They suggest this is because single men show more severe alcohol or drug misuse than those living with their families. Furthermore, they suggest that mothers with absent substance misusing partners have fewer resources for effective parenting. This at least seems to suggest a role for substance misusing fathers and reveal

² This was not initially identified as key objective for review, so a slightly different approach was taken to reviewing the literature. This involved searching the database using the terms 'father', 'fathers', 'fathering' and 'paternal' in the title field. This resulted in 123 hits, all reviewed at scoping level two.

they can offer something to their children. However, given that these findings are from one study, further work would be needed.

Level Three

McMahon & Rounsaville (2002) assert that, "although a number of socio-economic forces have converged across cultures to make fathering one of the more prominent social issues of the new millennium, the status of substance-abusing men as fathers is rarely acknowledged in the conceptualisation of public policy, service delivery or research focusing on the adverse consequences of drug and alcohol abuse" (p1109). The studies that do attempt to explore these issues further reveal that fathers are overwhelmingly placed, or place themselves, in a peripheral position where the care of their children is concerned.

In a study exploring drug addicted fathers' uncertainties about their importance to their children, Arenas & Greif (2000) describe how fathers often believe their children were better off without them. The authors found these men had a number of concerns about fatherhood, including, 'having no concept of what a father should be, confusing the roles of manhood and fatherhood, feeling inadequate as a provider and not knowing how to reconnect with children they have not seen, particularly daughters' (p339). The authors also describe the guilt the fathers felt if they abandoned their children. They go on to suggest possible interventions with fathers that focus on teaching them about positive fathering, and encouraging them to discuss their own parenting experiences. Again the study reveals the impact on parenting capacity, but more so, fathers' concerns about this. It is extremely positive to note the suggestion for working with such fathers on their fathering techniques, and their associated anxieties.

Only one study reported an impact on fathers where mothers were the substance misusers. Dumka & Roosa (1995) report mothers' problem drinking contributed to less positive father-child relationships. Further gaps in the literature include the role of fathers in families with substance misusing mothers. Studies looking into the efficacy of parenting interventions with fathers may also be useful in terms of finding strategies to build the types of relationship and family environment which are known to protect children from the risks associated with paternal substance misuse.

Conclusions and recommendations

There is a great deal of literature available that explores the impact of paternal substance misuse on children, but there is a major lack of research into fathering and fatherhood in relation to this area. Fathers are typically viewed as "entirely negative influences that need to be actively excluded from the lives of their children" (McMahon & Giannini, 2003, p337). Debates around the role of fathers within substance misusing families occur as part of a broader societal debate around the role of fathers in relation to social exclusion, environmental factors, and the role of the wider family and social networks. Thus, there is a need for further work and understanding, both on the role that fathers play in increasing risk to children, both directly via their negative behaviours and indirectly via both their negative behaviours towards the child's mother, and any lack of acceptance of responsibility for their role as a parent. However, it also needs to explore the more positive or protective role that they may play if they do accept responsibility as a parent for protecting their children or acting in ways that promote their children's resilience. There is little literature that has explored fathering in much depth; even fewer have explored fathers' voices on this subject. McMahon & Rounsaville (2002) suggest a number of areas that need investigation, including the ways in which substance misuse contributes to a 'compromise of fathering', the ways in which this compromise of fathering contributes to psychological distress in these men, and the ways in which intervention might be used to

minimise the harm associated with paternal substance misuse. Some work is underway in Scotland (Whittaker, 2005) to investigate this issue in more depth but more work is clearly needed.

CHILDREN'S VIEWS

An identified gap throughout the literature is work investigating or reporting children's views about a whole range of issues related to parental substance misuse. This needs to incorporate qualitative work in particular as well as the views of young children. Two key pieces of work provide recent reviews of the literature (Gorin, 2004; Kroll & Taylor, 2003). Other work of note is by McKeganey and colleagues in Glasgow (e.g. McKeganey, McIntosh & MacDonald, 2003). Due to a lack of detail in the majority of the other abstracts reviewed, this summary is heavily informed by these pieces. A number of key, overlapping, themes dominate the findings in relation to children's views. These include secrecy, isolation, emotions, conflict & disharmony, roles and coping. For the most part, these themes operate in two ways: within the family, that is between parents and children; and externally, between the child and the outside world, but the focus in the literature remains largely on the impact of substance misuse on children. The views expressed mirror the wider literature describing the impact of parental substance misuse on children so will not be detailed here. However, it is important to recognise the implications for service provision. Although some qualitative Scotland based work (Barnard, 2005) has been done to explore the impact of substance misuse on siblings, this focused on families where another child was the substance misuser rather than a parent. Further work is needed to explore the potentially differential impact and needs of siblings affected by parental substance misuse.

A key finding with particularly relevant implications for service provision relates to barriers to help-seeking. Reference is commonly made to children's reluctance to speak to people outside the family about the problems they are facing within it. A number of related reasons emerge, including loyalty, fear (of nothing being done), the reactions of others, shame and stigma. Interestingly, and somewhat conversely, children have reported feeling aggrieved that people have not tried harder to break down this barrier and uncover the truth (Kroll & Taylor, 2003).

However, regardless of the barriers, children's needs exist. Hay, Gannon & McKeganey (2005) have done the most recent prevalence related work in Scotland (focusing on Glasgow). Their conclusion states, "We know very little about those children – in particular we do not know who are caring for them when the mother is not caring for them. We know very little of the needs of these children or indeed what proportion have had their needs assessed or have remained hidden from services" (p28).

Because children are concerned about talking to people about what is going on at home, confidentiality is paramount. Children have frequently highlighted the importance of establishing trust when discussing their needs (Gorin, 2004). Gorin also describes the 'personal qualities' of helpers as being important for children – so, for example, confiding in someone who will listen, and someone who is kind and consistently valued by children (see also Bancroft et al, 2004; Liverpool DAAT, 2001). Whilst this may seem a simple need to fulfil, a number of studies have reported the fact that children often feel professionals in particular fail to listen or understand, and appear to talk in a different language. Additionally, professionals do not always speak directly to children (Gorin, 2004).

Christensen (1997) reports that children taking part in her study felt, 'the best place to get attention and help was...the treatment institution where the parents

get help' (p24). However, a common finding (Gorin, 2004) is that children talk about needing confidential support, for example from helplines. Both Gorin (2004) and Kroll (2003) also report the desire some children have to meet others who have had, or are having, similar experiences. Hill, Laybourn & Brown (1996) report on a Scottish study that talked to children, young people and professionals about impact and need - "Many wished they could meet with others in the same position, so they could feel less isolated and learn from each other" (p159).

Support also comes from protecting some sense of normality. Children describe the need to get out of the house and engage in childhood activities (Gorin, 2004; Liverpool DAAT, 2001). They also describe calling on parents, other family members and friends for informal support (Bancroft et al, 2004; Gorin, 2004; Liverpool DAAT, 2001). It is important to bear in mind the efficacy of more informal sources and types of support. Gance-Cleveland (2004) reports the efficacy of a school-based support group for adolescents. The young people reported benefiting from experiential knowledge gained at the groups, and said the groups "enhanced self-knowledge and led to self-care and self-healing" (p379). The author concluded that the opportunity to share experiences and learn from others 'empowered' the young people to make changes to the dysfunctional patterns in their lives.

Identified needs in a study by Hill, Laybourn & Brown (1996) are for a range of services to be available including group work, counselling, family mediation and education. More help needs to be available at a generic level, which triggers referrals to specific services targeted at children. Hill, Laybourn & Brown (1996) highlight five things to bear in mind when thinking about help for children: that parental substance misuse is a widespread problem, that problems arise mainly from excessive problem drinking, that there are diverse problems and therefore diverse needs, that children need to ask for help, and the importance of informal sources of support, for example from non-misusing parents, siblings and other adults needs to be recognised.

Conclusions and recommendations

Whilst the focus of many of the studies exploring children's voices about parental substance misuse is on their negative experiences, it is by no means taken for granted that parental substance misuse per se has a negative impact on children. Finding out what children think and want enables researchers to unpick the complexity of the relationship between parental substance misuse and unfavourable outcomes for children. As discussed above these studies have revealed that it is associated factors, such as parental conflict and family disharmony or worry about drinking or drug taking, that most significantly affect children. The implication of this is that interventions focusing purely on parents' use may not be the most effective. Children need support in dealing with their often confused feelings and emotions towards their parents and their families, they need strategies to help them cope with the various consequences of their parent's substance misuse. This support needs to continue in its own right, regardless of where the parent may be in their treatment, and needs to be provided in an environment where children can feel safe to talk, but not forced to. How to initiate the provision of support is perhaps a more problematic issue. What is clear from the findings discussed above is that professionals need to be open to even the subtlest signs of parental substance misuse, and respond with sensitivity and patience.

As we, and others (e.g. Gorin, 2004; Kroll, 2003) have found, there is a significant lack of research that has directly explored children's views and experiences of parental substance misuse, and therefore our understanding of impact, resilience factors, service needs, existing service provision, and

intervention and treatment often lacks an essential and informative angle. A clear recommendation must therefore be the commissioning of more work that will directly explore the views and experiences of children living with parental substance misuse, and this work must include attempts to talk to children of parents who are and who are not receiving help for their alcohol or drug problem, the voices of children whose parents misuse alcohol and the voices of children whose parents misuse drugs, and the voices of children from different cultural backgrounds (Gorin, 2004; Kroll, 2003). The majority of studies to date have reported the views and experiences of children who have been in contact with services – a factor which might influence the conclusions drawn. Finally, such work should take account of gender, age and developmental stage (Clever, Unell & Aldgate, 1999).

MENTAL HEALTH

The area of mental health in relation to parental substance misuse is a complex one. There were, however, few clear messages to emerge from the abstracts that were reviewed for this section, demonstrating a clear need for further work in this area. The key reason for this lack of clarity appears to be the number of possible relationships between mental health problems, parental substance misuse and the impact on children. The following list gives some examples of this variety:

- 1) Parental substance misuse and co-existing mental health problems, and the impact on parenting.
- 2) Parental substance misuse and its impact on children's mental health.
- 3) Parental substance misuse and its impact on children's mental health and co-existing substance misuse.
- 4) Parental substance misuse and co-existing mental health problems, and their impact on children's mental health.
- 5) Parental substance misuse and co-existing mental health problems, and their impact on children's substance use and co-existing mental health problems.
- 6) Prenatal substance use and its impact on children's mental health.
- 7) Prenatal/perinatal substance misuse and co-existing mental health problems.
- 8) Parental substance misuse and co-existing mental health problems, and their impact on children's substance use.
- 9) Parental mental health problems and its impact on children's substance use.

The above encompasses children who are infants/babies, younger children, adolescents and adult children. Any work in this area should take age, gender and developmental stages into account. Linked to this, 'mental health' could be interpreted widely to include both psychological development and psychiatric problems.

A number of the studies examined the extent to which parental substance use was harmful to the mental health or psychological development of the children in the family. The findings appear to be equivocal, with some evidence showing a clear negative impact on children (Cuijpers et al., 1999; Johnson 1995; Mathew et al., 1993; Obot and Anthony, 2004; Martin et al., 2000; Caudill et al., 1994; Williams and Corrigan, 1992; Carmichael-Olson et al., 2001; Beckwith et al., 1999). One study reviewed showed ethnic differences (Marse, 2002) and given the lack of research addressing ethnic differences this would be an area for further research.

Many studies, however, showed that parental alcohol and drug use does not predict psychiatric problems in offspring (Lehnert, 1998), nor that alcohol or drug use is solely responsible for children developing mental health problems. Any problems emerged from a number of individual and environmental variables (Glaun & Brown, 1999; Martin et al., 2000; Ellis et al., 1997; Luthar et al., 2003, Reder and Duncan, 2000; Lyman, 1997).

Several authors touched on service provision issues. Cornelius et al., (2001) found that parental substance problems and mental health problems acted as a barrier to accessing mental health services when their children needed them. Grella (1996, 1997) drew attention to the fact that services do not meet the needs of pregnant dually diagnosed women and Schwab et al., (1991) found that children's needs were not always met where there were "dual disordered" parents. Only one report reviewed addressed the practice and policy challenges of providing services to meet the needs of young children and parents with substance and/or mental health problems (Knitzer, 2000).

There were a number of studies that highlighted gender differences, either in terms of the children or the parent. Johnson (1995) found "female offspring" more likely to experience depression "regardless of the parental disorder", i.e. mental health or substance use problems, and that male children suffered more drug abuse problems. This was supported by other studies that tended to find female adult children suffering psychiatric problems and male adult children suffering alcohol and drug problems (Matthew et al., 1993). Conversely, Lynskey et al., (1994) found no gender differences. In relation to the gender of the parent, for example, Cuijpers et al., (1999) found the father's problem drinking was more closely related to the children's psychiatric problems, in particular the development of substance use problems. Luthar et al. (1993) found maternal mental health problems associated with mental ill health among children and the father's alcohol problems "showing associations" with black children's substance problems.

While this section focused on parental substance use and associated mental health problems, it was significant that domestic violence and childhood abuse were issues that arose in many of the studies. Alcohol-related domestic violence by the father had a negative impact on the children's mental health (Malpique et al., 1998). Chaffin et al., (1996) found that parental substance abuse and psychiatric problems increased risk factors for physical abuse and neglect, while physical and sexual abuse were features of adult children with mental health problems (Lehnert, 1998). In addition, Killeen et al., (1995) found pregnant dually diagnosed women had significant histories of childhood abuse. Moss et al. (1995) looked at the impact of father-son relationship in the context of paternal mental health and substance problems. While these sons were more aggressive this was not as a result of substance use or psychiatric problems of the father, rather it was associated with the father's other personality variables including paternal aggression and low self-esteem. Das Eiden and Leonard (2000, Das Eiden et al., 1999) also found that the mental health problems associated with father's drinking had a negative impact on parental attitudes to children and particularly the father's interaction with the child.

Conclusions and recommendations

This is a complex area, and for reliable conclusions to be made there would need to be a further review of the literature. This should take into account the various possible relationships between substance use and mental health problems for both adult and child. From this brief review of the abstracts, it is evident that there is a range of ways the two issues can relate and this has resulted in no clear messages about the impact on children and the family. However, the

findings show how such levels of complexity can have negative effects on the children but that these are often mediated or exacerbated by environmental factors. This again suggests that holistic approaches to intervention are needed that address the many variables affecting the family rather than focusing on just the mental health or substance misuse alone.

INTERVENTIONS / SERVICE PROVISION

The response to substance misuse remains largely focused on the individuals who are misusing alcohol or drugs. There is growing evidence, however, that services and interventions which have been found to be helpful pay attention to a number of factors including: the family and social context, engagement, support, communication, therapeutic and educational support, and being needs responsive (for example, sessions out of hours, child care, transport and home visits). There is evidence of the effectiveness of a range of ways of working with families affected by substance misuse though further work is needed in this area (Copello, Velleman & Templeton, 2005; Barnard & McKeganey, 2004). Services and interventions tend to be American, not always rigorously evaluated, use relatively small sample sizes, do not always differentiate between alcohol and drugs and are often resource intensive. There is therefore a need for further work and discussion in this area, with a particular focus on how responses could be adapted and transferred to the UK (and to Scotland).

Engagement, of both substance misusers and their families (including children) is paramount. A recent national evaluation of pump-priming drug prevention projects for vulnerable young people (University of Glasgow and the Department of Health, 2004) produced two fact sheets, one on drug prevention with parents and carers of drugs users and the other on drug prevention with children of drug using parents. Important issues when working with parents and carers include: mothers are more likely to access support; there needs to be a clear referral process for getting help, home visits are useful, support groups must accept that attendance will fluctuate thus emphasising the need for flexibility, and staff training and good links with others are important. Finally, GPs are often the first point of contact for many family members but GPs often do not feel well enough equipped to be able to respond. Drug prevention with children of drug using parents must consider the need for specialist skills / knowledge, have clear protocols for the work, both within the organisation but also with other agencies, understand the fear of social services held by many children and parents, offer help with transport where possible, and generally consider less structured work (i.e. work responsively and proactively) with clear boundaries and reassurance for parents on issues of safety and confidentiality.

Interventions or services with children and families can be broadly summarised into four categories:

- 1) Those working with whole families (usually at least one parent and at least one child);
- 2) Those focused on working with children;
- 3) Those focused on adult family members; and
- 4) Those more focused on complex situations, such as women who are pregnant, children who also live with domestic violence or who are from black and minority ethnic groups.

Interventions that are family focused

Many evaluated programmes come from the USA, and emphasise that the family is a substantial resource for healing and recovery. With a particular focus on work with severely fractured families, most of these programmes attempt to keep

children connected with their own families, even when circumstances prevent them from living together. Where family preservation is not possible, it is seen to be of critical importance to utilise strategies to keep families involved in the treatment process, to reinforce contact between parents and children. Many studies argue for the development of family preservation programmes and family-oriented substance misuse treatment programmes. Others (e.g. Velleman, Templeton & Copello, 2005; Copello, Velleman & Templeton, 2005) have reviewed the benefits of responding in a family focused way. Overall, however, it appears that there is a lack of focus on the children who attend such family services or programmes, on their experiences and outcomes.

One of the most widely known, and well evaluated, programmes is the Strengthening Families Programme (SFP). A systematic review of primary prevention programmes for alcohol misuse in young people (Foxcroft et al., 2003), concluded that this was the only programme that could demonstrate effectiveness, maintained longer-term. SFP is a community based, primarily drug and alcohol prevention programme, which combines family and child work, focused on factors of risk and protection, in a series of parallel and combined sessions over a number of weeks. Evidence of effectiveness has been demonstrated across a range of groups and settings. SFP is currently being adapted and replicated in North England (see Velleman, Templeton & Copello, 2005, particularly pages 101-102, for more detail and references).

Another approach that has been tested is the Focus on Families programme (see the Resilience section for more detail and references). One important factor to be highlighted here is the benefits of combining clinical, therapeutic work, with home visits.

Interventions with children

This is a key area for further attention. Most of the work that has been done has focused on prevention initiatives (the work of Cuijpers is useful here), or on American work that is biased towards 'children of alcoholics' or 'adult children of alcoholics'. Barnard (2001) reviewed interventions for drug dependent parents and their children, concluding that working in families where there are younger children brings higher rates of success, and that home-based interventions, peer support, work through schools, community based schemes and play based schemes all have potential. She also highlights the potential for engagement and continued work with parents and children identified through methadone maintenance clinics.

The abstracts reviewed support the general conclusion that a range of interventions is beneficial, including school-based programs, play therapy, social support development and group therapy. Emshoff & Price (1999) suggest that information, coping skills (emotion focused and problem-solving) and support (social and emotional) are key components for working with children of parents with alcohol or drug problems. Emshoff & Jacobus (2001) report that play therapy can be both a relief for children and can also reduce risk. A main element of the experience of having a parent with an alcohol or drug problem, reported in the general literature, is 'loss of childhood', demonstrated by children who miss out on opportunities to play, either because of a lack of positive parenting or because the child has to look after parents or siblings (parentification). Banwell, Denton & Bammer (2002) [summarised in Copello, Velleman & Templeton, 2005], summarise six challenges to be overcome when working with children: 1) getting the balance right between intervention and trust; 2) location; 3) staff support; 4) multi-agency collaboration; 5) funding (including for evaluation); and 6) the need for flexibility.

Recent developments in working with children affected by parental substance misuse in the UK have paid much more attention to the needs of the child, and of working with the whole family where possible, but where the child is at the centre. Linked to this is the increase in thinking and practical work that considers the importance for, and development of, resilience (Velleman & Templeton, 2005 provides a useful summary and references). Two examples in England and Wales are the Family Alcohol Service and Option 2. The Family Alcohol Service, a joint initiative between the NSPCC and the London-wide Alcohol Recovery Project, is a multi-disciplinary team that combines alcohol and family work. The service works centrally with the children but also with whomever else in the family wishes to engage (including the misuser). A report of the evaluation of the pilot year of this service discusses the project's success, but also some of the key challenges to have emerged when working in this way (Velleman et al., 2003). Option 2 is a short-term but intensive programme of work that engages with a family at a point of crisis, usually when a child is at serious risk of being removed from the family (see Hamer, 2005 for a detailed description of the Option 2 way of working). Both Option 2 and the Family Alcohol Service have the development and maintenance of resilience as a theoretical foundation to their practice. The authors of this current review are aware of a few other services in England that are similarly grounded in this family focused way of thinking and working. In the light of the principles of Every Child Matters (2003), with its focus on improving opportunities and outcomes for all children, and the contradictory lack of focus on children and the family within some substance misuse (particularly alcohol) policy, these developments are important and significant.

Baker & Cunningham (2004) list ten strategies to consider when working on parenting issues. They were developed for children living with violence, but could be more widely considered for parental substance misuse.

1. Positive role modelling
2. Clear expectations
3. Praise good behaviour
4. Focus on behaviour not qualities of child
5. Explanation for requests
6. Avoid emotional reactions and yelling
7. Givens and choices
8. Reasonable expectations
9. Boundaries around adult matters
10. Spending time with the children

Interventions with parents / adult family members

Copello, Velleman & Templeton's review of family interventions (2005), summarise (adult) family focused interventions as: 1) acting as a mechanism for the entry and engagement of substance misusers into the treatment system; 2) working jointly with substance misusers and (usually, adult) family members; and 3) responding to the needs of family members in their own right. All three areas demonstrate evidence of effectiveness though the authors (and others, e.g. Barnard & McKeganey, 2004) argue that further work is needed.

Interventions that act as a mechanism for the entry and engagement of substance misusers into the treatment system have been shown to be effective. The most well known examples are the Australian Pressures to Change approach (Barber & Crisp, 1995), and the American programmes of CRAFT (Community Reinforcement and Family Training [Smith & Meyers, 2004] and ARISE (A Relational Intervention Sequence for Engagement [Garrett et al., 1998])).

Joint work with substance misusers and (usually adult) family members is based on the demonstration that, "*attention to the person's social context and support*

system is prominent among several of the most supported approaches" (Miller & Wilbourne, 2002 p276). Miller & Wilbourne's major review (2002) demonstrated that several of the most effective treatments for alcohol problems included attention to social context. Behavioural, couples and marital work, social skills training and the community reinforcement approach are all good examples. A growing area of interest is in network approaches. Most recently tested is Social Behaviour and Network Therapy (SBNT; Copello et al., 2005; Copello et al., 2002), developed and tested as one of two treatments in the UK Alcohol Treatment Trial, an amalgamation of key elements of several other, socially grounded, treatments. A key finding from UKATT was that SBNT demonstrated effectiveness on a par with its comparison treatment of Motivational Enhancement Therapy, and that led to improvements in drinking behaviour and associated problems (UKATT Research Team, 2005).

Other recent work has focused specifically on responding to the needs of family members in their own right, by testing a brief intervention treatment package, to be delivered by primary health care professionals to family members (Copello et al., 2000). This is a coherent package that can respond to family members' identified needs in the primary care environment; it could be rolled out across Scotland. Further work has tested a self-help version of the intervention, and has also tested feasibility in specialist drug and alcohol teams (Templeton, Zohhadi & Velleman, 2004); and this work further demonstrates the potential for further consideration.

An additional and important area to mention is that of self-help support groups and interventions. Al-Anon (alcohol) and Adfam (drugs) are the most well known of these. Whilst rigorous evaluation of such anonymous organisations is difficult, membership numbers and anecdotal evidence are testimony of their reach, significance and benefits

As with the studies relating to children, the evidence therefore suggests that a range of interventions is beneficial to adult family members (including parents), and a range of positive outcomes can be demonstrated. Several studies report a lack of hypothesised differences between treatments, something that has also been noted in other comparative, trial-based studies of interventions with alcohol misusers and/or their families (e.g. Project MATCH, a major alcohol treatment trial in the USA [Project MATCH Research Group, 1997]; UKATT, the UK Alcohol Treatment Trial [UKATT Research Team, 2005], and a brief intervention delivered in the primary care setting in England [Copello et al., 2000]). Figlie et al. (2002) note that, "there is not a consensus about the type of treatment to be used" (p327) which, when combined with the point just made, suggests that factors other than the nature of the treatment or intervention are equally important for engagement, retention, positive change and maintenance of change. This needs further exploration with regard to children and family members.

Interventions that respond to complexity

There are several areas that will be considered here, first of which is working with pregnant women or mothers with babies / young children. There is a lot of work in this area, most of it again from the USA, and referring mainly to working with women who are, with or without children being part of the intervention, often involving a study within a residential treatment facility (usually USA studies), thus bringing implications of resources. Whilst acknowledging the potential for, and sometimes the benefits of, interventions (usually undertaken within these studies within residential facilities) for mothers / pregnant women, there is a lack of research that focuses on the short- and long-term outcomes for babies and children. Parenting is clearly a key issue for consideration here, both in terms of the low levels of parenting skills reported by the women in these studies and

hence in others who use such treatment facilities, and also in terms of parenting skills training and development needing to be a focus of the help that women, and their children, receive. There are some examples of residential facilities that cater for the needs of mothers and children in the UK (e.g. the Aberlour Child Care Trust in Scotland and Phoenix House in England) but further work is needed. This work must also consider the needs of, and role of, other members of the family and network, for example, fathers, siblings and grandparents.

Second, are the particular needs of children affected by parental substance misuse who also live with domestic violence. As already highlighted in this report, this is an area where further work is needed at all levels. This review has repeatedly highlighted the presence of domestic violence where there is substance misuse. Service response and family interventions need to think carefully about how family work can be made safe where domestic violence exists. Current evidence suggests that many network-based therapies have failed to screen for, or consider, domestic violence prior to starting family intervention, placing women and children at potentially greater risk. Any such change will involve training staff in responding to domestic violence and ensuring referral processes screen for domestic abuse. The London based Stella Project has been specifically established to provide services with training and policy guidance on the overlap between substance misuse and domestic violence. There are no known examples of services that cater specifically for children and families affected by both substance misuse and domestic violence, though some separate services (substance misuse or domestic violence) are developing joint-working protocols and providing mutual support to improve their service delivery, for example, the Family Alcohol Service in London and the Nia Project in London (formerly Hackney Women's Aid).

Finally, it is important to recognise the needs of children from black and minority ethnic groups living with substance misuse. The STARS Initiative in Nottingham, England, is one service that has considered the particular needs of these groups of children, though primarily in the area of child protection placements (Mayer, 2004). There is a need for further work in this area, to understand whether children from different backgrounds and cultures have different experiences and needs, and to develop culturally sensitive services that can maintain engagement.

Conclusions

"...children have only rarely been the direct focus of intervention, with the assumption that they will benefit from the support offered to their parents....[require] interventions that are equally cognizant of children's perspectives and needs....Interventions have also overlooked the significance of the extended family....[the] same point applies to fathers or partners with drug problems" (Barnard & McKeganey, 2004 p557).

- There is a clear and definable need for further work in this area, particularly with other family members, especially with fathers and with the children themselves. Copello, Velleman & Templeton (2005) say that future work in this area needs to focus on: "...1) pragmatic trials that are more representative of routine clinical settings; 2) cost-effectiveness analyses....3) explore treatment process; and 4) make use of qualitative methods" (p369).
- Given the amount of work in this area that comes from the USA, with its focus on the medical model, abstinence and associated terminology, discussion is needed on the transferability and adaptability of interventions and services to the UK / Scotland.
- Barnard & McKeganey (2004) say that those services and interventions that exist, and which have had their benefits demonstrated, tend to be

localised. One of the conclusions of Murray's (2003) assessment of the prevalence of children of substance misusers was that, "there are clear gaps in the delivery of local services that must be addressed to comply with national guidelines" (p4). The expansion and generalisability of such services, for example across the statutory sector, is a challenge for the future, and one to be considered as a recommendation from this review.

- Indications are that some services / programmes exist, but that solid research and evaluation, particularly focusing on children and their experiences / outcomes is lacking.
- In developing services for children and families, there are related training needs in working with children, in responding to complexity and in working with other agencies in a safe, ethical and helpful way. There is longstanding evidence from other areas of research that staff will only undertake new and potentially challenging work if they are both adequately trained and adequately supported in these new roles.
- Continued consideration should be given to issues of resilience and how factors likely to increase resilience could be potentially included as elements of intervention. Whilst the general resilience literature is sizeable, work on its practical application is particularly lacking (Newman, 2004), and this recommendation can be applied to children affected by parental substance misuse.

DISCUSSION³

A great deal of research has been undertaken in the area of parental substance misuse. However, this has tended to focus on certain issues, leaving some major areas where limited work has been done. The following summarises some of the key issues to have emerged from our review.

Differentiation between substances: There is evidence that different types of substances and patterns of misuse, and related negative behaviours, impact differently on people, both between individuals and within the same individuals at different times. It might also be expected that such differences might have a differential impact on children and other affected family members. However, although there are some general findings that are pertinent, the scoping review that we undertook did not reveal any material that examined this issue. Partly this was because there were no papers that specifically addressed this issue. But also it was because the literature frequently does not discriminate between different substances or patterns (e.g. 'catch all' terms are used to describe parental misuse such as substance misuse, abuse, addiction etc.). Furthermore, the rising rates of both polydrug use and co-existing mental health and other problems makes it hard to isolate the 'cause' of an impact.

The general findings mentioned above (e.g. Dore et al., 1995; Kolar et al., 1994; Murphy et al., 1991; Velleman, 2001) suggest that, although there are large personal differences in how alcohol or any other drug affects individuals, there are also commonalities: some types of drug or patterns of drug (mis)use are more associated behaviourally with some types of behaviour, which then are associated with how these affected individuals behave towards their children. Hence for example, related to type of drug, there are quite strong findings that

³ The majority of work reviewed emanates from the USA, thus bringing bias to the topic under review, both in terms of its underpinning theoretical orientation (disease and medically oriented), and its treatment philosophy (abstinence oriented as opposed to harm reduction). This is also evident in the language used, which is grounded in medical ways of viewing addiction, particularly linked to alcohol ('alcoholism'), and in terms of viewing people as 'alcoholics', 'drug addicts', 'children of alcoholics', and 'adult children of alcoholics'.

parents who misuse alcohol are more likely to demonstrate aggression and violent behaviour than are parents who misuse opiates, whose behaviour is more commonly associated with neglect. An example related to patterns of use is that there are quite strong findings that binge drinking patterns of consumption are more commonly associated with violent and aggressive behaviour than are patterns of very regular or constant heavy drinking over very long periods, which are associated with greater individual physical damage for the drinker but with less anti-social and violent behaviour towards others.

Nevertheless, it would be wrong to over-emphasise these differences in type of drug and pattern of misuse. The core dimensions (psychological, physical, interpersonal, social, academic, behavioural) of the experience of living with a parent (or other family member) with substance misuse are believed to be very similar (Orford et al., 2005; Velleman, 2001), and further work would be needed to explore how different substance and patterns of misuse affect children. Moreover, research has also demonstrated (Velleman & Orford, 1999) that often it is the behavioural impact of the substance misuse (family disharmony and disruption), rather than the substance misuse itself that causes the greater problems.

Prevalence: Clear and methodologically sound attempts to measure and validate the numbers of children and families affected by substance misuse are severely lacking. Estimates about specific issues relating to parental substance misuse, such as domestic violence, are also lacking. Similarly, child protection statistics do not always consider the role of issues such as parental substance misuse (it was not mentioned in the statistics for Scotland for 2004-2005). Estimates of the cost to society of having a relative with a substance misuse problem (for example, school days lost, illness, unemployment, use of health / social care service) are also lacking (Prime Minister's Strategy Unit, 2004). Given that parental substance misuse impacts upon children in terms of school days lost and developmental problems, it is fair to assume that the financial and social costs to families and communities is high, but firmer evidence is needed to convince policymakers, commissioners and other influential stakeholders to push forward the practice, research and policy agenda. However, uncertainty remains about the best way to calculate such estimates and this must be addressed.

A focus on risk: Much of the literature is biased towards the biochemical and pharmacological impact of addiction, and on genetics, and on specifically negative aspects of parental substance misuse, focusing on negative impact and risk, including inter-generational transmission and the development of own substance misuse (or other) problems. Given the number of previous reviews of work in this area, this is not one of the areas that we have explored in depth. However, it should be highlighted that, despite the predominance of this focus on negative impact, we have seen studies that found no evidence of heightened risk for children (compared to control groups who lived with other family problems or were not identified as having any family problems at all). Furthermore, it is clear from these studies that it is often the problems that are associated with or arise from the (parental) substance misuse, along with a wide range of environmental factors, which can have a stronger negative impact than does the misuse per se. Hence there is a need to view parental substance misuse as part of a far wider, multi-dimensional, picture.

Resilience: There is evidence that a shift has been taking place over the last decade or so, away from the over-emphasis on risk discussed above, and towards an understanding that many of these children are resilient, or have the capacity to develop resilience (either naturally or with stimulation within or external to the family). This is an important shift and one that can potentially alter the attitudes

of those delivering services, allowing them to become much more hopeful as to the possibilities of supporting children and families, and improving parenting and the parent-child relationship. Perhaps more importantly, such a shift could alter the quality of services for those who receive them: a focus on what they are 'doing right' as opposed to emphasising what they are 'doing wrong' could make them feel more valued as clients, and as parents and children. Whilst it is commonly recognised that the primary resilience (protective) factor is the presence of a safe and stable adult – parent, other family member, teacher, social worker etc., there is still a considerable lack of clarity over what many of the resilience factors are which determine these positive outcomes, and whether the factors which relate to resilience in this area are similar to or different from those factors which have been shown to be effective in more general resilience research. It is also the case that very few interventions have been developed to alter the social dynamics within families such that protective factors are increased and risk factors are reduced. The gap here is to consider how interventions to promote resilience can be integrated into service delivery. There are some examples in the UK social care field of the development of guidelines to support professionals to work within a resilience framework (Newman, 2002; Gilligan, 2000), but further work and evaluation is needed.

Children: Ultimately, there has been an overall lack of inclination, until fairly recently, to put the child first and this is where one of the biggest philosophical shifts needs to occur. The Scottish based work of McKeganey, Barnard and colleagues is a notable exception, and is thus an important contribution, but it is focused on drugs. Furthermore, the work that has been done has focused on the impact on children of having a parent with an alcohol or drug problem. There is a need for further work that incorporates children's views in relation to, for example, resilience factors, service needs, service provision, and evaluations of interventions and services. Further work is also needed at all levels with children from particular groups, for example, living in rural areas, living with domestic violence, children who have a parent who has died (as a result of substance misuse) or who is in prison (for a substance misuse related offence), and children from black and minority ethnic groups. The differing experiences, views and needs of siblings is a final area where further work is needed.

Mothers: Inevitably, a dominant theme in the literature is parenting or, perhaps more accurately, mothering. A popular area of research and intervention, largely from the USA, is on mothers, before, during and after pregnancy, how parenting affects them and their children, and the implications that this has for treatment of substance misusing mothers. Many women report unresolved feelings of guilt and shame associated with their perceptions of their failure in the maternal role because of their substance misuse. This can be both a critical issue and also a barrier to successful treatment, and needs more research attention. Pregnancy and motherhood bring ideal windows of opportunity to try and engage and work with mothers, but this must also include children and other family members (particularly fathers). Similarly, evaluation work must include attention to outcomes for children and other family members, such as fathers. There are strong links between this theme and that of issues relating to child protection. Of particular note for Scotland is one statistic, contained within the 2004-2005 children's social work statistics (Scottish Executive, 2005), that for children who were subject to a case conference, the primary known or suspected abuser was the mother in just over half (55%) of total known cases. However, it did not state whether she was a single mother or whether the father was also present, and given our findings that parental responsibility often means maternal responsibility, this statistic needs further exploration.

Fathers: There is a great deal of literature available that explores the impact of paternal substance misuse on children, but there is a major lack of research into fathering and fatherhood in relation to this area. Debates around the role of fathers within substance misusing families occur as part of a broader societal debate around the role of fathers in relation to social exclusion, perpetration of domestic violence, environmental factors, and the role of the wider family and social networks. Thus, there is a need for further work and understanding, influenced by these broader, fundamental, debates on how fathers and the fathering role is recognised. There are a number of areas for further investigation, including the ways in which substance misuse contributes to a 'compromise of fathering', and how this contributes to psychological distress in these men, and the ways in which intervention might be used to minimise the harm associated with paternal substance misuse, and to stimulate positive parenting (fathering) and father-child relationships.

There did not appear to be much literature that made comparisons about the impact of maternal versus paternal substance misuse on children or on mothering and fathering. This is an area where further work would be helpful, including a more focused and in-depth review of the literature.

Complex issues: Parental substance misuse rarely occurs in isolation. In addition to a range of environmental factors that increase both the risk of parental substance misuse but also the negative impact on children and the family, there are several particularly serious factors that might be present. Most notably, domestic violence, parental mental health problems and being pregnant (with the latter having the associated risk of fetal alcohol spectrum disorder or neonatal abstinence syndrome). The co-existence of parental substance misuse with any of these other issues can bring additional challenges for the professionals who work with or come into contact with children and other family members where substance misuse is a problem. The challenge is not just in how to identify, engage, assess and therapeutically work with these children and families, but in how professionals from different organisations can support and learn from each other, and work together to respond to these complex needs.

Service needs and provision: Substance misuse services often have no tradition of working with young people, and many specifically exclude children. Other services that encounter children, such as teachers, social workers, youth and community workers, and medical and nursing staff, are not well equipped to recognise or respond to substance misuse. This picture becomes more complex when the often co-existing problems of mental health problems of domestic violence are present, or when the needs of sub-population groups, such as children living in rural areas or who are from minority ethnic groups, are considered. There is an urgent need for both specialist and non-specialist agencies to recognise their responsibility to children affected by parental substance misuse, and for extra resources to be made available. Such a response should more equally include the earlier identification of families where substance misuse is a problem, and where children and family members might be affected, and hence early intervention and prevention, rather than the current reactive climate that is biased towards children and families in crisis, and who have come to the attention of social services, hospitals, the police and prison service, or addiction treatment services. Of equal importance is the need to talk to children and families about what their needs are and how these could best be met. There are no guidelines on whether addiction services, or child and family services, should take the lead with regard to working with children and families affected by parental substance misuse. Rather, each agency should acknowledge that both problems (as with many others that might arise through the course of therapeutic work, such as illness, relationship difficulties or bereavement) are

part of the broad remit to helping children and families. Training, support and guidance on joint-working and information sharing should help this process.

However, care must be taken not to assume that generic services will, and are able to, respond to the needs of children affected by parental substance misuse. There should be specifically negotiated access for children and families who are affected by a relative's substance misuse, as opposed to the assumption that generic services will automatically be able to respond to the needs of these children. In the absence of any such agreement, many generic services do not see children and families affected by someone else's substance misuse: this is why there is work ongoing in other parts of the UK to try to involve generic professionals in such work. If such generic services were to orientate themselves more to assisting children and other family members affected by a relative's substance misuse, then there would be implications for those services in terms of increased caseload, resources, staff training, and supervision. There is also a danger that, if DATs and other commissioners feel that children and families will be seen by other services, they may not see them as a major priority to fund specific services and interventions, nor to fund existing drug and alcohol services to broaden their remit.

Interventions: Whilst there is evidence of the benefits of a wide range of responses, the literature is largely focused on individualistic responses to substance misuse, usually geared towards the misuser to the exclusion of children and other family members. There is a need for further development of, and then further rigorous testing of, interventions and services for the wider family, particularly children, as has tended to be the case in the social care field. Ways of responding that include children, concentrate on resilience and focus on the whole family, with the express aim wherever possible to keep that family together, are gaining in popularity, unless extenuating circumstance such as domestic violence, serious mental health problems or neglect dictate otherwise. The key messages are that, rather than recommending any one intervention over another, there is a need to consider national and local need, and to be prepared to be creative and flexible and try to offer a range of interventions. It is also important to remember that children and families often need help with problems other than the substance misuse, and that help should also continue beyond cessation of the alcohol or drug misuse (and resolution of, or improvement in, any other problems). Life after substance misuse may be new, uncertain and daunting, and support may be needed during this time in order to ensure that the person does not return to the more familiar substance misusing environment. Support pre- and post-cessation of substance misuse is crucial in increasing the likelihood of the maintenance of positive change.

Finally, it is important to emphasise the need for monitoring and evaluation of interventions and services. This can take the shape of basic internal monitoring and audit, or of a larger scale evaluation, perhaps undertaken externally and with additional financial backing. Wherever possible, monitoring and evaluation should be built in and seen as core to any new intervention or service. There is some guidance available in this area in Scotland, for example the Scottish Executive Effective Interventions Unit guide (2004) on supporting families and carers of drug users.

Professionals: For many professionals, working with children and families of substance misusers will be a new area of work, and as such progress in this area must consider the knowledge, training and support needs of staff, whether they work in specialist or generic services. Often, confidence in working with substance misuse, and other co-existing issues, is the main barrier to progress. How to respond to co-existing issues, for example, domestic violence or parental

mental health problems, can bring additional challenges and training and supervision needs. On an organisational level, information sharing, joint-working, policies and procedures, training, supervision and monitoring are all areas that might need attention. Offering a diversity of therapeutic services beyond standard office hours, providing home visits, child care and transport are all important; and this again has implications for staff, in terms of training, contractual obligations and their expectations of their role. Identification of families where there are substance problems is also important, and supporting a range of people to respond to parental substance misuse is important, for example, primary care, education, probation and initiatives such as Sure Start.

Particular population groups: Children themselves, and fathers, have already been identified as two populations groups requiring particular attention. Other groups include grandparents, siblings, black and minority ethnic groups, the gay and lesbian population, children and families living in rural areas, children and families of those who are in prison or who have died, and children who are looked after or who are in care.

Families in which grandparents are raising their grandchildren have become a widespread distinctive familial structure. This reconfiguration of the family occurs across many socio-economic and ethnic groups, and for many reasons (including parental substance misuse). In one study, only 3% of these grandparents received consistent, reliable familial support in their role as surrogate parents (Burton, 1992). Although grandparents find parenting their grandchildren emotionally rewarding, and their involvement can be pivotal in preventing a child being removed / looked after (Barnard, 2003), they incur psychological, physical and economic costs in doing this. They have many service needs, although what these are has not yet been clarified. There is a clear need, therefore, for further exploratory work, followed by consideration of how to adapt traditional intervention methods to this population. However, Barnard's (2003) qualitative study in Glasgow identified that the involvement of grandparents, "*whilst often critical*", is not always positive and is not without its "*tensions and difficulties*" (p291).

A fifth of the Scottish population (one million people) live in rural Scotland, 6% of them in remote rural areas (EIU, 2004). A Scottish Executive EIU report (2004) on effective approaches to delivering integrated care for drug users concluded that, "many of the issues....were not peculiar to service provision for drug users in rural and remote communities.....issues....common to drug services regardless of the nature of the area they covered, or issues which were common to providers....regardless of the nature of the service...". Key issues to consider are: community denial, financial resources, higher unit costs, availability of premises, level and range of services, anonymity and confidentiality, travel and transport, and staff recruitment and retention. All of this is true in terms of service provision for people affected by their own misuse of substances; but it raises the question of whether these population groups have particular experiences or needs with regard to substance misuse and the family? Is there a potential for particular areas of service delivery, for example, via online counselling, websites or self-help books? Staff skills, flexibility, partnership working, innovation, devolved decision making and acceptance could contribute to development of rural services.

SCOTLAND

Progress and Gaps

This review has identified many gaps in the literature surrounding parental substance misuse, and particular areas where further work is needed and where attention and resources should be directed. However, it is important to highlight that Scotland is already quite far advanced in terms of work in this area. Key policy initiatives, along with the response to the death of Caleb Ness, demonstrate this. However, much of the work across Scotland has focused on children in need or at risk, and of the needs of children identified via treatment or social services populations. There is a need to consider the wider picture of how parental substance misuse affects children across Scotland.

In prioritising children affected by parental substance misuse, a lot of work undertaken in Scotland has focused on finding the best way to estimate prevalence (particularly the work of Hay and colleagues), and of talking to children themselves (particularly the work of Barnard, McKeganey and colleagues). However, the latter has focused largely on impact, and particularly on child welfare and parenting, and on drugs. Bancroft et al. (2004) identified that parental drug problems are particularly associated with anxiety and social stigma for the children whilst parental alcohol problems are particularly associated with violence and parental absence. Thus, care must be taken to consider separately the impact of, and associated needs from, alcohol and drug problems. Some further work on the impact of parental substance misuse is needed with some population groups (for example with siblings, children from black and minority ethnic groups, children living with parental mental health problems, domestic violence or in rural areas, and children who have a parent who has died or who is in prison). On a broader level, work is needed that considers how best to meet the needs of children, and to evaluate services and interventions that are developed. One qualitative study has focused on resilience in young people affected by parental substance misuse (Bancroft et al., 2004). This is an important growing area, and one that needs further work.

It is important to recognise that a great deal of what services should be doing is already known and has already been summarised in Scotland. For example, Getting our Priorities Right (2003) provides guidance for agencies in Scotland involved with families affected by parental substance misuse, looking at current knowledge about the extent of parental substance misuse and its impact on children:

- ⇒ Explaining what agencies need to ask of families when they present with drug or alcohol problems;
- ⇒ Providing guidance to staff on identifying risks;
- ⇒ Offering advice on what kinds of help may be needed and on how to work together more effectively;
- ⇒ Addressing issues of confidentiality and offering advice to agencies about when and how to share information;
- ⇒ Identifying the need to strengthen services for families and offering advice on how this might be done.

We contacted (via the DAT Association Administrator) all 23 Scottish DATS and asked them to provide service directories (or where this was not possible any information they could give us about services for this group); 9 responded. Each of the 9 has at least one service in place for children and families affected by parental substance misuse. However, generally service provision is lacking, and rarely explicitly includes children. Few of the services available to family members directly specify children or young people as their target group (in fact a number of support groups and counselling services on offer are available only to

young people aged 16 and above). However, a small number of services have no age limit for those wishing to access their services, and provide a service for children in their own right.

Provision tends to come in the form of support/ advice/ counselling services provided to family members, children and friends of individuals misusing substances alongside the substance misuse services that are available to the users themselves. However, there is limited information available on the services that are there, in terms of counselling orientation, offer of other services or forms of help. A small number of services offer family oriented support where children and parents are given support in parallel. The promotion of positive and safe parenting is as a key aspect of such services.

Examples of particular projects that focus on children and families are the Sunflower Garden Project (a Church of Scotland service in Edinburgh, two projects developed by the Family Services Unit (Harbour Project that covers some areas of Edinburgh, and Hearth Project in West Lothian), the Aberlour Child Care Trust and the Fraserburgh Families Service in Aberdeenshire (the latter has been nominated in the drugs and alcohol category of the 2005 Community Care Awards).

In working with children, services need to be supported in working together, and this includes having jointly agreed policies, procedures, and practice guidance, together with sound training, supervision and support. Additionally, it is not clear how, and even if, services are being monitored or evaluated with respect to their work with children (and other family members). Ensuring this is essential in our opinion, and must include the assessment of outcomes for children.

With regard to drugs, there have some moves to address the issue of drugs, communities and families in response to the Drugs Strategy (Young People, Treatment and Availability, with work yet to be undertaken to respond to the Communities pillar). The Review of Drug Treatment and Rehabilitation Services (Summary and Actions, 2004) recognises that, *"families play a key role in treatment and rehabilitation and we need to seek innovative solutions for involving them in sensitive ways in the delivery of drug treatment programmes"*. However, this has not been translated into concrete action points, though vulnerable children are highlighted as in need of help through the Executive's response to Hidden Harm. The Criminal Justice Plan has a section focusing on drugs, with particular acknowledgement of the need to respond to the needs of vulnerable children, including those affected by parental substance misuse. There has not been so much movement with regard to alcohol, with the updated Alcohol Action Plan due to be published shortly after the completion of this scoping review.

It is vital that responses to substance misuse and the family across sectors, and within and between key organisations and governmental departments, are as integrated and complementary as possible. They need to give more than lip service to the needs of children and families, with SMART (sustainable, measurable, attainable, realistic and time-limited) goals as far as possible. It is unclear to what extent checks will be made on recommendations listed in key documents such as Getting our Priorities Right, Keeping it Quiet or the Scottish Executive's response to Hidden Harm. It is known that at least three regions of Scotland have responded to Getting our Priorities Right and the Caleb Ness Inquiry, by developing child protection guidelines, all or part of which pay particular attention to children affected by parental substance misuse. The work of key groups, such as the Alcohol Misuse Co-ordinating Committee, and the Hidden Harm New Agenda Steering Group should include representation that

ensures full consideration and inclusion of children and families. The key sections of Getting our Priorities Right are a useful framework for taking this work forward, namely: 1) knowledge review; 2) what do agencies need to ask and assessing risk; 3) working together; 4) confidentiality and information sharing; 5) the need to strengthen services for families; and 6) building a foundation to work from. This, in turn, sits within the tiered levels of service suggested by the four-tiered framework in the Alcohol Problems Support and Treatment Services strategy (2003). The needs of children and families must be part of this, both in terms of mapping need and service response and in improving in joint-working and support/training from other agencies. Monitoring and evaluation of work should be fully integrated.

CONCLUSION

"...children formulate important opinions about their social, political and cultural contexts that are not simply reflective of their parents' ideas.....if children had greater access to a public voice through vehicles such as research, they would be able to contribute to the social structures that concern them" (Irwin & Johnson, 2005 p821).

The impact of and risks associated with parental substance misuse appears to have been well mapped, though a need for further exploratory work with particular population groups has been identified. Parental substance misuse is not the only, and sometimes not even the major issue and this wider picture must be acknowledged. Accumulation of risk associated with certain factors, such as domestic violence, marital break-up, unemployment, deprivation etc., has been highlighted. Particular risks and opportunities associated with pregnancy, motherhood and parenting have been emphasised. A philosophical shift towards resilience is occurring and this has clear potential when applied to children, and other family members, affected by parental substance misuse. There is growing evidence for a range of services and interventions for children and families, but there is a need for further expansion of such responses, and for their rigorous evaluation, with both service development and delivery being sure to include views of and outcomes for children. Threaded through all of this is a need to consider environmental factors, such as domestic violence, ethnicity, sexuality, geographical location, gender, age, substance of misuse, and the potential for responding to the needs of all those affected by substance misuse, not just children. Fathers, siblings and grandparents are three particular groups where further work is needed.

Diverse, flexible and creative ways of working with children and families are needed, delivered by a range of professionals who are well trained and supported, and able to work together, and who are able to respond to the diverse needs of children and families, and particular population groups, affected by parental substance misuse. The response to children and families affected by parental substance misuse should be focused on early intervention, with services and interventions that are proactive as well as responsive. A service should also be ready to support families when they reach crisis point, with services and interventions that are crisis driven and reactive. This drive to intervene as early as possible, well before child protection issues and social services involvement arise, is a cornerstone of Getting our Priorities Right. The potential for grounding services and interventions in the key messages to emerge from the work that has been done on resilience should be broadly recognised. Agencies must work together in planning and delivering services, in assessment and care planning processes with families, and in multidisciplinary training.

Whilst many gaps have been identified in this review, it is to Scotland's credit that, in several cases (for example, policy, policy guidance, own views, some practice guidance) work exists that is often part of a minority literature to address such gaps. In Scotland, one of the most important steps has already been taken, namely for the Scottish Executive to recognise and prioritise parental substance misuse. Care must be taken to ensure that this recognition does not just remain with the Executive, and other key organisations and stakeholders. It needs to be owned by all those who have a remit, at whatever level, to work with or come into contact with children and families affected by parental substance misuse and co-existing issues. We sincerely hope that Scotland can continue to be innovative in this way, using this review as another step in the right direction.

RECOMMENDATIONS

Identification of priorities for future research in this area:

1. Identify the most appropriate methodologies with which to estimate prevalence, and the definitions with which to work.
2. Estimate the prevalence, nationally and locally, of children (and other family members) affected by parental substance misuse, and of associated costs.
3. Future research, evaluation and service development should include, where possible and appropriate, the views and needs of children, both to map their experiences but also to establish their particular service and support needs.
4. Conduct further research on the experiences and needs of particular groups of children. For example, siblings, those living in rural areas, those from black and minority ethnic groups, those who have a parent who has died or is in prison as a result of substance misuse, those living in care, and children living with domestic violence or parental mental health problems, and children who have been exposed to alcohol or drugs in utero.
5. Conduct further research on the views, needs, roles and responsibilities of others central to parental substance misuse, particularly fathers and grandparents.
6. Ensure that the development and introduction of new services and interventions are properly and fully evaluated.
7. Undertake a review of 'what works' in relation to child protection, especially with overlapping issues of substance misuse, and of domestic violence.

Some of the recommendations could be partially met by further, more focused reviews of the evidence. In other cases, further exploratory or evaluative work is needed on a larger scale.

On effective practice:

Commissioners and providers of services in Scotland should:

8. Increase service delivery to the children and families of those affected by (parental) substance misuse, involving a range of service and intervention options. This includes services and teams that respond to the particular needs of pregnant mothers and their neo-nates, as well as services that more holistically meet the needs of children and families together.
9. Commission service provision that takes account of the broader context of substance use and parenting including involvement of the wider family.
10. Recognise and respond to local need where this differs from national need and national priorities.
11. Ensure that services are provided more holistically, focusing on all aspects of parenting, substance misuse and co-existing issues (such as domestic

- violence, mental health problems, or women who are pregnant and where children might have been exposed to drugs or alcohol in utero).
12. Reflect the equal importance of promoting resilience and reducing risk in the development of interventions and services for children affected by parental substance misuse.
 13. Investigate how addiction services, and child and adult services could best be integrated and encouraged to work together.
 14. Organisationally, ensure that joint working protocols, and information sharing procedures, are in place.
 15. Ensure that professionals in all services are well supported through managers and supervisors who have been trained in working with substance users and their families.
 16. Improve qualifying and post qualifying social work training to ensure that it includes training on alcohol and drug use and how this relates to working with children and families. The training of child and family social workers should be a priority; the role of adult social workers was not a focus of this review and would need further investigation.
 17. Take steps to develop the means by which data about child-related issues can be collected and collated from clients of services within Scotland whose primary problem is alcohol misuse.
 18. Establish a database and directory of services that respond to the needs of children and families.

LIMITATIONS

There were two limitations to this review. First, the review topic of parental substance misuse was an extremely broad one. This meant that we identified a large amount of literature, and that we were therefore unable to review all this literature, and its quality, in detail. Secondly, the quality of many of the abstracts that we reviewed was poor and this brought additional challenges. We had to be flexible and creative in our implementation of the search strategy, to account for different levels of complexity and sensitivity, particularly within the major electronic databases that have been searched. Applying the search strategy with too many layers of complexity resulted in key literature being missed. Further testing suggested that a broader search strategy, with more key terms and fewer levels of complexity, was more likely to include the literature that we would expect but was also more likely to include irrelevant literature. Librarian support at the University of Bath indicated that searches of such breadth would not normally be undertaken and that the problems that arose were understandable given the size of the task. The sheer size of the database, based on a very broad topic area, along with the volume of literature to emanate from the USA, meant that we had to plan very carefully how we scoped the database, ensuring that we covered both breadth and depth. This was a hard balance to achieve, but one that we hope we have achieved.

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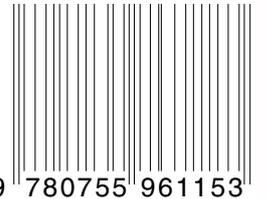
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