Understanding the needs of children living with parental substance misuse: Perspectives of children and professionals

H L TODMAN

PhD 2021

Understanding the needs of children living with parental substance misuse: Perspectives of children and professionals

Hannah Louise Todman

A thesis submitted in partial fulfilment of the requirements of the

Manchester Metropolitan University for the degree of

Doctor of Philosophy

Department of Social Care

and Social Work

Manchester Metropolitan University

2021

Research Abstract

Children living with parents who misuse substances are a group of children who are overlooked in policy and practice. Although research has identified that parental substance misuse (PSM) can cause significant harm to children, responses in practice remain fragmented. This research set out to understand the needs of children living with PSM and of frontline practitioners in their endeavour to support these children, with the overarching aim to bridge the gap between research and practice.

This research engages reflexively with qualitative research, adopting empirical creative methods, with the voices of children privileged at the centre. Guided by the principles of hermeneutic phenomenological research, seven children aged 7-16 years, participated in creative interviews, designed and analysed using interpretive phenomenological analysis with a total of four superordinate and 24 subordinate themes presented. The research design included three focus groups attended by 22 professionals, which were thematically analysed, with a total of three superordinate and 23 subordinate themes presented.

Through a reflexive engagement with this methodology, the findings provide a rich and in-depth understanding of the lived experience of children living with PSM. A discussion of the findings focusses on the complexity of the lives of children, including the severity of risk factors and enduring harm. The discussion of findings also focuses on the protective factors in the lives of children living with PSM, including the value of trusted adults to mitigate and lessen the burden. The discussion presents an exploration of the systemic failings in legislation, policy and practice, set against a backdrop of continued austerity measures, outlining the need for a whole system response for children living with PSM. Through attention to the children's narrative this thesis bridges the gap between research and practice, by proposing a model, informed by children for children. Further, a training model for front-line practitioners is proposed, to improve the assessment of risk and identify the needs of children living with PSM.

Acknowledgements

Thank you to everyone who has been a part of my PhD journey, this really has been a team effort. Thank you to the department of Social Care and Social Work at MMU for this scholarship opportunity.

This research would not have been possible without the bravery of the children who shared their stories with me and of their parents who placed their trust in me. One of the children told me just before the interview that they were a ‘hero’ for helping other children. And so, to the heroes, thank you! I hope I have done your stories justice. This research would also not have been possible without the practitioners who sacrificed their time and who shared so much, thank you.

Thank you to the local authority in which I am employed. Thank you for understanding why this research was needed and for your endeavour to help me through the recruitment phase. To my work family (past and present) thank you for all your support and your words of encouragement, throughout this journey and especially towards the end when there wasn’t much left in the tank.

Thank you to Cherilyn Dance who as my principal supervisor during my first year, helped me to see the wood for the trees. To my supervisors, Sarah Galvani and Sarah Fox, thank you for your guidance, encouragement, belief and friendship. Thank you to Sarah G for welcoming me into the Substance Use and Associated Behaviours research group and for the opportunities that have arisen.

With special thanks to Hugh McLaughlin, for stepping in as my principal supervisor, for your guidance and above all your belief in this project and me. Hugh, Sarah G and Sarah F, this last year has been tough, we haven’t seen one and other in over a year except on screen, but you have kept me connected, emotionally safe and with a big virtual hug saw me through the ups and the downs. We made it!

Thank you to my PhD friends at MMU and a special thanks to Sarah Fox for starting up the PGR SUAB group at the start of the pandemic. Your weekly quizzes, workshops and catch ups were a foundation of solidarity at time when we all needed an anchor.

To ‘the girls’ thank you for just being you and being there when I needed you the most. Your friendship, your love, kindness, laughter and being out but not out out, have seen me through this past year. I’m sorry we haven’t been able to holiday for the last few years whilst I’ve been studying, here’s hoping for brighter days and a long overdue girly holiday.

My final thanks, with all my heart, is for my family. To the strong and wonderful women in my life, my Mum, Grandma, Auntie Michelle and to my partner Jay who over the last three years has patiently lived every emotion by my side. Thank you to Mum for being my Mum, Dad, best friend, chef, DIY SOS, personal trainer, cocktail maker, source of belly laughs and everything in between. Not forgetting the men, thank you to my Grandad, Uncle Steve and my brother Owen, for your humour, kindness, love and football talk (a much-needed escapism). A mancunian family, with a mancunian worker bee ethic, that is instilled in me and that gave me the strength and determination to keep working hard. Your love, belief and financial support ;-) made it possible for me to even consider beginning this journey.

A special thanks to my Mum and Uncle Steve for your hours and hours of proof reading over the years and to Auntie Jayne for being on hand for last minute IT glitches and suggestions. This really was a team effort and I am fortunate and truly grateful to have had the A-team.

This thesis is dedicated to:

All the children and families I have had the privilege of supporting over the last 13 years and to all the children who participated in this research study.

I hope I have done you proud.

Table of Contents

Table of figures

List of tables

Part 1- Introducing the Research

Chapter 1- Introduction

[…] it's not very nice or right for a kid to see it. (Child participant aged 8)

[…] I'm seeing it and I'm only little. (Child participant aged 7)

This thesis begins with my connection to the topic of parental substance misuse (PSM). During my years of practice as a social worker I have had the privilege of supporting children and families affected by a loved one's substance misuse. The stories shared by children living with PSM and the disheartening truth of knowing that access to specialist support is a postcode lottery, has influenced my choice of research project. During my practice I have received countless calls from frontline professionals in neighbouring local authorities desperately seeking specialist support for children and their families due to PSM. Having to decline support to a child in need, simply because they live in another local authority with no specialist provision, leaves a feeling of helplessness and failure as a practitioner.

Throughout my 13 years in practice, I have observed the welcome change in policy and practice for different vulnerable groups of children. There has been a noticeable momentum for children who are young carers, as evidenced in the *Care Act 2014* (H.M. Government, 2014) and *Working together to safeguard children 2018 guidance* (H.M. Government, 2018), the development of the local authority offer for care leavers under the *Children (Leaving Care) Act 2000* (H.M. Government, 2000) and the *Children and Social Work Act 2017* (H.M. Government, 2017). In recent years there has also been a strategic response to the needs of children who are at risk of exploitation as evidenced in the *Child Sexual Exploitation: Definition and a guide for practitioners* (Department for Education, 2017). A momentum of positive change cannot be said for the needs of children living with parents who misuse substances.

Children living with parents who misuse substances are overrepresented in social work practice, due to the potential need for long term social care intervention, being subject to child protection plans and needing to be placed in kinship or local authority care (Forrester and Harwin, 2006; 2009). For those children who are removed from their parents care due to PSM, they continue to experience emotional turmoil as PSM has been found to be a significant factor in placement instability (Forrester and Harwin, 2009).

Despite the overrepresentation of children living with PSM in social work practice, training for frontline practitioners on substance misuse and PSM is not routine. Inconsistent training for social workers both pre- and post-qualification is a failure stemming over 30 years (Galvani, 2017). Despite the breadth of knowledge regarding the impact of PSM and the pivotal *Hidden Harm* report (ACMD, 2003) children living with PSM continue to suffer the consequences of a fragmented system.

The consequence of a system which fails to protect vulnerable children living with PSM is also evident in the overrepresentation of children in the findings from serious case reviews; an inquiry, conducted in every case in England where child abuse and neglect has caused a child to suffer serious injury or resulted in a child death (Sidebotham et al., 2011). PSM is identified as a primary factor in almost half of all serious case reviews and is a secondary factor in many more (Sidebotham et al., 2016).

This research is important because the needs and experiences of children living with PSM have remained under the radar of policy makers, commissioners and service providers for too long. This research addresses the fragmented and systemic failures which contribute to the continued silencing of children living with PSM. This research seeks to bridge the gap between research and practice and raise the profile of the needs of these children. The research design privileges the lived experience of children and the experiences of frontline practitioners in their endeavour to support children living with PSM. The research design uses the lens of children's rights, is guided by the philosophical paradigm of hermeneutic

phenomenology and is purposeful in aiming to inform sustainable changes in policy and practice.

Though it was my practice experience of supporting children living with PSM for over a decade which was my motivation to begin this research journey, I did not envisage the breadth and depth of failings which the findings from this research would highlight.

1.1 - Thesis Outline

This thesis explores the experiences and support needs of school aged (7-16 years) children living with PSM. The experiences of frontline professionals across a children's workforce are also included to provide another perspective and understanding of the needs of children living with PSM.

The thesis is presented in five parts as outlined below:

Part two- The review of literature

Part two presents the review of literature, including the research strategy and inclusion and exclusion criteria. The review of literature is presented across five chapters which explore the prevalence of PSM, how children living with PSM are represented in legislation and policy, social work training and responses in practice. The latter part of the review explores risk and protective factors associated with PSM and the long-term impact of PSM due to trauma and adversity. The systematic approach to the literature review identifies gaps in research which inform the research questions.

Part three- Methodology and methods

Part three articulates the ontological, epistemological position and chosen philosophical paradigm of hermeneutic phenomenology which has guided this research. The research design is outlined in two parts, including creative interviews with children and three focus groups with frontline professionals. Part three also outlines interpretative phenomenological analysis (IPA) as the most appropriate method for analysis. The ethical considerations for this

project, including the issues of insider research, consent and coercion are presented before the final chapter in this section presents the analytical stages.

Part four- Presentation of findings

Part four presents the findings from seven creative interviews with children, including their pictures drawn during the interviews and detailed quotes. The creative interviews were analysed using IPA, producing four superordinate and 24 subordinate themes. The superordinate themes are:

- Children's emotional responses to parental substance misuse
- Children's experience of living with parental substance misuse
- Understanding children's support needs within their immediate environment
- Understanding role of professionals in responding to the support needs of children living with parental substance misuse.

Part four also includes the findings from three focus groups, attended by professionals across a children's workforce, spanning multiple departments and professional backgrounds. The focus groups were thematically analysed and a total of three overarching themes and 23 sub themes are presented. Overarching themes include:

- Understanding children's experience of living with parental substance misuse (PSM) from the perspective of professionals
- Parental substance misuse- understanding protective factors and children's support needs
- Understanding challenges in practice in responding to the needs of children living with parental substance misuse

At the end of part four, the limitations for this research are acknowledged.

Part Five- Discussion and concluding chapters

The concluding part of this thesis connects the three data sets (literature review, creative interviews with children and focus groups with professionals) to present the key messages and points for discussion. The discussion is presented within a theoretical framework, Ecological Systems Theory, which illuminate the findings. Conceptualising the need for systemic change in response to the needs of children living with PSM. The discussion chapters are proceeded by recommendations for change, to bridge the gap between research and practice before the final overall conclusion for this research is presented.

1.2 - Definition of key terms

Throughout this thesis 'parental substance misuse' (PSM) is the adopted term.

Parent

A parent is recognised in legislation as any adult who has parental responsibility or who has care of a child either full time or part time, regardless of whether they are the child's biological parents, as outlined in section three of *The Children Act 1989* (Department for Education, 1989). The word 'parental' within this research therefore refers to the adult(s) who is the primary carer with whom the child lives.

Substance

This research adopts the word 'substance' as it encompasses all drugs, both illicit drugs such as heroin, licit drugs such as alcohol, prescribed drugs and poly (multiple) drugs (Gorin, 2004). This research project, in exploring and understanding the needs of children living with PSM, has specifically chosen not to differentiate between drugs or alcohol. Though there maybe some differences regarding the complexity of social and environmental factors relating to drugs or alcohol, the similarities of the 'core' experience of family

members will ‘outweigh the differences’ (Orford et al., 2010:60). As this research aims to bridge the gap between research and practice, the experience of children living with PSM needs to include both alcohol and other drugs (Forrester and Harwin, 2006).

Misuse

The term substance ‘use’ is a factual description of the use of a substance, that implies no judgement and that no harm is caused. Forrester (2012) argues that parents and carers in the United Kingdom who drink alcohol or use drugs can do so in moderation and, therefore, do not increase the risk of harm to their children (Forrester, 2012). The use of substances by parents in itself is not an indication of neglectful or harmful parenting (Huxley and Foulger, 2008).

The term ‘misuse’ is founded on the definitions provided by the Misuse of Drugs Act 1971 (ACMD, 1971) and the National Institute for Health and Care Excellence (NICE) which defines the ‘misuse’ of substances as having harmful effects. The term misuse can be used to describe a person’s dependence on or regular excessive consumption, thus impacting on their social, psychological and physical wellbeing (NICE, 2012). It is therefore the misuse of substances and not the use of substances that contributes to harmful behaviour (Gorin, 2004). For this research project, the term misuse accurately reflects the focus on understanding the needs of children where parental substance misuse is causing harm in relation to a child’s emotional, social and physical wellbeing.

This definition of PSM concludes part one of this thesis, the proceeding chapters in part two present the review of literature which will conclude with the research questions underpinning this thesis.

Part 2- A review of literature relating to parental substance misuse

Chapter 2- Introduction to conducting the literature review

This literature review aims to contextualise the research project by seeking to understand what is known about the impact of parental substance misuse (PSM) on children and understand how policy and practice is shaped in response to the needs of children living with PSM.

The literature review included key peer reviewed publications and all relevant literature that would contribute to understanding and answering the following questions:

- What is known about the prevalence of PSM?
- How are children living with PSM represented in policy?
- What do we know about the impact of PSM on children's emotional wellbeing, development and safety?
- What does literature say about the support needs of children living with PSM?
- How is this knowledge reflected in practice?

As the aim of this literature review was to be as inclusive as possible, no restrictions were made to the type of study or country of origin, however, literature was only included if it was written or translated into English. The exclusion criteria included studies which focussed specifically on:

- Adult substance misuse treatment and recovery
- Trajectories of substance misuse
- Substance misuse in pregnancy
- Foetal Alcohol Spectrum Disorder
- The needs of adult family members affected by a loved one's substance misuse

- The needs of children who are not living with their parents and are in local authority care or kinship care.

I adopted a systematic approach to search and record the relevant peer-reviewed papers, books, articles, government legislation, policy and guidance from within the United Kingdom, for inclusion in this literature review. Searches were conducted using the following databases, Manchester Metropolitan Library, Zetoc, Science Direct, CINAHL and Web of Science, as research regarding PSM can span a number of professional disciplines, including health, psychology and social care.

Boolean terms were used to maximise the number of relevant papers. The term ‘parental substance misuse’ was predominantly used within the search strategy, due to this being the term that yielded fewer irrelevant papers. Each search was cross referenced with previous searches to ensure duplicated papers were not included. The search strategy was conducted twice, once in 2018 and the second search conducted between June and September 2020. There was a noticeable difference in the number of relevant publications between the two searches, as very few publications were identified between 2017-2020. Across both searches, the dominant country of origin of publications was the United States of America and Australia. While the majority of papers have been included in this literature review, some papers were omitted because they did not add any new information.

The list of databases, search strategy and the number of included and excluded papers identified from the searches are shown below.

Table 1 Record of literature review search strategy

	C	D	E	F	G	H	I
1	**May 2018 Search string**	**Filters**	**Results**	**Included**	**Excluded**	**Final inclusion**	**New results not included in previous search**
2	'Parental substance misuse'	No	21,933				
3	All fields- 'Parental substance misuse' Abstract- 'children' AND 'Parental Substance Misuse'	All/ abstract	151	73	78	35	
4	abstract- 'parental substance *use' AND 'children'	Inc only Journal/ebook/book	765	82	683	48	70
5	"parental substance misuse"	all fields	39	34	5	7	13
6	"parental substance misuse" AND "children"	all fields	28	24	4	0	0
7	"Problematic substance use"	all fields	3	0	0	0	0
8	(parental substance misuse)	advanced search- title and abstract	33	6	24	2	2
9	(parental substance misuse) AND (children)	advanced search- title and abstract	14	4	10	0	0
10	'Parental substance misuse' AND 'children'	abstract	9	5	4	0	0
11	Parental substance misuse'	abstract	12	7	5	0	0
12	Parental substance abuse'	abstract	91	26	65	10	0
13	TS=(Parental substance misuse)	No	221	37	184	15	28
14							
15	**June-September 2020**	**Filters + Date June 2018-September 2020**					
16	**Search string**						
17	All fields- 'Parental substance misuse' Abstract- 'children' AND 'Parental Substance Misuse'	All/ abstract	33	20	13	8	6
18	abstract- 'parental substance *use' AND 'children'	Inc only Journal/ebook/book	196	28	141	5	3
19	"parental substance misuse"	all fields	10	8	2	0	0
20	"parental substance misuse" AND "children"	all fields	4	3	1	0	0
21	"Problematic substance use"	all fields	105	3	102	0	0
22	(parental substance misuse)	advanced search- title and abstract	0	0	0	0	0
23	(parental substance misuse) AND (children)	advanced search- title and abstract	0	0	0	0	0
24	'Parental substance misuse' AND 'children'	abstract	10	7	3	0	0
25	Parental substance misuse'	abstract	10	7	7	3	0
26	Parental substance abuse'	abstract	29	3	27	1	1
27	TS=(Parental substance misuse)	No	83	20	63	2	2
28							

Utilising my social work practice knowledge, as well as consulting with colleagues, I identified government (United Kingdom) documents to ensure relevant legislation and wider practice guidance were included. Relevant papers and texts were also retrieved using a 'pearl growing' technique (Schlosser, 2006:568), whereby relevant papers were identified through the reading and scanning of bibliographies of studies identified. The first stage of the systematic approach was to skim-read abstracts of search results and record if deemed to be relevant. The second stage involved reading more thoroughly and recording the aims, objectives, and findings of relevant papers, using the table below which I adapted from Hart (2014):

Table 2 Record of database results

Date and Database;						
Search string;						
Author/Date **Country of Origin**	**Title**	**source**	**Theory/ model**	**Method**	**Findings**	**Key notes**

This literature review aimed to include all relevant sources of literature with the intention of identifying gaps in knowledge in relation to the impact of PSM on children and responses in practice. The literature review will inform the overall research questions which guided the design of this research project.

Chapter 3

Parental substance misuse (PSM): Prevalence and government responses in the context of policy and legislation

This review of literature begins with an exploration of the prevalence of PSM and emerging trends in the use of substances. As this provides the foundation for understanding the scale of the problem. Though this research study is qualitative, quantitative findings are also important in understanding the social work world (Teater et al., 2017) and the needs of children living with PSM. The findings related to the prevalence of PSM are then explored in the context of responses in legislation, guidance and policy.

3.1- Understanding the prevalence of PSM

Estimating the number of children affected by PSM in the United Kingdom comes with a degree of uncertainty, as this is a group of children who have been described in literature as ‘silent voices’ and whose lives are characterised by denial and secrecy (Adamson and Templeton, 2012; Kroll and Taylor, 2009).

In 2003 the Advisory Council on the Misuse of Dugs (ACMD) published a report titled *Hidden Harm*, the first of its kind in providing an estimate of the number of children affected by parents with problematic drug misuse (ACMD, 2003), which they defined as:

> By problem drug use we mean drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them. Such drug use will usually be heavy, with features of dependence. In the United Kingdom at present this typically involves use of one or more of the following: heroin and other opiates, benzodiazepines, cocaine or amphetamines. (ACMD, 2003:7)

The definition of ‘problem drug use’ by the ACMD (2003) suggests the negative impact of parental drug misuse on children relates only to the specified drugs. The definition does not include the use of substances such as cannabis, new and emerging synthetic substances, the use of poly substances and excludes the use of alcohol. Further, the use of the word ‘heavy’ is arguably subjective and open to interpretation by practitioners.

Hidden Harm estimated that between 200,000 - 300,000 children were affected by ‘parental problem drug use’ in the United Kingdom. The sources of these figures were ‘predominantly in the fields of drug use and children’s services’ (ACMD, 2003:7), therefore, excluding the number of children who are affected by PSM where parents misuse alcohol and, children whose parents were not accessing adult treatment services. While *Hidden Harm* was, at the time a ground-breaking publication, the figures published by ACMD continued to be used for a number of years, thereby skewing our understanding of the actual prevalence of children impacted by PSM.

A more recent study by Velleman and Templeton (2016) examined UK data, including parental alcohol and drug misuse, and estimated that there were 3.5 million children under the age of sixteen, living with parental alcohol misuse. This figure represented children who were living with one or both parents who were binge drinkers, children who lived with a hazardous drinker, or children who lived with a parent who was dependent on alcohol (Velleman and Templeton, 2016). Based upon the data available, an estimated 335,000 children lived with an adult who was dependent on drugs, 72,000 lived with an injecting drug user, and 108,000 children lived with an adult who had overdosed (Velleman and Templeton, 2016).

Prevalence figures regarding children impacted by PSM, are collated from survey data in which it is likely that respondents may under-report their substance consumption or, there is uncertainty about what constitutes different levels of substance use/misuse (Parliamentary Office of Science and Technology (POST), 2018). It is also likely to be an underestimate as

children who have not come into contact with services are unlikely to be represented in the estimated figures showing the prevalence of PSM.

The estimated number of children affected by PSM was still largely based on two key publications: The ACMD (2003) report *Hidden Harm* and the 2004 *Alcohol harm reduction strategy* (Manning et al., 2009), both of which were published nearly four years after the data was collected. These figures which are cited by Velleman and Templeton, (2016) were 16 years old at the time of publication. There is, therefore, a major gap in up-to-date figures estimating the number of children impacted by PSM.

The data has further limitations in that it is extrapolated from treatment data alone, therefore only representing adults who are accessing treatment services. A further concern is that women are less likely to access treatment and yet are more likely to live with their child(ren) (Manning et al., 2009), which may further under-represent the number of children affected by PSM in the UK.

More recent estimates published by The Children's Society (2017) suggest that of the 5.8 million children aged 10-17 years, 700,000 are affected by problematic parental alcohol use in the UK. This data was extrapolated from a household survey of 3,000 children aged 10-17. The reliability of this data is questionable due to parents self-reporting of whether problematic alcohol use was a factor in their household (The Children's Society, 2017).

Recently published data by the National Drug Treatment Monitoring Services (NTDMS) showed a 4% increase in the number adults entering treatment in 2018-2019; this is the first increase since 2013 (Public Health England, 2019). Of the 132,210 adults entering treatment in 2018-2019, 21% were parents living with their child or someone else's child, and 31% of parents were no longer living with their children. Findings from the NDTMS data for 2018-2019 also demonstrated women were more likely to be living with a child (58%), compared to men starting treatment (48%). The data also highlighted that 80% of children whose parents entered treatment had

received no ‘early help’ (see appendix 2- Glossary of terms) (Public Health England, 2019:online).

The prevalence estimates of PSM published by the NDTMS, are largely based on treatment cohorts and excludes parents who are not dependant (physical or psychological) on substances. This is concerning as the prevalence of non-dependant PSM is likely to be higher than dependent substance misuse, therefore, the number of children who are affected by PSM is likely to exceed current estimates (McGovern et al., 2018).

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a report in 2018 which outlined the emerging trends in substance misuse across Europe. Since 2015, 14 new benzodiazepine-related substances have been identified, about which little is known regarding the toxicology and risks when used (EMCDDA, 2018).

New synthetic cannabinoids have been associated with deaths and acute intoxication (EMCDDA, 2018). Available data across 25 countries in Europe concludes that, from 2006 to 2016, there was an increase of 76% in entries to treatment centres for synthetic cannabis problems. The increase in potency of available products is suggested to be one of the contributing factors for this increase. An increase in the potency of heroin, fentanyl derivatives, and an increase in crack cocaine misuse are of further concern to public health (EMCDDA, 2018). The unknown risk of these new substances could cause considerable difficulty for professionals in accurately assessing the impact of PSM in relation to a parent being able to meet the needs of their children.

Whilst an accurate estimate of the number of children in the UK affected by PSM is not available, what is known is drug trends are changing. It could therefore be argued that increases in drug potency, risk of acute intoxication, and overdose through use of emerging substances, could result in an increased risk to children living in households where these substances are being misused.

3.2- Section summary

The figures outlined above raise concerns about the extent of the unknown number of children affected by PSM due to inaccurate data, a reliance on data from treatment services and changing drug trends. The following section explores how the knowledge of the prevalence of PSM has influenced responses from government in the United Kingdom. The chapter begins with an exploration of the rights of children which underpin child legislation in the UK and will explore how the needs of children living with PSM are represented in legislation, policy and guidance.

3.3- The representation of children affected by PSM in policy and legislation: A national picture

The Universal Declaration of Human Rights 1948, declared that everyone is entitled to all rights and freedoms, without discrimination of any kind such as race, colour, sex, language, religion, political opinion, national or social origin, property or other status. The United Nations Convention on the Rights of the Child (under the age of 18) (UNCRC, 1989) recognises the status of children and the importance of international cooperation to improve the lives and living conditions of children in every country. A key principle of the UNCRC is the need for adults and governments to work together to ensure all children 'can enjoy their rights' (UNCRC, 1989:online)

The convention includes 54 articles which cover all aspects of a child's life. It was adopted by the United Nations Assembly in 1989 and was ratified by the UK in 1991. To date, the UNCRC remains the most complete statement on children's rights in history. Article 33 of the United Nations Convention on the Rights of the Child outlines;

> States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to

> prevent the use of children in the illicit production and trafficking of such substances. (UNCRC 1989:9)

Though article 33 does not specifically state PSM, the article does outline the need for children to be protected from the illicit use of substances which, it could be argued includes the impact of PSM. The UNCRC (1989) came at a time of significant reform in the UK with the implementation of The Children Act 1989, which sought to reform and consolidate existing family laws in the UK relating to children.

The Children Act 1989 remains fundamental to social work practice and is synonymous with three key principles; that the welfare of every child is paramount, delay in responding to the needs of children will impact negatively on their welfare and, children and their families should be supported to remain together unless doing so would further impact on the welfare of the child (H.M. Government, 1989). There is no single legislation that covers child protection in the UK, but the Children Act 1989 is the starting point in legislation for the safeguarding and protection of children and underpins all subsequent guidance, policy and additional amendments (Foster, 2020).

Approximately every three years statutory guidance, titled; *Working together to safeguard children* is published. This guidance (*Working together*) synthesises continued learning from frontline practice, with the purpose of making it clear what individuals, organisations and agencies must and should do to keep children safe (H.M. Government, 2018:11). Although, *Working together to safeguard children* is referred to as guidance, it is not optional and imposes a legal duty on Local Authorities to act under the general guidance' (Davis, 2014).

The current *Working together to safeguard children* guidance for local authorities regarding the welfare of children affected by 'parental alcohol and drug use' was published in 2018 (H.M. Government, 2018). The opening

summary of the guidance provides a clear outline of the impact of PSM on children:

> Parents' dependant alcohol and drug use can negatively impact on children's physical and emotional wellbeing, their development and their safety. The impacts on children include:
>
> - physical maltreatment and neglect
> - poor physical and mental health
> - development of health harming behaviours in later life, for example using alcohol and drugs at an early age, which predicts more entrenched future use
> - poor school attendance due to inappropriate caring responsibilities
> - low educational attainment
> - involvement in anti-social or criminal behaviour (H.M. Government, 2018:1)

The current guidance outlines that practitioners need to be 'alert' to children who are in a family with 'presenting challenges' such as drug and alcohol misuse, adult mental health issues and domestic abuse (H.M. Government, 2018). The guidance appears contradictory as it describes how children affected by PSM maybe at 'greater risk of harm' and need additional help (H.M. Government, 2018), and yet there are no specific requirements for local authorities to commission services to respond to those needs of children affected by PSM.

Unlike other identified vulnerable groups of children, such as young carers, where *Working together* stipulates that, under section 17 of the Children Act 1989, a Young Carers Needs assessment 'must' be carried out if a child is identified as a Young Carer. *Working together* also states Local Authorities 'must' commission services to respond to the needs of Young Carers (H.M. Government, 2018). There are currently no statutory requirements for the provision of services to children affected by PSM. It could be argued that in some cases children affected by PSM are young carers, however children

affected by PSM who are not young carers are not adequately protected in current legislation. The use of the words ‘alert’ rather than ‘must’ within the *Working together* statutory guidance regarding local authority responses to the needs of children affected by PSM, leads to an absence of a statutory obligation for local authorities to assess and respond to the needs of these children.

In contrast,15 years prior to the publication of the 2018 *Working together to safeguard children* guidance, Scottish policies and legislation went further in recognising the needs of children affected by PSM, stressing that helping children affected by PSM was a task for Health, Education and Social Services departments (ACMD, 2003). Tackling drug misuse in Scotland was a key priority; the *Drugs Action Plan: Protecting Our Future* (2000) sets out how the Scottish Executive planned to respond to young people and communities (Scottish Executive, 2000).

The Scottish drugs strategy was supported by the *Good practice guidance for working with children and families affected by substance misuse* (Scottish Executive, 2003). The guidance outlined key factors agencies should consider when working with parents who misuse substances, stressing the need to be alert to the needs of the children and providing a checklist to guide assessments, which is adapted and expanded from the guidance produced by the Standing Conference on Drug Abuse (SCODA) in 1997 (Scottish Executive, 2003).

Following the implementation of *Drugs Action Plan: Protecting Our Future* (2000), all drug action teams and child protection committees were required to have local policies in place that support substance misusing parents and their children. With a focus on social work solutions that were unique in response to the needs of Scottish families (Robertson and Haight, 2012).

Getting it Right for Every Child (GIRFEC) guidance was published in 2003, providing key policy and practice guidance in Scotland in response to the recognised need of children affected by PSM (Robertson and Haight, 2012).

Shortly after GIRFEC was implemented, in 2003 the Advisory Council on the Misuse of Drugs (ACMD) published its report, titled *Hidden Harm-responding to the needs of problem drug users* (ACMD. 2003). The enquiry was commissioned by the UK government in response to 'tackling' substance misuse becoming a high priority; the focus of the report was the children of 'problem drug users' (ACMD, 2003). Although the report primarily focused on parent's drug misuse, it outlined that there is evidence from across Scotland, Wales and Northern Ireland that parental alcohol misuse could be addressed alongside parental drugs misuse (ACMD, 2003). This section has outlined how children affected by PSM are represented in child legislation and practice guidance. The following section will detail the responses to PSM within adult legislation relating to adult substance use.

3.4- Government responses to adult substance misuse in the United Kingdom.

In 2017, the UK government published its *Drugs Strategy* which shifted its focus to recognise the vulnerabilities of people who misuse drugs (Home Office, 2017); a move away from its focus on crime and a hard-line approach to tackling drug use as previously seen in the 2002 and 2010 drugs strategies. For the first time, the 2017 Strategy acknowledged the needs of children affected by PSM outlining how PSM can have a significant impact on children and their families due to a parent's impaired ability to care for their children due to substance misuse. The 2017 *Drug Strategy* suggested that children of parents who are dependent on substances were more likely to misuse substances themselves:

> Supporting vulnerable families to break the intergenerational pathways to dependence is a part of our approach to prevent and reduce the demand for drugs and to help build recovery (Home Office, 2017:12).

The *2017 Drugs Strategy* outlined the Government's response to the needs of children affected by PSM on a national level, through *The Troubled*

Families Programme. This programme was billed as an initiative which supported local areas to ensure their services took an 'integrated and coordinated whole family approach' (Home Office, 2017:12). The *Troubled Families Programme* was 'targeted' towards families experiencing multiple problems associated namely with crime, anti-social behaviour, children truanting from school, adult mental health and domestic abuse, and aimed to provide interventions to target families at an earlier stage before they were in need of more costly interventions (Bate and Bellis, 2018:3).

The 2017 Strategy also outlined the need for evidence-based and psychological interventions which 'should' be available and ensure that the needs of children and their families affected by drug misuse were 'appropriately met' (Home Office, 2017:36). However, there does not appear to be any clear guidance on how to respond to this recommendation on a practice level. There is also a lack of information on how children whose parents are not accessing treatment, or whose families are not identified as a 'troubled family' would have access to support and interventions.

In 2018, Public Health England (PHE) commissioned a consultation exercise to refresh their document *Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services*, with the aim of understanding the current environment in practice from the perspective of professionals from both adult treatment and children's services (Public Health England, 2018). The commissioned consultation received 319 responses from professionals, commissioners and managers, with 64% working in substance misuse services and 17% from children and family services. From the initial survey of qualitative and quantitative questions, 20 in-depth interviews were also conducted (Public Health England, 2018).

The findings from the PHE report highlighted the difficulties experienced by professionals in practice and supports the recommendation that clear guidance on a practice level is vital. The report outlined that fewer than half (44%) had a joint protocol or working agreement between adult substance

misuse services and children's services. Where local joint working arrangements were in place, only 6% felt they were 'very effective'. Effective joint working was identified when there was visible presence of the identified practitioner who was the point of contact to 'bridge the gap' (Public Health England, 2018: 38). A further 6% stated they were non-existent or simply not effective and of the remaining 88%, respondents felt local joint working arrangements were adequate (Public Health England, 2018).

Interestingly, respondents from children and family services had a lower awareness of guidance published by Public Health England, in comparison to professionals working in substance misuse, 56% and 76% respectively (Public Health England, 2018). The report found that professionals felt there were fewer options available to parents who misused substances such as cannabis, and their access to support was not clear. Further, there was an identified need that 'thresholds and pathways' to receiving support were clearer if parents were dependant opiates users. (Public Health England, 2018:31).

The responsibility for children affected by PSM appears to span a number of national government departments as well as local authority departments both in adult treatment services and children's services (POST, 2018). It appears that neither adult legislation nor childcare legislation fully take responsibility for the needs of these children. Therefore, the lack of clarity in relation to whose responsibility is it to respond to the needs of these children (adult treatment or children's services) and the lack of clarity in legislation in comparison to other vulnerable groups, continues to be a contributing factor in the fragmented provision of services. This sentiment is shared by Turning Point, a leading health and social care service in England, who highlighted this concern in relation to inadequate policy responses back in 2006. Despite the 15 years that have passed, this sentiment continues to ring true:

> The current lack of a nationally shared direction results in a poor use of resources and a commissioning process that is not given the lever to change. This leads to provision that is inconsistent and

> uncoordinated with lack of joint working and shared understanding around the needs of children and their parents. In the end it is the children who are paying the price for inadequate policy responses (Turning Point, 2006:5)

The acknowledgment of the needs of children affected by PSM is well documented across numerous government and health publications, both in statutory and non-statutory guidance. However, this chapter has highlighted the difficulty in relying on guidance rather than statutory obligation to assess and respond to the needs of children affected by PSM. The proceeding chapter explores the impact of disjointed legislative guidance on responses in practice.

Chapter 4

Social work training and practice in response to parental substance misuse

As chapter three illustrated, there are gaps in reliable and accurate data regarding the prevalence of PSM. Despite this, the prevalence of PSM and the estimated number of children affected by PSM remains stark. Chapter three also presented findings in relation to national government responses to PSM and the evident lack of clarity which impacts on frontline practice and professional responses to the needs of children living with PSM. In light of these findings, this chapter will focus on international and national findings in relation to social work training and practice in response to the needs of children living with PSM.

4.1- PSM: International social work practice

Research findings from United States of America (USA) raise questions about the disproportionate involvement of children affected by PSM in the child welfare system. A review of literature by Becci et al., (2015) identified that children from across the USA, who had experienced PSM, were found to experience poorer outcomes, were more likely to enter foster care and remain in care for longer.

A study from the USA, aiming to identify the primary causes for children entering the care system have estimated that up to 80% of children in foster care have a parent who misuses substances (Testa & Smith, 2009). PSM was also found to be linked to poor outcomes for children in relation to the stability of their foster placement, and linked to children being less likely to be reunited with their birth family (Akin et al., 2017).

A research study using secondary data analysis from nine ‘regions’ across the USA, found the frequencies of child maltreatment were associated with a broad range of substance misuse behaviours among adults, including the

neuropsychological effects of certain substances, and impact of acute intoxication and/ or withdrawal that affects a parent's ability to respond to their child's needs (Kepple, 2018:48). While PSM does not necessarily correlate with child 'maltreatment', the research findings suggest that PSM is complex and varied in relation to levels of substance misuse and type of substance being used, and should, therefore, be viewed by practitioners along 'multiple dimensions' (Kepple, 2018: 53). Prolonged and 'heavy' use of substances by parents was found to be associated with a 'chronic failure' to respond and meet their children's basic physical and emotional needs (Kepple, 2018:52).

A study (USA) which extrapolated national survey data on child and adolescent wellbeing and also from interviews with caseworkers, concluded that there was significant variation across child welfare agencies in their identification of, and response to, PSM (Chuang et al., 2012). Despite caseworkers in this study having a specific substance misuse assessment tool which could aid decision making and care planning for children and their families, caseworkers did not utilise this tool. The paper indicated that insufficient training and the perceived burden of high caseloads were factors in caseworkers' reluctance to use such tools (Chuang et al., 2012).

Research findings from a Canadian study followed a similar vein to studies from the USA. Berube et al., (2017) conducted a study whereby the 'journey' of 55 families within child protection services were followed. One child from each family was randomly selected to be the focus of the research and each caseworker (social worker in the United Kingdom) for the family completed a questionnaire. The questionnaire focused on the responses of parents to their child's needs and identified risk factors were reported in the questionnaire separately (Berube et al., 2017). A significant limitation of this study was the sparse data regarding fathers, even when caseworkers knew the father, questionnaires were not completed. This raises the issue of the burden of responsibility and the 'blame' placed upon mothers for their family's situation and the need for further research to understand how practice can be more inclusive of fathers (Berube et al., 2017:371). The

analysis of available data identified an indicator of concern for caseworkers was a child's age (preschool), in relation to issues about parental guidance, boundaries and the child's physical safety. The results also indicated that caseworkers had increased concern for a parent's ability to respond to their children's emotional needs, providing warmth and stimulation, when parental mental health and substance misuse were factors (Berube et al., 2017).

It is not clear from the study why parents' substance misuse raised caseworkers concerns for the safety and welfare of the children in the families they were supporting. A possible limitation of this study is the lack of clarity about caseworkers training and knowledge regarding PSM. If caseworkers had not received training regarding PSM and the impact on children, it is possible that caseworker's assessment of risk could be influenced by personal judgement, stigma associated with different substances or PSM could be missed. What this study does highlight, is the need for different interventions and services to be available to meet the presenting needs of families. For families where parents have multiple problems such as substance misuse, mental ill health, and poverty, supporting families to address these problems is, at best, described as complex (Berube et al., 2017).

The statistics from the USA regarding the prevalence of PSM in families who receive interventions from child protection workers/caseworker are mirrored in Australia. Although there are no accurate figures for the number of families where PSM co-exists with child maltreatment, estimates suggest that in 50-80% of families in Australia who come to the notice of child protection services, PSM is a significant factor (Taylor et al., 2017). There is no clear reason in this Australian study as to why this figure is so broad. The study by Taylor et al. (2017:244) 'extracted data from 88 Australian custodial grandparent completed 'Grandcarer Needs, Wellbeing and Health Surveys'. PSM was identified as the major reason parents were unable to 'adequately care for their child/ren' (Taylor et al., 2017:251). The findings from the study outline the experiences of grandparents who cared full time for their grandchildren and how their grandchildren had experienced complex and

multiple ‘maltreatment’ relating to PSM, including ‘witnessing domestic violence’ and having experienced ‘acts of emotional/physical/sexual abuse’ (Taylor et al., 2017:247).

As with studies from the USA and Canada, perhaps the disparities across states and provinces respectively, of the prevalence of PSM and the need for child protection services, is due to differing methods of assessment, recording, training and knowledge within the child protection workforce.

While there are identified disparities across the USA, in terms of professional responses to the needs of families where PSM raises safeguarding/ welfare concerns, research presented throughout this review of the literature highlighted that PSM can and does impact on the safety and wellbeing of children. As Taylor et al. (2007:242) summarises, PSM is attributed to a child’s increased risk of exposure to ‘unsanitary living conditions’, exposure to domestic abuse, increased risk of injury resulting in hospitalisation and experiencing homelessness. This increased risk of harm to a child because of PSM can require the need for statutory child protection services to intervene to place a child in a place of safety.

Similar findings linking PSM and children being unable to be reunited with their parents can be found in research from the USA. Children affected by PSM are also found to experience less stability in foster care, remain in foster care for longer, are less likely to be reunited with their families and are more likely to re-enter the care system after reunification (Akin et al., 2017; Ghertner et al., 2018). Similar conclusions were drawn from Australia and the United Kingdom in relation to poor placement stability and family reunification which was particularly fragile for children affected by PSM (Harwin et al., 2013;Taylor, 2017).

Further research from Australia supports the notion that families where PSM is identified are overrepresented in statutory child protection services. Statistical analysis of a cohort of 273 child protection cases in a children’s court in Australia identified that PSM was present in 51% of cases. Of those

51%, two thirds of cases detailed polysubstance misuse. The study concluded that in order to protect children and support parents into treatment services earlier, there needs to be an earlier assessment and prompt recognition of PSM by child protection professionals (De Bortoli et al., 2013).

The complexity of PSM is outlined in a large qualitative study, where 171 women with at least one child under the age of sixteen, across nine treatment clinics in Sydney Australia were interviewed (Taplin and Mattick, 2013). The research identified three key factors which increased the likelihood of social care involvement: 1) having more than two children, 2) being on psychiatric medication and 3) having less than daily contact with their own parent. Consequently, factors such as mothers being isolated, having poor support, PSM co-existing with parental mental ill health, and being part of a large family can increase the severity of the impact of PSM (Taplin and Mattick, 2013).

4.2- PSM: Social work practice in the United Kingdom

The findings from international literature have highlighted the complex nature of PSM and how it is often intertwined with additional safeguarding concerns including domestic abuse and poverty. Although it is not the case for all families, PSM is linked to an increased risk of significant harm to a child's emotional, physical health and wellbeing, often requiring the intervention of children's statutory social care services (Brandon et al., 2008).

This can be seen from an empirical research study by Cleaver et al. (2008) which focussed on child protection practice and responses in social care to families where PSM and domestic abuse was identified as a safeguarding concern. This mixed methods study reported that of the 349 cases, across six English local authorities, almost half recorded PSM as the reason a family was referred to children's social care. The study also identified that in one-fifth of referrals to children's social care, both PSM and domestic violence co-existed as a safeguarding concern (Cleaver et al., 2008).

Further connections between the prevalence of PSM in children's social work practice is outlined in a study examining all cases going forward for long-term allocation over a one-year period in social care across four London boroughs (Forrester and Harwin, 2006). The findings from this study found that of the 290 families, 'one hundred and eighty-six children from 100 families' (34% of families) received long term social worker intervention because of actual or alleged PSM (Forrester and Harwin, 2006:327).

At the two year follow up study by the same authors, across the same London boroughs, 85 children (46%) had stayed with their main carer, with the remainder placed in the care of their wider family or the care system (Forrester and Harwin, 2009). Children in the study who remained at home often struggled with continuing emotional difficulties and poor educational outcomes, due to being exposed to further PSM which was often linked to substance-related domestic abuse (Forrester and Harwin, 2009). The study also concluded that children living with PSM were twice as likely to be subject to care proceedings. For those children who were placed in the care of wider family or local authority care, a high proportion continued to struggle and had poor outcomes, primarily due to placement instability (Forrester and Harwin, 2009).

The study, whilst only representative of London boroughs, highlights the significance of PSM in terms of its prevalence in social work and the long-term impact on children's emotional health and wellbeing. The study draws attention to the children whose opportunities to achieve their potential was limited due to the impact PSM had on their academic achievement. The study also highlighted the high proportion of children being placed in the care of the local authority because of PSM. A further concern was that families where PSM is a significant factor often come to the attention of statutory services at a point of severity, where statutory social care intervention is necessary to protect and safeguard children (Forrester and Harwin, 2009).

There is limited literature regarding early intervention and practice relating to preventative work. Studies to date appear to be largely focussed on families

coming to the attention of services at a statutory level. Therefore, there is a gap in research relating to the needs of children living with PSM and how those children can be supported before safeguarding concerns escalate.

One reference to statistical information regarding early intervention and PSM can be found in a recent UK government guidance document, where the proportion of new cases in need of an early help assessment due to multiple risk factors (substance misuse, domestic violence and poor mental health) had doubled in 2017-2018, in comparison to the previous two years (H.M. Government, 2018).

A report by the Children's Commissioner for England (2018), identified the connection between PSM and additional safeguarding factors such as domestic abuse and poor parental mental health. The report also outlines the difficulty which practitioners had experienced in identifying PSM (Children's Commissioner, 2018). The findings presented are largely reliant on data relating to statutory social care intervention and findings regarding the correlation between PSM and children entering the care system. This suggests that children are not coming to the attention of services early enough, resulting in limited time for practitioners to promote positive change and reduce the risk to children. Significantly, the Children's Commissioner (2018) report also raises questions about whether social workers are equipped with the knowledge and training to respond to PSM.

4.3- Understanding the training needs of the social workers in the United Kingdom

McCarthy and Galvani (2004) strongly advocated the need for social workers to be equipped with adequate knowledge and training to respond to the needs of 'vulnerable people' who came to the attention of social care. The very nature of social work practice requires a holistic approach to assessment and intervention, meaning social workers routinely explore the needs of those they are supporting for a 'variety of reasons', be that health, mental health, safety, suitable accommodation, finance and wider social

factors (McCarthy and Galvani, 2004:91). The core value of social work practice is centred on supporting people in need and being equipped with the knowledge and skills to identify and assess those needs. Despite social work practice being about supporting people, this does not appear to extend to people with drug and alcohol problems (Galvani and Forrester, 2011).

Unlike practitioners within a substance misuse service, social workers may become involved with service users for a variety of reasons. Therefore, if equipped with the knowledge and skills to explore a person's substance misuse, social workers could provide earlier intervention and signpost those in need to substance misuse services (McCarthy and Galvani, 2004:91).

Galvani and Forrester (2011) conducted a study in England to explore the views of newly qualified social workers in relation to how their qualifying programme had prepared them for practice when supporting people who were using drugs and alcohol. The findings from 284 questionnaires concluded that the majority of respondents felt inadequately prepared for working with substance use and misuse issues. The research also concluded that almost a third of respondents had received no training on substance use. This resulted in social workers being ill-equipped with the knowledge to appropriately and confidently respond to the needs of service users and few examples of good practice being identified (Galvani and Forrester, 2011).

Similarly, a national survey of both adult and children's social workers, reported 'overwhelmingly' that social workers felt substance use knowledge was important to their practice, yet 'their professional education had not prepared them well' (Galvani et al., 2013:894). Further research was conducted to explore practitioners' experience within social care of alcohol and drug use in their practice. This study comprised an online survey, complimented by focus groups and interviews with 21 participants, across 11 local authorities including both children and adult directorates (Dance et al., 2014). The findings identified participants across all areas of social care facing alcohol and drug related problems among their service user group.

Children's social workers, however, were more likely to encounter problematic use of substances than social workers in adult services.

The study concluded that despite the extent to which social workers encounter drug and alcohol use in their practice, practitioners felt uncomfortable asking questions and instead focussed their assessment on 'observable signs of impaired functioning' (Dance et al., 2014:568). The research concludes that the training needs of social workers are two-fold; firstly, social workers need adequate training to identify and assess risk and secondly, they need to be equipped with knowledge and practice skills to respond effectively (Dance et al., 2014).

Galvani et al's. (2014) qualitative research identified that despite the absence of formal training, guidance and practice tools, many practitioners were attempting to engage with service users and assess the impact of substance use. The research also found that disparities in responses from social workers, in not being equipped with the tools to routinely explore alcohol and drug issues, meant there was a 'danger' that service users presenting needs were not being addressed. Further, the research identified problematic substance use only came to the forefront when the negative effects were visible, as Galvani et al. (2014:1908) notes:

> Waiting for observable substance-related problems before asking questions may miss the opportunities to identify harm or potential harm at an earlier stage. Once a person's substance problems are observable, it is likely to be late in their problematic use of the substance. Harm to self and others may well have already occurred by this stage.

A theoretical analysis of substance use knowledge within social work education and post qualifying workforce highlights the systematic failings regarding substance use, from government policy and guidance, social work education programmes through to training for social workers on the front line. As Galvani (2017:6) states:

> For more than 30 years there have been calls for improved and consistent substance use education within qualifying and post qualifying social work programmes although this has resulted in minimal attention and improvement.

4.4- Section summary

This section has presented findings from peer reviewed international research conducted in English speaking countries regarding the relationship between PSM, child welfare and social work practice. Data from both empirical research and literature reviews, have highlighted not only the complex nature of PSM and the subsequent impact on children but also of the challenges social workers face in their endeavour to accurately assess and respond to the needs of children living with PSM. The research has also shown the prevalence of PSM in cases where children can no longer live at home and for their safety are placed in either kinship or foster care.

The absence of a formal requirement of PSM knowledge both in education and practice has major implications for social work practice. Whilst many practitioners will try to assess and provide interventions, without accurate knowledge and training they are ultimately being set up to fail. The impact of this failure on a systemic level has consequences for the safety and wellbeing of people who social workers seek to support.

4.5- PSM: Learning from serious case reviews.

In England, every case of child abuse and neglect which results in a child death and/or serious injury is subject to a Serious Case Review (SCR). The purpose of the SCR's is to determine whether lessons can be learnt to prevent future fatalities, and to learn about how professionals and organisations can work together to better safeguard children (Sidebotham et al., 2011). The findings from the analysis of SCR's are published by the same team approximately every three years. The publication in 2020 marked 14 years of research, reporting on SCR's between 2003-2017. This section

explores the findings from the two most recent SCR reports which were published in 2016 and 2020 and draws on findings from earlier reports to explore, over time, the severity of the impact of PSM.

In 2012, the fourth consecutive two-yearly study of SCR's in England between 2009-2011, was published. As with previous studies, domestic abuse, parental mental ill-health and PSM were identified as significant factors in the death of a child (Brandon et al., 2012). Of the 184 SCR's which were notified to the Department for Education, the three significant factors named above were present in 86% of cases, with PSM identified as the single most significant factor in 42% of SCR's. The study reported that the difference between alcohol or drug misuse was marginal and, as with previous reports, the prevalence of PSM was consistent (Brandon et al., 2012).

Following the 2012 published report, there was a change in the team's methodology in collating and analysing data from SCR's, and in 2016 cases where a child had suffered significant injury were included in the study (Sidebotham et al., 2016). This would account for the increase in the number of cases, from 185 to 293, though only 175 of those 293 cases could be analysed due to the available reports. (Sidebotham et al., 2016). The findings from the 2016 report mirror similar conclusions to the preceding reports and found PSM to be the primary significant factor in almost half (47%) of the 293 SCR's which were examined (Sidebotham et al., 2016). However, the figure of 47% does not include the serious case reviews whereby PSM co-existed with other significant risk factors, namely domestic abuse and parental mental health (Sidebotham et al., 2016). It is therefore a possibility that the extent to which PSM features in the findings from serious case reviews, could be even higher than reported.

The 2016 report was the first report to overtly identify the impact of poverty and austerity on the lives of families, naming poor housing, overcrowding, homelessness and unemployment as contributory factors within SCR's. Due to issues in data not being collected to indicate markers of deprivation and

poverty, a true reflection of the impact of ‘socio-economic gradient in serious or fatal maltreatment’ was limited (Sidebotham et al., 2016:34).

A further key theme from the 2016 SCRs was the need for the focus of professionals to remain on the needs of the child but that listening to the wider family may provide a more holistic insight, as Sidebotham et al. (2016: 14) outlines:

> Hearing the voice of the child is crucial but so too is hearing the voice of the immediate family and wider family. Hearing children requires safe and trusting environments for children to be seen individually, speak freely and to be listened to.

The findings from the 2016 review outlined key learning points for professionals, that the effect of PSM, particularly when coexisting with domestic abuse, is significant. It is therefore essential that the focus of practitioners remains child-led and that support is available to the young people as well as the parents. The focus should not shift solely to the needs of the parents therefore excluding and losing sight of the young person’s needs (Sidebotham et al., 2016).

In 2020, the analysis of SCR’s between 2014-2017 was published and, as with previous reports, the trio of PSM, domestic abuse and parental mental ill-health featured strongly. The 2016 report began to highlight the direct impact of poverty on families, however, in the 2020 report, the impact of poverty on the lives of families came to the fore in the analysis of the complexity and stresses experienced by families which led to child neglect, abuse and fatality (Brandon et al., 2020).

The 2020 report was the first time PSM had been split into alcohol and drug misuse, although the reasons for this are not mentioned in the report. Between 2014-2017, 368 SCR’s were reported to the Department for Education. Of those, only 278 SRC’s could be analysed due to available reports; only reports which had been published by the Department for Education could be included. Of the 278 SCR’s, 165 children had died and

113 were seriously harmed (Brandon et al., 2020). The report outlined that out of 278, there were 99 SCR's where alcohol misuse was a significant factor, and 99 SCR's for drug misuse (Brandon et al., 2020). What is not clear from the report, is the number of cases where parents used both alcohol and other drugs. It is, therefore, difficult to understand the total of SCR's where PSM was the primary significant factor.

As with the previous published reports, spanning over 14 years of enquiry into SCR's, the connection between PSM, domestic abuse, parental mental ill-health is a significant contributory factor in the harm and death of a child. In the 2020 report an added connection was the significance of poverty. It highlighted the beginning of apparent 'poverty blindness' by frontline practitioners and normalisation of the existence of poverty (Brandon et al.,2020:62). In relation to PSM, the report highlights the need for practitioners to explore the causes of poverty and to work with the wider family, especially where parents attempted to 'close down' professional involvement, in seeking to understand the lived experience of the child. The report also recommended the need for improved information sharing between adult and children's services, as Brandon et al. (2020:59) outlines;

> The links between domestic abuse, substance misuse and poverty are complex and often inter-dependent […]. Substance misuse can result in money needed for food and clothing being diverted to satisfy parental needs. Short-term solutions followed by case closure leaves children at risk. Practitioners need to understand how poverty affects children and, through hearing their voices, seek to safeguard and improve the quality of their lives. When families are receiving services from both adult and children's services, information sharing and joint working enables the development of more realistic plans to safeguard children.

Knowledge of substance misuse is not just essential for specialist substance misuse practitioners but for all social workers across both adult and children's services, as Sidebotham et al. (2016:19) states:

> We owe it to children and their families to identify those lessons, disseminate learning and implement actions for improvement.

As outlined in the previous chapters, social workers do not routinely receive education and training regarding substance misuse. In the absence of formal education and training, social workers are arguably left ill-equipped to assess the impact of PSM on children. The consequence of this failure to educate and train front line professionals to assess and effectively respond to the needs of children living with PSM, as outlined in this section, can be fatal.

4.6- Chapter summary

This review of literature has, so far, presented findings from research relating to substance use legislation, policy, guidance and training. The literature review has also presented data which illustrated the implications for practice regarding PSM. The findings from the reports of SCR's, spanning over 14 years, illustrate the severity of the impact of PSM. Time and time again PSM is reported as a significant factor in cases where a child has suffered serious harm or fatality.

To gain an in-depth understanding of the needs of children living with PSM, the following chapters will focus on the voice of the child and explore the complexity and connection between PSM, domestic abuse and parental mental ill-health. Research relating to the impact of longevity of exposure by children to PSM will be explored. Finally, existing models of practice which seek to support and respond to the needs of children affected by PSM will be explored.

Chapter 5

Understanding children's experience of living with parental substance misuse

PSM does not always lead to negative outcomes for children, nor does PSM indicate a certainty that children will experience neglectful or harmful parenting (Huxley and Foulger, 2008). Although this is important to acknowledge, PSM can present acute risks to children within the family home due to a parent not being able to respond to a child's needs, or to supervise and to protect them from hazards (Huxley and Foulger, 2008).

As outlined previously in this literature review, some children whose parents misuse substances come to the attention of social care. That said, children who experience PSM who do not come to the attention of services may still experience 'persistent adversity' (Barnard and Barlow, 2003:45)

Prior to the publication of *Hidden Harm* in 2003, PSM and the impact on children had rarely been seen through the eyes of children. This chapter explores the body of knowledge regarding how children experience PSM and the associated emotional and physical impact on children. Throughout the chapter, reference is made to the age of the children who participated in research. This is an important consideration because, as the following sections will show, there has been a reliance on the participation of older children in research, therefore neglecting the voices of younger children.

Throughout the chapter, the voices of children will be presented, because, as Kroll and Taylor (2009:305) state;

> It is only through hearing the voices of children and young people that the totality of their experience can be considered […] We also need to know and understand the reality of the lives they lead.

5.1- Children's negative experience of PSM

For many children living with PSM life can be fraught with difficulty, danger and fear. To allow for an accurate understanding of the needs of these children, the negative aspects of PSM should not be avoided (Kroll and Taylor, 2009). Children living with PSM can be hidden within families, and more so when parents are misusing drugs rather than alcohol (Barnard and Barlow, 2003). This, in part, may be due to the 'illegalities surrounding drug misuse' and the needs of parents to keep their drug misuse hidden, consequently reducing the visibility of their children (Barnard and Barlow, 2003:46).

When *Hidden Harm* was published by the ACMD in 2003, the voices of children, parents and professionals were collated from numerous sources. The plight of children living with parents who misused drugs was outlined throughout the report. The report presented direct quotes from children who had participated in the research, many of whom had witnessed parental drug misuse, including injecting drug use. Children reported missing school or being at school and worrying about what their parents were doing at home. Other children shared memories of being only seven years old and seeing multiple adults in their home using drugs together, and they knew from a young age what substances were being taken, while other children said they had tried to stop their parents using by refusing to leave the house (ACMD, 2003).

In the same year *Hidden Harm* was published, a two-year qualitative study was carried out in Scotland, which aimed to explore the ways in which drug dependency had an impact on parenting, from the perspective of both children and parents. The study included 36 interviews with children, of whom 23 children were living with their parents. The study outlined the challenges faced by researchers in interviewing children, largely because of parents' reluctance for their children to take part. Further challenges were highlighted with regards to children's age, as the research had to predominantly rely on the involvement of older children; of the 36 children

who participated, only 12 were under the age of 12 (Barnard and Barlow, 2003).

Children and young people who participated in the research study, identified a range of behaviours which had ‘puzzled’ them; they experienced parents bad temper and parents being too busy to spend time with them. Despite parents providing explanations for their absence, many children reported knowing they were in another room taking drugs, and many had witnessed parents injecting drugs. Underpinning the experience of the children who participated, was the importance of keeping secrets, both within their family but especially with ‘outsiders’ (Barnard and Barlow, 2003:51).

The association between PSM and children’s experience of needing to keep secrets and of parental denial has been referred to in literature as ‘living with an elephant’. The substance is the elephant, that nobody within the family talks about or which becomes the focus of investigation by professionals, which leads to the needs of children ‘remaining invisible’ (Kroll, 2004).

Although the studies detailed so far are focussed on the misuse of drugs, the needs of children experiencing parental alcohol misuse are of equal concern, as Turning Point (2006:5) outlines:

> Parental alcohol misuse damages and disrupts the lives of children and families in all areas of society, spanning all social classes. It blights the lives of whole families and harms the development of children trapped by the effects of their parents’ problematic drinking.

An Australian study which focussed on systems’ responses for families affected by PSM, draws findings from 15 young people aged 11 to 17 who were asked by researchers to talk about their perspectives on how alcohol and drug use affected their families. The young people were also asked how services might best respond to them (Moore et al., 2010). The findings from this study revealed similar findings to the study by Barnard and Barlow (2003), in that, the lives of young people living with parents who misused

substances were marred with a deep sense of stigma and social isolation because of the need to ‘keep their family situation secret’ (Moore et al., 2010:5). In addition to PSM, some children were exposed to multiple drug use by several family members. Their experiences were intertwined with additional factors which impacted on their emotional and physical wellbeing, namely living in poverty, being socially isolated and experiencing family conflict (Moore et al., 2010*).*

Young people also shared their experience of feeling unsafe because of the adults their parents associated with and who, in some cases, ‘treated them badly or exposed them to drugs and drug paraphernalia’ (Moore et al., 2010:3). The complexity and chaos of the lives lived by these young people is evident. The compounding issues of PSM, family conflict, poverty, neglect, isolation, family separations, secrecy and fear created a plethora of barriers for these young people when needing support (Moore et al., 2010). The impact on children’s lives and their need to be ‘strong’ to endure such hardship was evident, as stated by Moore et al. (2010:7):

> The young people were strong and resilient but also vulnerable. They had survived and were still trying to survive through tough times.

This study highlighted the need for children to have support to ensure their safety, to promote positive mental health and resilience, and to lessen the impact of the negative factors. Yet, many of these young people felt it was up to them to find support; nobody reached out to them despite them coming into contact with professionals (Moore et al., 2010). For some young people, they felt that there were times when health professionals did not support them as the workers’ main focus was on supporting the parents. The findings from this Australian study mirrored the findings outlined in the previous section relating to the findings from serious case reviews, whereby the professionals’ focus on the needs of parents had overshadowed the needs and voices of children.

This sense of children being ignored, and the needs of their parents being prioritised above theirs, was a theme identified in a report by the Children's Commissioner for England (2018). The report explored the lives of children living in households where PSM, domestic abuse and mental health coexisted. Children and young people between the ages of six and 19 participated in the research, with the aid of the practitioners who were supporting them from a range of services. Of the 15 participants, five children were under the age of 12. Many children reported feeling unable to speak out, to seek support and, when support was offered, they often felt as though this offer was centred on the needs of their parents (Children's Commissioner, 2018). As with the studies presented above by Barnard and Barlow, (2003) and Moore et al. (2010), the report by the Children's Commissioner is also heavily reliant on the voices of older teenage children.

Concerns highlighted in literature describe the isolation that children living with PSM experience. They also fear talking to people outside of their family unit for fear of the negative consequences and shame (Kroll and Taylor, 2009; Velleman and Templeton, 2007). The challenge for professionals attempting to support children affected by PSM is that families who may be in most need of support, may also be the families most reluctant to be contacted. This can further exacerbate the feeling of isolation children experience, leaving them to carry the burden of secrecy for longer (Taylor et al., 2011).

As children enter into their teen years a further potential risk factor is the longevity of exposure to PSM and the normality of living in a household where adults misuse substances (Velleman and Templeton, 2007). Specifically, the exposure to PSM in relation to drug misuse and the associations with crime to fund drug misuse, violence, gang culture and drug dealing are all factors which can contribute to the normalisation of 'street life' and initiation into drug misuse (Hedges, 2012).

A research study by Bancroft et al. (2004) aiming to understand the experiences of young people affected by PSM as they transition into

adulthood, highlights the trial and error of strategies that these young people adopt in an attempt to cope. A theme which emerged from the findings was that young people would try to reduce the amount of substance their parents were taking, using a number of strategies such as managing the family budget, pleading, and shouting at parents; therefore, children were in many ways 'parenting their parent'. However, this method was futile and often resulted in further conflict between parent and child (Bancroft et al., 2004).

5.2- Direct impact of PSM on parenting

The direct impact of PSM on parenting can result in the substance becoming the parents primary focus, as Melhuish, (2011) found when they interviewed three parents about their accounts of crack cocaine. This was a small-scale study using interpretative phenomenological analysis to analyse the semi-structured interviews with two mothers and one father. The parents' accounts of their crack cocaine use highlighted that during the height of their use, crack cocaine often took priority over their child's needs. The need to use crack cocaine meant every aspect of their life revolving around the drug (Melhuish, 2011).

The experience of children living with parental drug misuse is powerfully portrayed in *Hidden Harm* by one parent's reflection of their life when misusing drugs;

> I was running about with folk that were injecting and I was injecting myself. I was taking temazepam, valium, acid, really just anything at all. Not eating or sleeping, my house was a mess, folk coming into my house at all hours, folk having parties at my house. It was disgusting the lifestyle I was leading and it was scary as well 'cause I had my wee boy with me and he was seeing everything that was going on around him. (ACMD, 2003:46)

Little is known about the impact of different drugs on parenting and parent-child interactions, as research has focussed largely on the study of PSM relating to alcohol and heroin use (Holland et al., 2014). In a study by

Slesnick et al. (2014), 183 mothers who had a child/ren aged 8-16 years in their care and who were accessing substance treatment services participated. All participants were receiving treatment for alcohol, opiate and/or cocaine misuse. The study found that mothers who were addicted to opiates showed less negative parenting than the mothers who were addicted to alcohol. Overall, all mothers who participated in the study struggled to manage their addiction and implement effective positive parenting (Slesnick et al., 2014).

Similar findings were identified by Holland et al. (2014) in a mixed methods qualitative study which included parents from 26 families; except for two, all participants were single mothers. There were 86 children and although five of the children participated in the study, none of the data from the semi - structured interviews with children were included in the final report (Holland et al., 2014). The reason for this exclusion was not outlined. Participants included parents who were misusing substances and parents who had successfully achieved abstinence or were maintaining controlled drug use.

There was a noticeable difference between the reflections shared by parents. The parents who were misusing substances at the time of interviews, described how they were maintaining a ‘normal family life’, despite fluctuating episodes of substance misuse (Holland et al., 2014:1496). It is possible parents felt unable to talk openly about how their substance misuse was impacting on their children, perhaps through fear of the consequences, of their confidentiality being broken, of children’s social care being informed, and because of feelings of shame.

Parents who no longer misused substances reflected on their achievement of maintaining positive change. They were able to give detailed reflections of how their substance misuse had impacted on their children growing up (Holland et al., 2014). There was no clear distinction between the impact of parental alcohol or drug misuse, but a common theme throughout the study was that both are indicative of ‘chaos, lack of consistency and irrationality’ (Holland et al., 2014:1500).

The study by Holland et al. (2014) illustrates the complexity of the lives of parents attempting to manage their substance misuse and meet the needs of their children. Common factors included domestic abuse, frequent home moves to escape violent partners, experiences of poverty, and 'the stories told by mothers wove strands of abuse and neglect in childhood' (Holland et al., 2014: 1503). Evidencing that substance misuse rarely stands alone and that experienced trauma and disadvantage can span generations.

An Australian study by Cattapan et al. (2008) also highlighted the complexity of PSM, including the violence suffered by parents, the impact of their own upbringing, and exposure to PSM. This qualitative study interviewed 15 parents (13 mothers and two fathers) and aimed to identify 'patterns that occur in the family when a parent is juggling both an addiction and the nurture of children' (Cattapan et al. (2008:78). As with the studies presented in this section by Slesnick et al. (2014) and Holland et al. (2014), this study is primarily focuses on participants who are mothers. The study by Cattapan et al. (2008) presents parents' recollections of the dangers they exposed their children to and the precocious maturity children had to adopt. The study brings to the fore, the generational impact of exposure to PSM, as Cattapan et al. (2008) suggest:

> Children's lives emerge from the shadows of the lives of their parents and grandparents. Drug use seen in one generation affects the lives of the next (Cattapan et al., 2008:77)

In response to the complexity of issues associated with PSM, Neger and Prinz (2015) also draw attention to the body of literature regarding the interaction of PSM and parenting. Neger and Prinz (2015) argue that to address substance misuse without support for parents to address their parenting is futile, since insufficient parenting skills to manage their children's behaviour could lead to a parent relapsing. Further, managing a child's behaviour and responding to their emotional needs requires intrinsic motivation and emotional-regulation which is argued to be incompatible with substance misuse and varying states of withdrawal (Neger and Prinz, 2015).

5.3- Section summary

This section has begun to explore the complexity of PSM and the myriad of risk factors experienced by children. The interplay of three significant risk factors; domestic abuse, parental mental ill-health and PSM have historically been referred to as the 'Toxic Trio' (Gorin, 2004). This term is no longer used and, as advised by The Association of Directors of Children's Services (ADCS), the preferred term is 'trigger trio' in reference to the three most prevalent child safeguarding concerns (ADCS, 2018:23). The following section will explore the findings in research regarding PSM and associated safeguarding risk factors relating to parental mental ill-health and domestic abuse.

5.4- Trigger Trio: PSM, parental mental ill-health and domestic abuse

PSM, parental mental ill-health and domestic abuse are identified as significant risk factors experienced by children, and are the most prevalent reason's (80-100% of families) why children and their families come to the attention of children's social care (ADCS, 2018). The complexity of the combination of these three factors can increase the severity of the risk of harm to a child, as outlined in the findings from serious case reviews, presented in chapter 4.4.

Children living with PSM can experience unpredictable parental behaviour and poor parental mental health linked to their parents' pattern of substance misuse, referred to as the 'before and after' parent (Kroll and Taylor, 2009:114). A parent's overwhelming need to use substances can take priority over the emotional and physical needs of their children. This relationship with substances competing with the relationship between parent and child can pull a parent away from their child, impacting on a child's emotional health and psychological development (Kroll and Taylor, 2009).

Increased severity of PSM can have increased negative consequences for children. An impaired parent-child relationship, which is categorised by low warmth and involvement, can impact on a child's emotional, physical, social, and academic progress. Therefore, reducing a child's ability to build internal coping strategies to be able to cope and to respond to presenting difficulties and difficulties in later life (Gance-Cleveland et al., 2007).

An Australian qualitative study by Reupert et al. (2012) sought to explore the issue of dual diagnosis, and the needs of children whose parents had both a 'mental health and substance use disorder'. Of the 24 identified children only 12 children were able to participate due to parents not consenting to their child's involvement. The study highlights the difficulty in seeking to ensure children's voices are heard in research. Children who participated in this research were aged between 8 and 15; of the 12 participants, only two children were under the age of eleven (Reupert et al., 2012). Children who took part in the semi-structured interviews lived in complex family circumstances. The demographics of the children highlighted family histories of violence, sexual abuse, parent suicide, absent parents, and instability due to multiple care episodes. All of the children expressed a view that their family situation needed to improve and that they needed support for their family (Reupert et al., 2012).

The impact of parental dual diagnosis on the lives of these children was evident through their reflections of experiences. Including their parents physical and emotional absence; their experienced neglect was further compounded by poverty. The impact of PSM and parental mental ill-health is illustrated by this 12-year old's description of her mum;

> Mum [is] sick all the time. It can be hard to look after her and [this] puts stress on me sometimes when it is bad. When you go to the fun parks, she can't join in on the rides… when your parent is sick, they don't have much time for you to show you attention or anything (Reupert et al., 2012: 157).

Research has identified a connection between parents' drug and alcohol misuse and the occurrence of domestic abuse and its equally debilitating impact on the capacity of parents to meet their children's needs (Holland et al., 2014). The impact and strain on children, living under considerable stress due to parental alcohol misuse and serious domestic abuse, often for long periods of time, is evident in a cross European qualitative study by Velleman and Reuber (2007). Of the 57 young people aged 12-18 years who were interviewed, 36% reached clinical levels of mental health concern. Witnessing distressing incidents left young people feeling sad and angry and most had found it incredibly difficult to cope (Velleman and Reuber, 2007).

The connection between parental alcohol misuse, domestic abuse, and the impact on children was further evidenced by Templeton et al. (2009). A cohort of 13 young people aged 12-18 years participated in this qualitative study, which explored young people's experiences of living with parental alcohol misuse and violence. The study found that all participants had experienced hearing fights between parents when they were 'drunk' (Templeton et al., 2009). Five of the cohort had experienced witnessing a parent being hit, or had been hit themselves when trying to protect another family member. The young people's experiences of living in a household where alcohol misuse and violence co-existed was depicted as a life of fear, isolation, stress and feelings of being unloved. These young people felt that they had to just cope and survive (Templeton et al., 2009).

The extent of children's knowledge of their parent's substance use, and the complexities within their family when coupled with domestic abuse, can be seen in a study by Galvani (2015). Galvani used creative methods within focus groups, with 14 children, aged 10-15 years, who were accessing specialist support due to their parent's substance use. The level of knowledge and insight children had regarding levels of substance use and their understanding regarding predictors of harm and violence, was evident from the children's accounts of their experiences (Galvani, 2015).

Many children viewed some substances as less ‘dangerous’ than others; drugs were associated with the risk of death, as recalled by one child who had a family member who had died from a heroin overdose. The children did not identify substance use as a precursor to violence but did identify from their experience that the quantity and strength of a substance influenced a person’s behaviour (Galvani, 2015). A key message from this study was the view from children, that their parents receiving support for their substance use did not always mean that family life improved. Reduced substance use did not mean reduced violence and having professionals such as social workers involved did not reduce the stress and tensions within the household (Galvani, 2015).

5.5- Chapter summary

The research presented so far within this review of literature has drawn attention to the complexity of PSM and of the direct impact on children, in relation to both their physical and emotional care needs. The research has highlighted that the voice of children is limited and, where children’s participation in research is included, the voices of younger children are largely absent. The research presented has evidenced the increased risk of emotional and physical harm experienced by children when PSM co-exists with parental mental ill-health and domestic abuse. The following chapter draws on literature relating to the long-term impact of PSM on the lives of children.

Chapter 6

Understanding the long-term impact of parental substance misuse on children

This chapter will explore the literature regarding the potential long-term impact on children's emotional and physical health and wellbeing due to PSM. The chapter will draw on findings from literature on childhood adversity, childhood attachment and longitudinal studies which explore the impact of PSM and associated multiple adversities.

6.1- Adverse Childhood Experiences

Pivotal to the understanding of the long-term impact on children exposed to PSM and associated risk factors, is the seminal study by Felitti et al. (1998). The study sought to explore the long-term relationship of adverse experiences in childhood and emotional and physical health problems in adult life. Adverse childhood experiences (ACE's) were initially categorised into seven forms of abuse: psychological, physical, sexual, household dysfunction, substance abuse, mental illness, mother treated violently and criminal behaviour in the household (Felitti et al.,1998:248). Children's exposure to 'substance abuse in the household' was the most prevalent of all seven categories of abuse, with '25.6%' of the respondents experiencing this ACE (Felitti et al.,1998:248).

In addition to poor physical health outcomes in adulthood, exposure to multiple ACE's drew strong correlations to poor mental health in adulthood and the risk of developing problems with substances in later childhood and adult years (Felitti et al., 1998). Felitti et al.'s. (1998) study concludes that children who experience four or more ACEs are more likely to suffer long-term adversity and are increasingly more likely to develop substance misuse problems as the number of ACEs increases.

The findings from this ACEs study are mirrored in a recent study by Merrick et al. (2017) who identified a clear relationship between adversity in childhood (namely emotional, sexual and physical abuse and household substance misuse) and poor mental health and substance misuse in adulthood. Since the ACE's study, further adversities have been identified and the categories of abuse have been updated to include both emotional and physical neglect, as well as absent parents (Burke et al., 2011). A study by Hughes et al. (2017) brings to the forefront a more detailed categorisation of ACEs and expands the original categories to include, 'neglect, family financial problems, family conflict or discord, bullying, death of a parent, serious childhood illness or injury' (Hughes et al., 2017:361).

A limitation of the ACE studies is that the prescriptive list could lead to professionals who are supporting children and their families to miss or ignore other factors and sources of adversity, such as the impact of poverty. Though the studies identify the impact of accumulative ACEs, they do not provide insight and understanding of a person's wider environment and the impact of social inequalities. As Asmussen et al., (2020:4) outlines, the ACE's narrative needs to engage with the limitations, as ACE's 'do not occur in isolation' and prevalence is increased for children who live in deprived areas and who experience poverty.

6.2- PSM and the risk of negative outcomes for children

The adversity that children affected by PSM experience is intertwined with, and exacerbated by, the systems in which they live. Kepple (2018) draws on the work of Bronfenbrenner (1977), to explain how multiple systems within society can impact on a child's life. A child's micro-system including their immediate family, their mesosystem, (a child's surrounding community/neighbourhood), the macrosystem (government legislation and service provision), and the society in which the child lives (exosystem), are all variables which define levels of neglect and impact (Kepple, 2018). In this study, data from the 'National Survey of Child and Adolescent Well-Being (NSCAW I)' in the USA was used to assess the 'relationship' between PSM

and child ‘maltreatment’. The study sample was composed of 2100 parents of children ages 2–17 years (Kepple, 2018:44). The study concluded that the direct impact of PSM alone does not ‘dictate’ child maltreatment and it is the ‘types of social supports’ that may play a role in mitigating or exacerbating the effects of parental impairments’ (Kepple, 2018:53).

Further studies have drawn similar conclusions regarding the correlation between adversity in childhood and negative outcomes in adulthood. A longitudinal study by Jaaskelaine (2016), was conducted in Finland using regression models of data analysis on children born in 1991 who were followed until their eighteenth birthday. The study found that both maternal and paternal substance misuse were significant predictors of mental disorders and harmful substance use in children aged 13-17 years. (Jaaskelaine, 2016). Similarly, preliminary results from an Italian study of young people experiencing substance misuse problems, concluded that young people experience more severe neuropsychological impairments such as clinically diagnosed anxiety, depression and poorer cognitive function when PSM is a factor (Parolin et al., 2016).

The impact of experiencing neglect in childhood, coupled with PSM, and the associated risk of child development problems with substances, was explored in an American study by Kirisci (2001). This longitudinal study recruited 344 boys aged 10-12 years, recruited through their fathers who were accessing specialist support, including substance abuse treatment programmes. The findings from the study found that boys who have experienced emotional neglect and PSM were at a greater risk of developing substance use disorders in later childhood and into adulthood. Further, the study concluded the severity of neglect in late childhood was also associated with adverse psychosocial outcomes in later life (Kirisci, 2001).

This conclusion is supported by a youth development study in Northern Ireland (Percy, 2008), which concluded that it is not uncommon for children of parents who misuse alcohol to require treatment and intervention for their own alcohol misuse in later life (Percy, 2008). While the findings from various

studies conclude that being exposed to PSM can greatly increase the risk of developing problems with substance misuse in later life, this does not mean that all children exposed to PSM become substance misusers themselves (Velleman and Orford, 1999).

The research findings presented in this chapter present a strong connection between adversity experienced in childhood and negative outcomes in later childhood and adult life. That said, children and families are unique and as Velleman and Templeton (2016) suggest, it is unhelpful to generalise and draw links between particular risk factors and particular negative outcomes. However, what is evident is that there is an increased risk of negative outcomes for children who are exposed to multiple adversities.

6.3- Chapter summary

This literature review has presented research findings relating to the complexity and severity of the impact of PSM on the lives of children. This section has explored the body of literature relating to the longevity of exposure to PSM. The pivotal study of ACE's evidenced the connection between childhood adversity and the long-term impact of poor physical and mental health in adulthood. The ACE's study was not without limitations, as ACE's rarely occur in isolation and the study failed to include the impact of wider environmental factors such as the impact of poverty on children and their families.

This is not to say that all children who live with parents who misuse substances will suffer long term consequences. The ACE's study does not account for the protective factors in a child's life which can help to mitigate the impact of PSM and promote positive mental health and wellbeing. As such, the following chapters will explore the protective factors which are of significant importance to support children living with PSM.

Chapter 7

Understanding children's protective factors, and responses in practice to parental substance misuse

PSM as illustrated throughout this review of literature, is a significant risk-factor that can impact on children's safety, emotional and physical health, and wellbeing. While it is important not to shy away from the complex and negative realities, it is also important to recognise the significant factors in children's lives, which enable them to develop strategies to cope and arguably more importantly, the ability to thrive. The literature so far has largely focused on the negative impact of PSM both in terms of the short-term and long-term impacts. This chapter aims to explore the protective factors that are significant in helping to lessen the negative impact of PSM on children.

7.1- Protective factors for children experiencing PSM

Protective factors are recognised in research as having huge importance when assessing the needs of children affected by PSM. They can serve to balance risk, and, cumulative protective factors can help children to achieve greater resilience (Velleman and Templeton, 2016).

Newman and Blackburn (2002) suggest there are four core constructs of protection for children; a child's personality (including cognitive skills), the absence of 'chronic life stresses' (including child abuse and parental illness), opportunities for 'meaningful social roles', and the structure of a child's family. The structure of the family refers to a child receiving 'high warmth/low criticism', especially in times of high stress; parental warmth is a key protective factor for children (Newman and Blackburn, 2002:8).

Similarly, Sattler and Font (2018:3) suggests protective factors can be identified at multiple levels, including individual traits (such as 'self- efficacy' and 'easy temperament'), familial factors (including 'nurturing and cognitively

stimulating parenting'), and community factors (including living in a positive neighbourhood and experiencing 'social cohesion'). Although protective factors are important, it is critical to recognise that their existence in a child's life does not necessarily equate to reduced risk, or risk factors being cancelled out by protective factors (Velleman and Templeton, 2007).

The concept of resilience is often inextricably linked to research relating to protective factors in childhood. Newman and Blackburn (2002:1) simplify the clinical definitions of resilience and suggest resilience is, in essence, a child's ability to 'bounce back from adversities'. Resilience is therefore an ability to function in spite of the stresses and adversity being experienced.

Ungar et al. (2013) suggests improved outcomes and increased resilience in children are linked to a combination of protective factors; namely, children's individual temperament, their caregivers' characteristics (capacity to provide a secure attachment), a child's wider environment (neighbourhood) and a child's social and physical ecologies (Ungar et al., 2013).

Importantly, the longevity of a child's exposure to adversity needs to be considered. Research findings suggest that the more a child is exposed to adversity, the more the child will need to depend on the quality of their environmental protective factors and resources available to them (Ungar et al., 2013). The notion of longevity is supported by Newman and Blackburn (2002), who outlined the 'heightened probability' that children who experience risk factors will experience poorer outcomes when risk factors are cumulative.

A qualitative study by Backett-Millburn et al. (2008) in Scotland, involved interviews with 38 young people, aged 15-27 (20 women and 18 men). The age range was chosen to include a transitional phase from childhood to adulthood and would allow the young people the opportunity for reflection on their past experiences (Backett-Milburn et al., 2008). The study aimed to explore participants' retrospective accounts of their childhood and their view of factors which would contribute to their ability to cope. Avoiding terms such

as coping, resilience, and protective factors, the study adopted the term ‘getting by’ (Backett-Milburn et al., 2008).

In their reflections of what helped them to ‘get by’, participants shared their accounts of ‘escaping’ either to their bedrooms or leaving the house, they ‘cried’, they ‘vented’ and found escapism in the form of watching TV or listening to music in an attempt to muffle the noise (Backett-Milburn et al., 2008: 468). PSM rarely existed in isolation and many of the participants reflected on their experiences of witnessing parental violence, parents’ poor mental health, and, for some, having harm inflicted upon them, including physical and sexual abuse (Backett-Milburn et al., 2008).

7.1.1- Family and friends

Some protective factors stand alone in their significance, such as having a parent at home who does not misuse substances or having a positive bond with at least one adult in a caring role, for example grandparents or older siblings (Osbourne and Berger, 2009; Velleman and Templeton, 2016).

For children who live with PSM, trusted adults such as a grandparent who live outside of the family home can provide a much-needed break. This safe place provides respite for children and is a significant protective factor (Bancroft et al., 2004; Velleman and Templeton, 2016). Having support inside and outside of the family home is key to helping children feel they are being ‘looked-out for’ and to feel less isolated (Bancroft et al., 2004).

Though having a non-substance misusing adult in the family home and/or having a trusted adult in close proximity is deemed to be a significant protective factor, it is important to be cautious and mindful of the dynamics of family relationships. This is because the identified trusted adult may become embroiled in the difficulties associated with substance misuse and thus the focus may return to that of the adult and not the child (Forrester and Harwin 2011: Velleman and Orford, 1999).

Findings from a qualitative longitudinal study by Eiden et al. (2016) highlighted the importance of maternal warmth and sensitivity in early childhood. It is this warmth and parental monitoring in middle childhood that supports children to self-regulate and reduce the risk of children developing behavioural problems and engaging in risk-taking behaviour in adolescence (Eiden et al., 2016). Whilst parental warmth in a child's early years is important, parents' knowledge of the whereabouts of their children in later childhood is argued to be an important protective factor in reducing the risk of teenagers entering a pathway to substance misuse (Eiden et al., 2016). Alongside emotional warmth and security, a further significant protective factor for children is their experience of being encouraged by parents and/or family expressing aspirations for their children (Velleman and Templeton, 2016).

It is very evident that family relationships play a pivotal role in helping to secure and shape a child's safe base, giving a child the best opportunity to develop positive emotional health and wellbeing. However, what is assessed as a protective factor for one child may not be a protective factor for another. Not all families play a significant role in safeguarding children (Kroll and Taylor, 2009), especially where there is family disharmony, family breakdown, disputes regarding the shared care of the child, and the denial by family members of the very existence of the 'elephant' in the room (Kroll, 2004).

Further studies by Bancroft et al. (2004) have highlighted the importance of family members, siblings and friends who can in times of need be an invaluable source of comfort and support for children experiencing PSM. Bancroft et al. (2004), conducted interviews with 38 young people, aged 15-27 years to explore their experiences of PSM. The young people in this study shared their experiences of having had difficult lives and at the centre of all the difficulties and harm they had endured was PSM (Bancroft et al., 2004). They spoke of their need to remove themselves from the situation and how seeking respite at neighbour's or friend's houses, or simply taking refuge with their siblings in their bedroom was their way of coping (Bancroft et al., 2004).

Further findings by Bancroft et al. (2004) highlighted that friendships can be a source of comfort but also a source of anxiety, as children are left with the task of assessing whether they can trust their friends. For children who could confide in a trusted friend, especially when their friend really understood them because they too had experienced similar worries, this source of support was regarded as very special (Gorin, 2004).

7.1.2- Community resources

The significance of relationships with adults both inside and outside of the family home can, for many children, act as a buffer and protective factor against the harm and difficulties experienced at home. A further source of protection for children can be opportunities outside of the family home. Having access to positive activities can have an 'important influence on their welfare and sense of self-worth' (Forrester and Harwin, 2011:47).

Accessing positive activities, perhaps sports or clubs in the community, may not be in reach for all children. The complexities of a child's environment are significant when considering protective factors. For example, heroin misuse is strongly linked to neglect and social deprivation (Forrester and Harwin, 2011). The environment in which a child lives is significant in relation to the compounding effect and cumulative risk factors. In contrast, if a child was to live in an affluent home, they are more likely to have multiple buffers which protect against the negative impact of their parent's substance misuse (Forrester and Harwin, 2011). The findings from the study by Forrester et al. (2014) identified that for children living with PSM, their protective factors were linked to two key sources of support: children having opportunities for success outside of their family home and having at least one positive relationship with a trusted adult outside of their family.

A qualitative study by Fraser et al. (2009), utilising creative methods with children and semi-structured interviews with parents, explored the impact of PSM on children and the implications for services. Participants included 25 parents from 18 families and 41 children; the study did not outline why only

eight children (aged 4-14 years) participated. All of the families who participated in the research were receiving support from children's social care (Fraser et al., 2009). The findings from this study, highlight the anxiety experienced by children who were worried about their parent's substance misuse because of the fear of being removed from their parents' care. The findings also highlighted that where professional support was available to children, trusted long-term relationships were of significance importance.

Children identified key characteristics that they found helpful, which included being trustworthy, being believed, being listened to, kindness and confidentiality (Fraser et al., 2009). Of particular importance alongside the role of children's social workers, was the pivotal role of teachers, as described by one 11-year-old boy;

> […] she gave me high hopes, she encouraged me to do my school work ... and listened to me if I was upset. (Fraser et al., 2009:857)

When children and their parents have support from specialist provisions in order to share their experiences, to develop positive communication, or to meet other families experiencing similar circumstances, there is a reduction in family conflict, and an increase in children reporting improved emotional wellbeing of the family (Templeton, 2014). The presence of a positive support network for both children and their parents can protect against the harm that PSM may cause. However, there is a need to reach children where the threshold of concern is maybe not high-risk but where a child is still in need of support, if poor outcomes for children affected by PSM are to be avoided (Huxley and Foulger, 2008).

The study by Fraser et al. (2009) also draws attention to outcomes for children who have experienced PSM and suggests that the children who participated in the study were resilient and that this was evident 'from their ability to move on from damaging experiences' (Fraser et al., 2009:853). The study also suggests that children 'demonstrated resilience in being able to look forward to a positive future', the evidence for this conclusion was based

on the optimism from parents and children of their future and parents resolving their ‘substance-use problems’ (Fraser et al., 2009:863). The study presents a singular view that a child is able to move forward and become resilient, because of a reduction in their parents substance misuse. As this study is not longitudinal, the study is only able to discuss findings in the present, it is not possible to predict the future impact of PSM on the lives of these children or the quality of relationships between parent and child when PSM has reduced. As Forrester and Harwin (2011) outlined, children who experienced PSM can achieve positive outcomes, although ‘exceptionally difficult’ it is by no means impossible.

7.2- Section summary

This section has presented research findings relating to protective factors and the concept of resilience. Children receiving warmth from their parents, living in an environment of social cohesion and having trusted adult relationships were all protective factors which could act as buffers to reduce the impact of PSM.

Some protective factors stood alone in their significance; having a parent who did not misuse substances was important, as well as having a wider network of trusted adults and positive family relationships. The research findings also outlined the importance of children being able to engage in positive activities such as sports and access to community resources. Engaging in positive activities was identified as an important protective factor in helping children to develop sense of achievement and self-worth.

The availability of protective factors was influenced by environmental factors, as children who lived in more affluent homes were more likely to have multiple buffers/ protective factors to lessen the impact of PSM. The role of professional relationships was also identified as a significant protective factor, teachers and social workers were identified as professionals who could listen to and encourage children.

With an understanding of risk and protective factors, the following section will seek to explore the responses in practice both internationally and nationally to the needs of children affected by PSM.

7.3- International responses in practice

Research on models of intervention for children affected by PSM remains sparse outside of the USA (Broning et al., 2012). Broning et al. (2012) argues, much of the research surrounding interventions for children affected by PSM has focused primarily on two types of intervention: family focused preventions which focus on increasing positive parenting, in relation to support and warmth, and, peer group programmes, with the aim of building mutual peer support for children (Broning et al., 2012).

In response to the knowledge of the needs of children affected by PSM and the poor response in practice, a German research study aimed to explore the effectiveness of a community-based group programme 'Trampoline' for children aged 8-12 years with at least one substance-abusing parent (Broning et al., 2012). Trampoline runs for nine weeks and each week a different topic is introduced. Parents are also offered two sessions of support. The programme is innovative in that prior to this study there had been no evaluative studies in Germany and thus services for children affected by PSM remained scarce (Broning et al., 2012).

The study followed a randomised control design in analysing data from 27 participating centres, which were predominantly adult substance misuse services. The study tested the effectiveness of Trampoline which was described as an educational programme for children affected by their parent's substance misuse, compared with an intervention focussed on 'fun and play' (Broning et al., 2019:1). The study hypothesised that children aged 8-12 years who received the Trampoline intervention would have an improved ability to cope with stress, however, this hypothesis was not confirmed as 'no changes were observed in self-efficacy, self-perception, physical stress symptoms, and in other health-related quality of life aspects'

(Broning et al., 2019:7). The study concluded that although children who had received the Trampoline intervention had improved ‘addiction related knowledge’ and a reduction in experiences of stress and isolation, the children also benefited from play. The study acknowledged the need for interventions which promote play, to build confidence in a safe and predictable environment and enjoy social interactions with other children and adults (Broning et al., 2019).

International examples of practice models in response to the needs of children affected by parental substance misuse can also be found in Australia. ‘The Mirror Families Programme’ brought a shift from the service sector to the community, bringing together families who can provide support to vulnerable families, to help with everyday life (Tsantefski, 2013). The findings from the review highlighted the significance allied families can have in reducing the risk of vulnerable children and parents from being socially isolated. The benefits for the children were hugely important as the support can become life long, providing a consistent source of support even if a child has to be removed from their parent’s care (Tsantefski, 2013).

Further developments have emerged from studies in Australia in response to PSM and the associated risk of harm and poor long-term outcomes for children (Dalziel, 2015). The ‘Parents Under Pressure’ (PUP) programme, is an intensive intervention for parents who have been prescribed methadone. PUP is underpinned by two key constructs; first, that a child’s wellbeing is dependent on a parent’s capacity to provide a sensitive, nurturing and caregiving environment and secondly that in order for the first to occur, a parent needs to manage their substance abuse and behaviour (Dalziel, 2015).

The analysis of PUP indicates that investment in this intervention is cost-effective and, more importantly, the findings indicate a significant reduction in abuse cases (Dalziel, 2015). This study highlighted the complex nature of PSM and socio-economic factors that contribute to further suffering, neglect and, in some cases, child abuse. Given the complex nature of the

disadvantages these children and their families face, there is compelling evidence that approaches which target single domains such as parenting skills are unlikely to be sufficient (Dalziel, 2015).

The study does not refer to, or identify how children are directly supported. The programme undoubtedly benefits the children indirectly, by parents' positive changes in behaviour and stabilised methadone treatment. As outlined in previous chapters, parental abstinence or reduction in substance misuse does not automatically equate to positive or improved parenting. Therefore, the programme appears to be weighted towards responding to the needs of parents, but does not provide a direct response to the needs of children and how they can be supported to overcome the trauma and possible abuse they have suffered.

7.4- National responses in practice

The Advisory Council on the Misuse of Drugs *Hidden Harm* report, called for dedicated services for children (ACMD, 2003). Prior to *Hidden Harm*, there were few services available to children living with PSM. Further, the focus in practice was centred on adult treatment and less focused on the holistic needs of the substance misuser and their family (Templeton et al., 2011).

Despite an increased understanding of the needs of children affected by PSM, research findings by Templeton et al., (2011:115) have concluded a lack of clarity regarding the provision of support and that responses in practice are a 'postcode lottery'. Whilst Templeton et al's. (2011) research is ten years old, arguably it remains a current concern. The Children's Commissioner's report, published in 2018, highlights the concerns from children affected by PSM, particularly that they were not aware of specialist services available for them. Of the data that has been collated, the provision of support services for children affected by PSM appears to be primarily focussed on the needs of children affected by parental alcohol misuse (Children's Commissioner, 2018). Further evidence of a continued postcode lottery of service provision for children affected by PSM can be found in a

recent government paper published in 2018. The study (focussed on only on parental alcohol misuse) found that, of the 126 local authorities (84% of all English local authorities) which responded, less than half had a specific strategy to support children affected by parental alcohol misuse (POST, 2018).

M-PACT (Moving Parents and Children Together) is an example of innovative practice and one of the growing number of interventions which aims to meet the complex needs of children and families affected by PSM (Templeton, 2014). The programme consists of an eight-week structured group session programme, combining separate work with children, their parents, family and whole family group sessions. The programme covers topics such as making sense of addiction, family communication, feelings/beliefs and safety (Templeton, 2014).

The findings from a mixed method evaluation model (including questionnaires and interviews with practitioners and families) of 13 M-PACT programmes in England, indicate that M-PACT helped to increase openness and honesty, family relationships grew stronger and there was a reduction in conflict (Templeton, 2014). Practitioners, parents and children shared how families had bonded towards the end of the programme and many of the families wished the programme was longer or that they could do it again (Templeton, 2014). Given the complexity and multiple risk factors associated with PSM, it is not surprising that families wished for support to continue.

The voices of the children who have shared their experience of accessing such specialist support provisions highlight the important need for these children to have support in their own right. The evaluation findings indicate positive outcomes for children and their families; however, the research does not indicate how children came to the attention of services or how children whose parents who were not engaging in treatment services were supported.

The cumulative effects of PSM on family relationships, attachments, and the enduring psychological and physiological distress and violence which

children experience require longer-term intervention (O'Conner et al., 2014). Whilst the developing provision of services for children affected by PSM is welcomed, the evaluative studies bring to light that established services appear to be led by substance misuse treatment services. Further, research findings have also shown that although family-focused services have improved outcomes for substance misusers as well as for children, and have cost-effective benefits (POST, 2018), family focus may lead to less powerful individuals (children) within the family becoming invisible (Forrester and Harwin, 2011).

A further example of a model of practice in response to the needs of children living with PSM can be found in Northern Ireland with the development and introduction of the 'Steps to Cope' model (Templeton and Sipler, 2014). The 'Steps to Cope' model derives from the 5-step method which was developed in response to the needs of adult family members affected by a loved one's substance misuse, and the stress and strain experienced by family members (Copello et al., 2010). As with the 5-step method, 'Steps to Cope' focuses on five key building blocks, namely; stress, strain, information, coping and support (Templeton and Sipler, 2014).

The feasibility of adopting an adult model of intervention to meet the needs of children are summarised by Templeton and Sipler (2014). The findings indicate that practitioners felt the intervention was valuable, gave structure and focus to their work, and that it was possible to adopt an adult model for children. However, the study also highlighted significant limitations, in that practitioners felt there needed to be more flexibility, particularly when children were facing challenging and chaotic times. During these times of crisis, practitioners felt it was difficult to engage with a child and work through the steps in sequence (Templeton and Sipler, 2014).

The 'Steps to Cope' model, appears to provide practitioners with a framework in which to deliver needed support to vulnerable children. However, there is a limitation to this study in that the intervention is short-term, ranging from approximately eight weeks to six months. In response to

comments made by practitioners about the length of time it takes to build trust with a child (Templeton and Sipler, 2014), it would seem that although time-scaled interventions may meet the needs of adult family members, they do not necessarily meet the emotional and practical support needs of children. Taking into consideration the impact PSM can have on children, including knowledge of cumulative risk, ACE's, and the concept of resilience, short-term and time-scaled models of practice do not appear to effectively respond to the needs of children affected by PSM. The response to children needs to be meaningful, as Kroll (2004:10) outlines:

> Children need to be seen, heard and engaged with on a real level if they are to feel confident about being helped. Communication between professionals needs to be made open and the child's perspective needs to be brought firmly into the entire assessment process so that workers can gain a sense of what children's lives are really like.

Even if children and young people do have the confidence to confide in a trusted adult, especially outside of their family home, they may be doing so with much trepidation. It is important, therefore, to listen, to allow children time to talk at their pace, and for children to be involved in any subsequent decisions. It is then likely that the child will continue to trust and seek comfort from their chosen trusted adult (Gorin, 2004).

The limitations of existing models of practice presented within this section have included interventions being time limited and aligned to adults' services or based on parent engagement. A further exclusion and missed opportunity to respond to the needs of children living with PSM, appears to be a focus on models of practice which are implemented at a statutory level and therefore not accessible for children who do not come to the attention of statutory services.

The findings from an evaluation of the Option 2 model is evidence of a practice model which is designed as an intervention for families at 'crisis

point' and where there is a risk of children 'entering care' (Forrester et al., 2008:412). The study by Forrester et al. (2008:415) found that the Option 2 intervention did not reduce the 'likelihood of children entering care' but did delay this outcome. The study also found that children whose families had received the Option 2 intervention were more likely to return home and therefore spend less time in local authority care (Forrester et al., 2008).

The children who participated in this evaluation study of Option 2, shared their thoughts about how family relationships had improved and how they liked being able to talk to their Option 2 worker (Forrester et al. 2008). Similarly, parents spoke of their experience and the positive impact Option 2 had on their substance misuse and family conflict. Both children and their parents described how positive change was not always sustained and when Option 2 ended, the positive change 'ceased' (Forrester et al., 2008). A significant limitation of this model was the risk that decisions to safeguard and protect a child could be delayed and such delays could mean the possibility of children suffering prolonged abuse.

The focus on interventions for children living with PSM at a statutory level, at the expense of early interventions, can be seen with the development of the Family Drug and Alcohol Court (FDAC) in the United Kingdom. The aim of the courts is to reduce the risk of children suffering abuse, through collaborative efforts of treatment professionals and children's social care (Gifford, 2014). Where possible, FDAC aims to give families a chance to overcome their difficulties through joint working with social care, health, adult's treatment, rehabilitation, housing and probation teams (Bambrough et al., 2014). Where families are not able to overcome problems, FDAC will seek, as soon as possible, to place a child in a permanence placement, whilst also ensuring the care of parents to attempt to avoid repeated patterns of pregnancies and children being removed from their care (Bambrough et al., 2014).

Findings from an initial study following the outcomes of the first 41 families to go through the court process found significantly better outcomes in

comparison with families in the usual court proceedings (Harwin et al., 2013). Examples of such outcomes included higher rates of parent-child reunification, parents receiving substance misuse services quicker, parents remaining in treatment, and an overall reduction in PSM. FDAC not only appeared to be a more inclusive and supportive process for parents but was also regarded by the professionals involved to be a more focussed process and less antagonistic for families (Bambrough et al., 2014).

A longitudinal study involving interviews with 42 parents and 154 court observations of 89 cases explored the long-term outcomes for families, five years after their involvement with FDAC. The study illustrated key findings which have implications for policy and practice. Parents involved in FDAC were predominantly mothers and substance misuse was rarely a stand-alone concern; co-existing mental health issues and domestic abuse were common.

A striking, and concerning, finding from this longitudinal study was the number of mothers who had been known to children's social care for more than ten years (Harwin et al., 2018). This finding raises significant questions regarding what could have been done to reduce the number of PSM cases coming to the attention of the courts, and the issue of how long a child has had to endure PSM and associated risk factors.

The findings from the longitudinal study raised further safeguarding concerns, as a quarter of all mothers over the five-year follow-up period suffered domestic abuse and had continued to misuse substances. Further, the study found that a third of all the children who were reunited with their mothers at the end of the court proceeding, either developed or continued to display worrisome behaviour. These behaviours included anxiety, self-harm, violence, offending behaviour and bed wetting. As Harwin et al., (2018) concludes;

> It thereby raises the difficult question of whether family drug courts only postpone decisions about best ways to achieve the long-term interests of children (Harwin et al., 2018:163).

The evidence base to inform interventions and models of practice to support children affected by PSM is poor. There is an identified need particularly in the United Kingdom to address this (Woolfall and Sumnal 2009), given the research evidence that children affected by PSM are disproportionately victims of neglect and abuse (Gifford, 2014).

In reference to models of practice which are short term interventions; if a child required support longer term this would require the practice model to exist within a wider infrastructure, to enable children to be signposted to other relevant services. Given the absence of any statutory obligation for local authorities in the United Kingdom to respond to the needs of children affected by PSM, service provision is likely to remain minimal and fragmented. Finally, a model needs to be developed that is designed around the child, from the child outwards and not an adult model which is adapted downwards to apply to a child.

7.5- Chapter 7 summary

This chapter has presented findings relating to protective factors for children living with PSM. The findings have highlighted how the availability of protective factors are influenced by additional factors such as experiencing poverty. The research findings have also illustrated the need for children to have protective factors outside of their family, including access to positive activities and having a relationship with at least one trusted adult.

Findings from international and national research have illustrated there is a clear endeavour in practice to respond to the needs of children living with PSM. However, there are limitations to existing models of practice, including support being time limited and often children's access to support is reliant on their parent's engagement with substance treatment services.

7.6- Literature review summary

The literature review has identified many gaps in research regarding legislation, practice guidance, education, training and responses in practice to the needs of children affected by PSM. Of significant concern are the findings from serious case reviews and, in spite of this knowledge, PSM continues to be largely absent from social work education and training.

The literature has evidenced the complexity, severity and the impact of the longevity of expose to PSM on the lives of children. Yet, the response to the needs of children living with PSM in legislation, education and practice remains at best fragmented.

Although the experiences of children affected by PSM are documented in research, the voice of younger children is noticeably absent. The majority of research studies have focussed on exploring the views of teenage children or retrospective accounts from young adults.

Literature relating to childhood adversity have been presented and have provided further evidence of the negative impact of PSM. This literature review has also presented research findings relating to protective factors and what children need to limit the impact and burden of living with PSM. There is a further gap in knowledge, as current contextual and environmental factors relating to risk and protective factors associated with PSM are absent due to a lack of current research.

Although fragmented due to a postcode lottery of provision, there are clear examples of a commitment in practice to respond to the needs of children affected by PSM. The literature review has critically explored existing models of practice and although there are examples of a clear endeavour to support children and their families, interventions do not appear to reflect the wider knowledge surrounding childhood adversity, protective factors and building resilience. This literature review has highlighted the multiple limitations of models of practice for children living with PSM:

- Services are time limited
- Services accessible to children are dependent on parental engagement
- Services dependant on parents accessing substance misuse treatment
- Services only accessible to children if safeguarding concerns require statutory social care intervention.

In response to the gaps in research relating to legislation, social work education, responses in practice and most importantly the voice of younger children, the following research questions have been identified:

- How do school aged children (aged 5-16) experience living with a parent who misuses substances?
- What do children need in order to promote and strengthen their emotional resilience and enable them, when appropriate, to live safely with parents who misuse substances?
- From the perspective of professionals what changes are considered to be necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

Part three of this thesis will outline the methodology and research design for this project, detailing how I will be addressing the identified research questions.

Part 3 - Methodology and methods

Chapter 8 - The research aims and objectives

The literature review explored the nature of research relating to children's experiences of PSM and drew attention to the needs of children living with PSM. Literature on the topic of children and PSM gained momentum following the publication of *Hidden Harm* (ACMD, 2003), yet this momentum has appeared to dwindle. The search strategy for this research project also highlighted the limited empirical research in recent years. Since 2015, one small-scale study was identified that explored the experiences of children living with PSM (The Children's Commissioner for England, 2018). This lack of children's voices in literature has resulted in a gap in knowledge regarding the experiences of children living with PSM.

The literature review identified further gaps in knowledge relating to the experiences of children living with PSM, particularly in cases of younger school-aged children. The review illustrated that research often focused on one aspect of PSM such as domestic abuse or parental mental ill-health. The literature review also highlighted the fragmented responses in policy and practice, inadequate training for frontline professionals, and few services available to meet the complex needs of children living with PSM.

In response to the findings from the literature review, this study seeks to understand the needs of children living with PSM, and the needs of frontline professionals supporting families where PSM is a safeguarding concern. At the core of this project is the intention to bridge the gap between research and practice, to enable families to stay together where appropriate and enable professionals to make informed and timely decisions when this is not possible.

Specifically, the objectives of this research are to:

1. enable children and young people to talk about their experiences of PSM in a safe and supported way

2. investigate the experiences of professionals across children's workforce in responding to PSM and how they can be better supported

3. build a model of practice grounded in the experiences of children and professionals.

This study will, therefore, seek to answer the following research questions:

1) How do school-aged children (5-16 years) experience living with a parent who misuses substances?

2) What do children need in order to promote and strengthen their emotional resilience and enable them, when appropriate, to live safely with parents who misuse substances?

3) From the perspective of professionals, what changes are considered necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

8.1- Theoretical framework

This research is designed to understand the needs of children living with PSM and the complexity of risk and protective factors within children's immediate and wider environment. This study is framed by Bronfenbrenner's (1977) ecological systems theory, which will guide this research to explore multiple factors associated with PSM, and the interaction of behaviour and environmental factors. As Bronfenbrenner (1977:514) outlines:

> …the understanding of human development demands going beyond the direct observation of behaviour on the part of one or two persons in the same place; it requires examination of multi-person systems of interaction not limited to a single setting and must take into account

aspects of the environment beyond the immediate situation containing the subject.

Adopting this theoretical framework allows for the consideration of factors beyond a child's immediate environment and guides the research to understand the complexity of the lives of children living with PSM. The framework supports the consideration of factors across multiple systems, how those systems interact, and how they may compound both risk and protective factors (Bronfenbrenner, 1979).

It is this theory which will aid further understanding of the presenting and potential lifelong impact of PSM on children, and, of the factors within which these systems can mitigate the impact and lessen the burden of PSM. Figure one below illustrates an overview of the ecological systems theory (Bronfenbrenner, 1977):

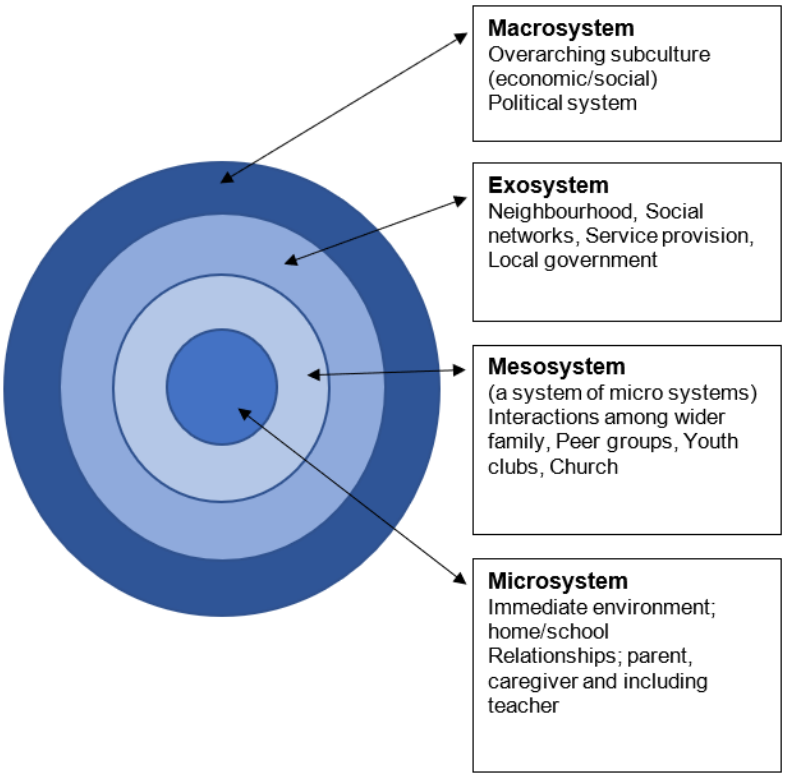


Figure 1 Bronfenbrenner's ecological systems theory

The inclusion of both children and frontline professionals in the design of this research study (outlined further in chapter 10 and 11) is supported by the ecological systems theory. Bronfenbrenner (1979) stresses the importance of the inclusion of multiple perspectives which allow for a greater understanding of the complexity of the phenomena being researched.

The forthcoming methodology and methods chapters will present the chosen research paradigm to support a response to this study's research questions. The choice of IPA, both as a methodology and a method in relation to data collection with children will be explored in chapter 9.4-9.5. It will provide a clear rationale for the research design, with specific focus on the justification for the child's voice being at the centre of this study. The phenomenological approach will also be explored in relation to the inclusion of front-line professionals who support children living with PSM (chapter 11).

In-depth exploration of the chosen approach and steps taken in the analysis is presented (chapters 10.4 and 11.4) before concluding with the ethical considerations regarding both the safety and wellbeing of all participants. This is a sensitive area of research with a vulnerable participant group, as children participating in this research project will be living with parents who misuse substances. Concerns regarding consent, assent, confidentiality, and responding to safeguarding concerns will be discussed in chapter 12. The issue of insider knowledge will also be discussed, due to the research taking place in the local authority borough in which I am employed as a social worker.

Chapter 9

Epistemological and methodological understanding

9.1 - Ontological and epistemological perspective

This research study adopts a subjective (also referred to as 'relativist') ontological position in which it is deemed that there is no one 'objective truth' (Guba and Lincoln, 1989). A subjective position is taken because this study seeks to focus on the varied experiences of children living with PSM, and on the varied experiences of professionals in contact with children living with PSM. The subjective position is not concerned with 'discovering meaning' but for meaning to be constructed (Crotty, 1998) from the perspective of each participant and their own unique experience.

In congruence with a subjective ontological position, this research adopts the epistemological position of social constructivism. Social constructivism and interpretivism can be difficult to differentiate and are often 'combined' (Creswell, 2003:8). Though subtle, the difference is noteworthy; interpretivism focusses on meaning being 'linguistically constituted', while social constructivism focusses meaning on the social construct and 'impersonal discourses' (Gorski, 2013:661). The epistemological consideration for constructivism is therefore focused on 'meaning-making', and the way people make sense of the world, however unique their experience (Crotty, 1998:58). The essence of this epistemological position is that a constructivist researcher 'addresses the process of interaction' between individuals and their environment, and seeks to understand the 'world in which they live and work', as well as 'cultural norms' (Creswell, 2003:8). To embrace the complexity of meaning, and in seeking to understand a person's world, the social constructivist researcher is reliant on the participants' views and will listen sensitively (Creswell, 2003).

9.2- Phenomenological theoretical framework

This study presents research questions which are focused on understanding the lived experience and seeks to answer questions about what needs to change for children living with PSM. Although framed by the ecological systems theory (Bronfenbrenner, 1977) this qualitative research lends itself to a phenomenological approach.

Phenomenology is a philosophy initiated by German mathematician Edmund Husserl. A significant aim of phenomenology was to ground the foundations of knowledge so that 'scepticism of rationality and procedures' could be overcome, therefore building a secure base for knowledge (Smith, 2008:26). As Husserl, (1931:43) explains:

> Phenomenology requires us to place our usual understandings in abeyance and have a fresh look at things.

Heidegger, a student of Husserl, moved away from the transcendental (descriptive) form of phenomenology towards existential (interpretive) and hermeneutic phenomenological philosophy (Smith et al., 2012). Heidegger believed Husserl's form of phenomenology was 'too abstract' and that his form of phenomenology was in fact more 'phenomenological'. Heidegger questioned whether any knowledge of a person's experience could be known, without an 'interpretivist stance' and understanding of 'the world of things, people, relationships and language' (Smith et al., 2012:16).

However different the philosophical arguments between writers, the commonality rests upon common ground that phenomenology is the study of the lived experience of persons and the explanation of these experiences (Creswell, 2013). Phenomenology aims to reach an 'ordinary meaning of the phenomenon'; the phenomenological term 'lived experience' does not necessarily lead to a deeper and rich meaning, until phenomenological questions such as 'What is this experience like?' are asked (Van Manen, 2017:811).

In this study, the ‘phenomenon’ comprises both children living with PSM and professionals who support children and families affected by PSM. A phenomenological approach aims to clarify an understanding of situations and how those situations are lived, through people who experience such situations in everyday life (Smith, 2008). As opposed to reducing the phenomena to a statistic, phenomenology aims to remain true to the phenomenon and a person’s ‘first-hand’ experience. The detail of this experience is significant in capturing as closely as possible the lived experience (Smith, 2008:28).

The phenomenological endeavour is to question ‘what is taken for granted’, to critique and awaken a new meaning and understanding (Crotty, 1998:80). Further, it is to ‘lift up’ and bring to the forefront a raw moment in a lived experience to understand the ‘living meaning’ that arises from the experience (Van Manen, 2017:812). This aligns with ecological systems theory as Bronfenbrenner (1977) argues that to fully understand the phenomena, the researcher needs to account for the complex interactions between an individual and their environment. As Crotty (1998:79) suggests:

> We are beings-in-the-world. Because of this, we cannot be described apart from our world, just as our world-always a human world-cannot be described apart from us.

Husserlian transcendental phenomenology asserts that the researcher must bracket one’s particular beliefs in order to clearly understand the phenomena (Laverty, 2003). Moustakas (1994) focuses on Husserl’s concept of bracketing, and is guided by the principle that the researcher must ‘set aside’ their own experience in order to ‘take a fresh perspective’ (Creswell, 2013:80). Giorgi’s (2010) interpretation of bracketing is that it is not a matter of forgetting, but rather, not allowing past knowledge to be engaged whilst determining experiences in research (Creswell, 2013). In contrast, Van Manan’s (1990) view of hermeneutic phenomenology is concerned with a description of a person’s lived experience, and the interpretation of ‘the meaning of the lived experience’ (Creswell, 2013:90). The decision to

conduct this research, to understand the needs of children living with PSM and the needs of professionals in their endeavour to support children is grounded in my practice experience. It is not possible to bracket or desirable to forget my knowledge; this research project is, therefore, guided by the principles of hermeneutic phenomenology.

9.3- Hermeneutic Phenomenology

The clear distinction between phenomenology and hermeneutic phenomenology is that phenomenology is, in its purest form, descriptive and 'pre-reflective' (Van Manen, 2016:9). Hermeneutic phenomenology differs, however, as it encompasses both description, but also highlights the importance of 'our reflective grasp' and, interpretation of 'the meaning of the lived experience' (Van Manen, 2016:77). Hermeneutic phenomenology is therefore an attempt to construct interpretive meaning of the life world, whilst remaining mindful that the life world is more complex than the meaning that is revealed (Van Manen, 2016).

The constructivist researcher as outlined in chapter 9.1, seeks to construct meaning and is influenced by 'experience and perceptions' as well as the 'social environment, and the interaction between the individual and the researcher' (Ponterotto, 2005:130). The constructivist researcher understands there are 'multiple meanings' as well as 'multiple interpretations' or realities, and therefore this position aligns with the principles of hermeneutic phenomenology:

> The constructivist position espouses a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection. (Ponterotto, 2005:129)

Heidegger saw bracketing as impossible, arguing that it is the interpretive process, the researcher's bond with the subject, that allows for a deeper understanding and engagement (Laverty, 2003). From Heidegger's perspective, a researcher's 'intersubjectivity', 'relatedness' and ability to 'communicate with, and make sense of, each other' is central to the

phenomenological endeavour (Smith et al., 2012:17). As Reiners (2012:3) illustrates:

> As we understand something we are involved and as we are involved, we understand.

Van Manen (2016) identifies that the problem with a phenomenological inquiry is that knowing too much about a phenomenon under investigation can pre-dispose the researcher to interpret the nature of the phenomenon before even considering the significance of the research question. Therefore, a researcher needs to be explicit about their understanding, beliefs and biases, as simply trying to forget (or to bracket) would arguably see such understandings filter back into their reflections (Van Manen, 2016).

This research study is founded on my practice experience, experiential knowledge and my compassion for, and interest in, supporting children living with PSM. It is important to note here my positionality, as the researcher. Since 2008, I have been employed as a social worker for a specialist service supporting children and their families, affected by PSM.

I recognise the influence of my professional background and how this may shape my interpretation. I adhere to ontological and epistemological positions described above, in that my view of reality is that there is no single truth, and in aiming to achieve an improved response to the needs of children living with PSM, meaning needs to be constructed not discovered.

It would be difficult to remove myself from the study, or to set aside my experience and pre-understanding as it is my practice experience which is my bond to this topic. Further, it is my practice experience and understanding of working therapeutically with children that will contribute to the research design.

To harness my practice experience and knowledge, and allow for reflexivity to respond to the needs of participants (especially children), hermeneutic phenomenology is the preferred philosophical approach for this research

study. Aligned with the epistemic theory of hermeneutic phenomenology is Interpretive phenomenological analysis (IPA). IPA is both a theory and a method and will guide one part of this research study; to understand the lived experience of children living with PSM.

9.4 - Interpretive phenomenological analysis

Interpretive phenomenological analysis (IPA) 'synthesises ideas from phenomenology and hermeneutics' as it is concerned with both description and the interpretation of meaning. The fundamental philosophy of IPA is that there is 'no such thing as an uninterpreted phenomenon' (Pietkiewicz and Smith, 2012:3). The term 'idiography' is also synonymous with IPA, the fundamental principle of the idiographic approach is the in-depth analysis of every case. The focus of the researcher is therefore on the 'particular rather than the universal' (Pietkiewicz and Smith, 2012:3).

IPA is a tradition which interprets the 'lived experience' and the stories of research participants. According to Alase (2017:12), for those stories to be interpreted the researcher 'must have a true and deeper understanding' of the participants' lived experience. Whilst the essence of IPA is in the centrality of the participant's own perspective and lived experience, the researcher's interpretation is what distinguishes it from descriptive phenomenology. Therefore, IPA seeks to illuminate a phenomenon and, in doing so, the researcher employs an 'empathic and hermeneutic process' (Wagstaff et al., 2014). As Wagstaff et al., (2014:2) explain:

> IPA draws on interpretation to make manifest what is normally hidden and to look for meanings embedded in human experience.

In congruence with my epistemological constructivist paradigm, and practice experience of working therapeutically with children living with PSM, IPA was the chosen approach. IPA has allowed me to harness this knowledge and facilitate reflective and interpretive analysis. A coherent paradigm allowed a 'truly conceptualized IPA research study' (Alase, 2017:12), allowed for a deeper understanding, and interpretive narration of how the phenomenon

has impacted on the lived experiences of the children participating in this study (Alase, 2017).

The emphasis of IPA is on sense-making; however, children may struggle to express what they are thinking and feeling, and there may be reasons for non-disclosure (Smith, 2008). IPA recognises this complexity and the importance of the researcher's role in interpreting people's emotional state from what they do and do not say (Smith, 2008).

My professional experience of supporting children affected by PSM has provided me with the knowledge and practice skills to build rapport, increase protective factors and respond sensitively to disclosures. Research interviews required me to set aside some of my professional practice skills, including 'interactional habits' or 'steering participants towards new and more positive appraisals of their problems' (Smith et al., 2012: 67).

In place of the usual responses and perhaps a desire to support a child to problem-solve and make sense of their world, my role was to listen intently and ask questions which were sensitively timed. Ordinarily, in practice, silences may be a cue to a practitioner to reflect, problem-solve and gain further understanding. However, in interviews, 'silences have to be waited out a little longer', as participants may pick up the topic again (Smith et al., 2012:67). Further, as a researcher, it is better to use the silence to ask a new question, as opposed to a practitioner response which may be to provide perspective on the matter (Smith, 2012:67). The study was dependent on a child's willingness to talk, but also on the careful planning to create a context in which children felt empowered and enabled to tell their story.

9.5- Research through the lens of children's rights

This research study is framed by the ecological systems theory and is guided by a hermeneutic phenomenological approach but is also designed through the lens of children's rights and a child's right to participate in matters which affect them. This research is embedded within a firm belief and epistemological stance that advances in research can be gained through the

perspective of children, that children have agency and can inform research, and as such are regarded as competent social actors (Christensen and James, 2008).

Traditionally, a child's perspective was seldom sought and their voice was represented in research, through the perspective of adults acting for them (Christensen and James, 2008). This approach neglects an understanding of children as 'social persons' in their own right. While perhaps underpinned by a genuine wish to protect children, it nonetheless views children as 'incompetent or vulnerable' and leaves the researcher with a doubt as to whether a child can 'give and receive factual information' (Christensen and Prout, 2002:478).

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC 1989) states that where children are capable, they have a right to express their views freely:

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child (UNCRC 1989:4).

Significant advances in research have followed since the UNCRC in 1989. These advances have seen greater inclusion of the voices of children in research and are a welcome development in the way they are 'treated and understood' (Aldridge, 2017). Bronfenbrenner argued the importance of understanding the role social and consequential factors play in a child's life, and the value of including children in research to understand their experience (Greene and Hogan, 2005). The developments in research regarding children involvement has seen a shift from the perspective of children as objects, but rather children as subjects, and more recently children as social actors (Christensen and Prout, 2002). Children are no longer solely perceived to belong within a group such as a family, a school, or social institution, but as dependent 'social actors' who have their own experiences

and understandings (Christensen and Prout, 2002:482). Recognising children as subjects, rather than objects of research, requires an acceptance that children can voice their opinions and perspectives in their own right and report ‘valid’ experiences, as Alderson (2000:243) explains:

> To involve all children more directly in research can therefore rescue them from silence and exclusion, and from being represented, by default, as passive objects, while respect for their informed and voluntary consent helps to protect them from covert, invasive, exploitive or abusive research.

Children’s lived experience, and their perspectives on what they need to thrive, will remain central to this research study, based on the philosophy that children can bring perspectives which need to be taken into account (O'Reilly et al., 2013). By including children within this research study, there was a temptation to design the research around the inclusion of older children, or young adults, who could potentially have provided a detailed retrospective account of their lived experience. Making such an assumption and not allowing younger children to participate is discriminatory and does not account for their abilities and capabilities (O’Reilly et al., 2013).

A reliance on retrospective accounts and the exclusion of young children in research could limit our knowledge base, and so, as researchers, it is important to include younger children (O’Reilly et al., 2013). The researcher who values children’s perspectives and wishes to understand their lived experience has a responsibility to use appropriate methods to support inclusion and enable children to ‘feel they have control’ (Christensen and James., 2000:5).

The following chapters will present the chosen research methods for child and adult participants in separate parts. Firstly, the research design for the inclusion of child participants, and the analytical process will be presented. Secondly, the research design which includes professional participants from across a children’s workforce and analytical process will be presented. The

methods section will conclude with a discussion of the ethical considerations for this research project.

Chapter 10

Methods part 1 – Research design with children

This research aimed to explore the lived experiences of children impacted by PSM and seeks to gather the views of professionals who support children and families impacted by PSM. As chapter nine illustrated, this is a qualitative study that will use the principles of hermeneutic phenomenology, framed by the ecological systems theory, to influence the research design.

Part one will begin by discussing the need for child-sensitive research methods. This section will present the use of an adapted version of 'draw and write' as the most suitable data collection method for this group of children. Details of the recruitment and interview process with the children is presented, before concluding with the analytical steps of IPA.

10.1- Creative methods with children

To successfully undertake research with children, we cannot treat them like adults, or use the same research methods. For children's voices to be heard we need to understand their individual abilities, and design a research process that empowers them to communicate (Punch, 2002). It cannot be assumed that the age of a child will determine their level of understanding; therefore, the methods adopted need to suit the unique and individual preferences of the participating child (Greene and Hogan, 2005).

Child-friendly techniques should not be assumed to be more appropriate; therefore, the notion of reflexivity should be central to research with children, not only for a researcher to reflect on their role and assumptions about a child's level of understanding, but to be reflective and reflexive in the choice of methods (Punch, 2002). The voices of children are central to this research; to ensure their participation was valued and meaningful, it required an innovative and creative design (Sewell, 2011).

This research study adopted and adapted the ‘draw and write’ technique to empower children who may have limited vocabulary, and/or who have shorter attention spans (Punch, 2002). The crux of the ‘draw and write’ technique is to invite participants to both draw and write about a relevant issue. For younger children, those lacking in confidence to draw, or those who do not want to draw, the option of children simply talking can be used (McWhirter, 2014).

In this research study, children were not asked to write but were invited to draw a picture and talk about it. The use of drawings can give children more time to think about what they wish to portray. The drawing can be adapted, allowing a child more control to express themselves at their pace, unlike an interview situation where responses are more immediate (Punch, 2002). The strength and skill of this technique lies in the careful selection of open questions which allow children to express their thoughts and feelings (McWhirter, 2014).

Through my experience of supporting children affected by PSM, I have gained invaluable insight into a child’s ability to communicate about the most sensitive information. I had considered photovoice as an alternative method, whereby children take photographs to document and reflect on issues important to them (Woodgate et al., 2017). Upon exploration, I chose not to adopt this method as I felt it had the potential to be too intrusive, and would take away a child’s autonomy during the interview. It also had the potential to evoke anxiety and/or embarrassment, as a child may have taken a photograph that they no longer wanted to talk about (Evans-Agnew and Rosemberg, 2016). In contrast to the method of photovoice, this project’s method of ‘draw and talk’, conducted within the constructivist paradigm, is about ‘shared meaning-making’ and empowering children to express themselves through their drawing and storytelling, under their control and in their time (Russo et al., 2006:236).

The tools chosen to support the application of the ‘draw and talk’ technique are ones which have informed my social work practice. The first tool, which I

have found to be especially powerful with younger children, is use of the question ‘If alcohol/drugs could turn into an animal, what would it look like?’. This tool enables children to use their imagination, to tell their story through a character, in this case an animal. Through my practice experience I have observed the benefit of this tool, as telling their story through an imaginary character can lessen the burden children feel of being disloyal to their parents. As Russo et al. (2006:231) explains:

> The imaginary world of young [children] often makes it easy for them to engage in storytelling and to make unconscious connections between their stories and their lives.

The second tool, which I believe would be more suited to older secondary school-aged children, is ‘The Tree’ exercise, which invites children to explore the things that worry them and the people and things that help to keep them safe. The branches represent the worry ‘what shakes your branches’, the trunk represents ‘the strong parts of you’, and the roots represent the ‘people and things that keep you safe and secure’ (Tait and Wasu, 2012). I did not presume that primary-school aged children would want to use the first tool, or that secondary-school aged children would want to use the second exercise; rather, all children had the option to use either, both, or none at all.

The use of arts-based methods within this project is a conscious decision that stems from my practice experience of working therapeutically with school-aged children. As Barone et al., (2012:3) state:

> The arts make such empathic participation possible because they create forms that are evocative and compelling.

While the strengths of the ‘draw and write’ technique lie in its potential to elicit deeper meaning, understanding and perspectives ‘not immediately visible to the researcher’, this approach does have its limitations (Sewell, 2011). If a child has limited verbal skills or language which adults may not understand, the data may lack the depth of interpretation the research is seeking (Punch, 2002).

The use of this method brings ethical challenges in preserving anonymity and confidentiality, as the drawings and contextual information could lead to identification of the participant. Despite these challenges, advocates for this method argue that drawing can provide access to different meanings and interpretations that are not possible through other methods (Sewell, 2011).

10.2- Sample size and recruitment of child participants

The creative interviews with children were guided by the principles of interpretive phenomenological analysis (IPA). The fundamental ethos of IPA is ‘quality, not quantity’; as such, participant numbers within an IPA study tend to be small (Smith et al., 2012:51). IPA is concerned with powerful and detailed accounts from participants; therefore, having too many participants is more problematic than having ‘too small’ a sample (Smith et al., 2012:51). The guidance by Smith et al. (2012) does not prescribe a recommended sample size but suggests the IPA sample is dependent on the time constraints of the study and richness of the data from the individual cases, as a successful IPA study requires time and reflection. Although there is no prescriptive guide for the number of participants in an IPA study, the ‘clinical doctoral programmes in Britain recommend having six to eight participants’ for an IPA study (Pietkiewicz and Smith, 2012:4)

Recruitment to this research was purposive; children who lived with parents who misused substances were invited to participate to offer their perspective of their experience. This is consistent with IPA’s paradigm, as participants are selected on the basis of the ‘phenomenon under study’ and for ‘whom the research question will be meaningful (Smith et al., 2012:49).

Following Smith et al.’s (2012) guide to sampling, and because IPA advocates for small sample sizes to engage with the narrative and richness of data, I planned to interview up to eight children aged between 5-16 years. The decision to invite school-aged children to participate was made because the voices of younger children (primary-school age) is largely absent in PSM research. The decision was also influenced by the infrastructure of support,

ensuring that children have access to support during and following their participation in the research. Just as the emotional wellbeing of the children participating in this research is paramount within social work practice, so is their access to ongoing support post-participation in research.

I received ethical approval from Manchester Metropolitan University in January 2019 (see Appendix 1). In March 2019, I began the data collection phase of this research project, upon receipt of approval to conduct this research from a local authority in the North West of England. Recruitment of child participants began in April 2019 and, between May and August 2019, four children were identified by their keyworkers as possible participants. Unfortunately, because of increased safeguarding concerns due to their parent's substance misuse, those four children were unable to participate. Specialist keyworkers informed me of the reasons why it was no longer appropriate for the children to participate:

- One child's mental health had worryingly deteriorated, and they had planned to take their own life.
- Two children were placed out of area with extended family members by social care due to increased safeguarding concerns and risk of significant harm to the children.
- The fourth child did not take part as both keyworker and researcher assessed it was no longer ethical for them to participate. The child concerned had been emotionally overwhelmed in their one-to-one key working sessions and it was deemed that the interview process could potentially have too great an emotional impact on them.

Between August and December 2019, seven children participated in creative interviews; this number was governed by time constraints and the parameters of this research project, as this project includes both interviews with children and focus groups with professionals.

10.3- Creative interviews with child participants

Prior to each interview a detailed research design was followed step by step:

Step 1 - Child identified by their keyworker. The keyworker and I discussed the appropriateness of the child's involvement. Topics discussed included child's current emotional wellbeing, home circumstance and whether involvement in the research would escalate any potential risk of harm to the child.

Step 2 - Keyworker contacted parents, provided a brief overview of the research project and sought permission for me to contact them via telephone. Parent informed that their child's involvement and their decision whether or not to consent was confidential and would not be shared with children's social care.

Step 3 - I contacted parents to provide details and the purpose of the research and to answer any questions from parents. If parents agreed to their child participating, the next steps were followed.

Step 4 - Home visit by keyworker and I to meet with parents and their child. During this home visit, the participation information sheets for parents were given (Appendix 3) along with the parental consent and child assent forms (Appendix 4 and 5). Details of when the interviews would take place were arranged and children provided a list of the drinks and snacks, they would like during the interview.

Step 5 - The week of the interview, the child's keyworker spoke with the child during their scheduled one-to-one session, to check whether they still wanted to take part. If the child still wished to do so, a courtesy call was made by the keyworker to parents to check they still consented and to confirm the date and time of the interview. Each child was collected from their home and brought to the specialist service by their keyworker for the research interview. The creative interviews took place at the specialist service provision in a family

room. Prior to each interview, the room was set up to provide a child-friendly space (Figure 2 below), with bean-bags on the floor for comfort, art materials, and the drinks and snacks the children had chosen during the initial home visit.

Figure 2. Family room for creative interviews

The family room as seen in figure two, is used by the specialist service provision and is specifically designed for therapeutic sessions with children and their families. For some children who participated, the room was a familiar space they had visited before. The room was private, it is not overlooked (due to being on the first floor), and to enter the room a key fob has to be used by practitioners who work in the building. This room was the preferred option, as opposed to a private room in the child's school, where it was possible other children may have mistakenly entered the room.

As the primary aim of an IPA study is to 'elicit rich, detailed and first-person accounts of experiences and phenomena under investigation', semi-structured interviews are a method of data collection to facilitate this (Pietkiewicz and Smith, 2012:5). This research project adopted a semi-structured interview schedule (Appendix 7 and 8) which was designed around the creative tools ('draw and talk'), to allow 'space and flexibility' (Pietkiewicz and Smith, 2012:5). Two interview schedules were designed to

account for the difference in ages of the children; the youngest participant was aged seven and the oldest was aged 16 years.

The creative interview began with revisiting the child assent forms, and reassuring each child that it was okay if they wanted to stop the interview, or if they needed me to phone their keyworker to come into the room. At the start of each interview, children were encouraged to choose to sit where they felt most comfortable; at the table, on the comfy chairs, or on the bean-bags. Once they were comfortable and had their drink and snacks, I turned on the tape recorder and asked each child to tell me about where and who they lived with. This was a 'warm up' exercise which is recognised within IPA as a way of building rapport with participants and supporting participants to become comfortable talking to the researcher (Pietkiewicz and Smith, 2012:5; Smith et al., 2012).

The structure of the interview schedule was designed to be 'open and expansive' (Smith et al., 2012:59). I was mindful when designing the interview schedule that some children may not want to use the creative methods and would simply prefer to talk. A further consideration was that children may not want to talk about PSM in the present for fear of the consequences (social care being informed), or because of their loyalty to their parents. Questions were designed to support children to talk about a memory, as it was anticipated this would be less challenging for children.

After each interview the child and their keyworker spent time together during the drive home. This was planned to ensure each child had time to debrief, if they wished to, with their keyworker, or for their keyworker to offer comfort if they had become upset during and after the interview. One child found the interview incredibly difficult; I stopped the interview schedule and we drew unrelated pictures together. The child didn't wish for me to call their keyworker or for the interview to end; they just needed a break.

On the day of each interview, the transcribing phase began; each interview was transcribed verbatim. The names of child participants were anonymised,

and pseudonyms were used throughout the transcript. Each transcript was saved onto a password-protected computer and secure server. The anonymised transcript was uploaded to computer-based software NVivo 11 in preparation for analysis.

10.4- Data analysis of creative interviews

A significant influence of interpretive phenomenological analysis (IPA) is the notion of idiography: this is concerned with ‘the sense of detail’ and a commitment to an understanding from the perspective of ‘particular people’ (Smith et al., 2012:29). As (Pietkiewicz and Smith, 2012:4) outline:

> With IPA, we aim at producing an in-depth examination of certain phenomena, and not generating a theory to be generalised over the whole population.

In this study the ‘particular people’ are children living with parents who misuse substances. Idiography is also concerned with the commitment to understanding a single claim, as well as the process of understanding more generalised claims (Smith et al., 2012). This study adopted an idiographic approach, as singular experiences shared by children were not excluded and both ‘shared themes and distinctive voices’ are represented (Smith et al., 2012:38).

Alongside the concept of idiography, also pertinent to this research study, for both the creative interviews and focus groups, was the notion of reflexivity. Reflexivity can be identified along a continuum, with reflection at one end, reflexivity at the other and critical reflection in the middle (Finlay, 2008). To be reflexive requires a thoughtful and deeper level of reflection or disciplined ‘self- reflection’, which encompasses awareness of one’s own belief and engagement with the method of research (Finlay, 1998:1).

Finlay (1998:1) argues researcher bias or the ‘problem of subjectivity’ can be turned into an ‘opportunity’ when researchers engage with reflexivity, as deeper meanings and understanding can be achieved. The significance of

researchers engaging reflexively with their research and the depth of meaning which can be elicited, is supported by Shaw (2010). Reflexivity is especially pivotal in IPA, as Shaw (2010:239) outlines:

> Engaging in reflexivity during analysis helps us to navigate our way through the participant's account and our responses to it. In thinking through our reactions in this way we can bring to the fore our assumptions and the mechanisms that construct those assumptions. This often involves revisiting the data and our reflective log throughout the analysis process.

The fundamental principles of IPA, including the notion of idiography and reflexivity, are all critical to the analysis of data from the creative interviews with children. It was anticipated that younger children would share less descriptive accounts in comparison to older children and so being reflexive was pivotal. As Smith (2008) suggests, alertness to the said and the unsaid has the potential to generate a richer understanding and deeper meaning. The findings chapters, presented in part four of this thesis, illustrate the importance of reflexivity, including the recording of the changes in children's behaviour, their tone of voice and their need at times, to say nothing at all.

The literature relating to the process of analysis for an IPA study does not provide a prescriptive method; however, there are 'common processes' which include 'moving from the particular to the shared and from the descriptive to the interpretive' (Smith et al., 2012:79). Though the process of IPA is 'subjective', Smith et al., (2012:80) suggest there are six steps to the analytical process which will evidence 'rigour' in the application of IPA. The six steps of the analytical process of IPA, which I adopted, are as follows:

Step 1 - Reading and re-reading

This stage involved 'immersing oneself' in the data, by reading the transcript and listening to the audio recording. Each transcript was then cross-referenced with the original interview recording two to three times, to ensure the transcript was accurate. It was during this intensive listening of the audio

recordings that additional reflexive notes were made, relating to a child's change in voice tone and the flow of the interview.

Step 2 - Initial Noting

'This initial level of analysis is the most detailed and time consuming' (Smith et al., 2012:83). During this step, the attention to detail was key in noting the micro details, including moments of laughter, pauses, emotive responses and in this study even the way a child drew and coloured their picture (for example, one child drew their picture with time and care and another child was rushed and seemingly angry in the manner they drew). It has been acknowledged that whilst in a traditional sense a phenomenological study relies on the verbal and written data, this is not to say that children's preferred expression (such as drawings) cannot be 'fruitfully explored' (Danaher and Briod, 2005:221).

Although IPA does not require detailed recordings of pauses and nonverbal sounds, as conversational analysis would require, certain 'prosodic aspects' were recorded. The purpose of this was to further aid the analytical process of sense-making and interpretation of the children's lived experience (Smith et al., 2012).

Step 3 - Developing emergent themes

This step involves 'breaking up the narrative flow of the interview' and interpreting the data in parts and as a whole (Smith et al., 2012:92). The main task for this step was to turn the transcript and reflective notes into themes; this step was aided by the use of Nvivo 11 to identify initial themes. In total, 79 themes were identified during the initial coding phase.

Step 4 - Searching for connections across emergent themes. The transcript and reflective notes were recorded and coded in a chronological order. The purpose of this step was to take the chronological list of themes and begin the process of mapping. During this step, not all themes were incorporated. Themes were grouped together because of similarities, and 15 themes were

identified as not relevant in content to the research, resulting in 51 identified subordinate themes. The idiographic aspect of IPA meant themes were included depending on the 'contextualisation' and 'function' as opposed to the numerical significance, meaning themes were not mapped simply because of their frequency (Smith et al., 2012:96). The process included 'abstraction' in that themes were identified dependent on the interplay of meaning and mapped into superordinate themes.

Step 5 - Moving to the next case

This step involved repeating previous steps for each interview transcript, i.e., initial noting, initial coding on Nvivo and being guided by the principles of IPA and the 'idiographic commitment of IPA', ensuring new themes were coded as they emerged within each transcript (Smith et al., 2012:97). Repeating the process for each meant there were no 'fixed' themes (Smith et al., 2012:81) and it was only in the writing phase of the analysis that the four superordinate themes were identified:

- Children's emotional responses to parental substance misuse
- Children's experience of living with parental substance misuse
- Understanding children's support needs within their immediate environment
- Understanding the role of professionals in responding to the support needs of children living with parental substance misuse.

As Smith et al. (2012:8) explains:

> […] analysis is open to change and it is only 'fixed' through the act of writing up (Smith et al., 2012:81).

During the writing phase, further themes were identified which were not incorporated or were grouped together due to similarity. At the end of this step a total of 24 subordinate themes were identified.

Step 6 - Looking for patterns across cases

This step allowed for a further in-depth exploration and interpretation of meaning. During this step, utilising supervision was key to reflexively discuss how one theme from one child illuminated a theme for another. The presentation of findings will evidence this step, especially relating to children's unique circumstance and how the same theme can both compound the impact of PSM or lessen the burden for children.

10.5 - Chapter summary

This section has presented the research design for the inclusion of child participants. The adopted methods and adapted tools to empower children's participation have been illustrated. A descriptive overview of the steps taken during the analytical process of the creative interviews with children has been presented. The following chapters will present the research design, methods and analytical process relating to the inclusion of professional participants.

Chapter 11

Methods part 2 - Research design with professionals

The phenomenon of the lived experience of children living with PSM and of professionals who support families where PSM is a safeguarding concern, requires a research design that responds to the complexity and 'multidimensional' factors relating to the phenomenon (Kamenopoulou, 2016:517). This research is guided by the principles of hermeneutic phenomenology but is also framed by the ecological systems theory (EST). The parameters for a research design which is informed by EST requires participants in different roles and within different systems (Bronfenbrenner, 1979). Bronfenbrenner (1979:218) outlines that the 'building blocks of an ecological structure' require a 'greater number of persons' 'in common with the phenomena' to participate. It is this knowledge gathered from different participants and the 'interconnections' of information and experience which allow for a greater understanding (Bronfenbrenner,1979:218).

This research design includes participants from across a children's workforce and was adopted to explore the multiple perspectives and interactions of factors relating to PSM. The inclusion of professional participants was not to validate the voice of children living with PSM, but to consider the contextual factors beyond a child's microsystem.

The following chapters will detail the research design, specifically the use of focus groups as the most appropriate data collection method, and the analytical process using thematic analysis. The ethical considerations for this research are then explored and discussed.

11.1- Focus groups with frontline professionals

The use of focus groups within a phenomenological research study is worthy of consideration, as to whether the combination is acceptable or a 'methodological crime' (Bradbury- Jones et al., 2009:664). As Bradbury-Jones et al. (2009:664) discuss, there appear to be two perspectives; one perspective being that 'focus groups and phenomenology are methodologically incompatible' and the second that they are compatible.

The perspective that phenomenology and focus groups are methodologically incompatible stems from a view that the phenomenological endeavour is to understand the 'essence' of the phenomena and this requires an individual to describe their experience (Bradbury-Jones et al., 2009:666). At odds with this view is the perspective that focus groups can enhance 'the credibility' of research 'by providing an environment that encouraged interaction and clarification of dialogue among the participants' (Bradbury-Jones et al., 2009:666). Bradbury-Jones et al's. (2009:668) exploration of multiple research projects and discussion of the compatibility of phenomenology and focus groups, conclude:

> We accept that individual experiences are at the core of phenomenological research and that analytical emphasis is on subjective, idiosyncratic perceptions of the individual participant […] However, we argue that individual accounts need not necessarily be sought by one researcher from one, lone participant. Furthermore, we suggest that the individual perspective can still be preserved in a group context.

To gain further understanding of the needs of children living with PSM and, of the needs of professionals who support children where PSM is a safeguarding concern, focus groups were the chosen method for data collection. Focus groups are a qualitative method adopted by researchers to enhance the richness of data where an agreed topic is explored (Liamputtong, 2016). The emphasis of the focus group is on the researcher

seeking to understand the ‘experiences, interests, attitudes, perspectives and assumptions’ of the participants (Wilkinson and Birmingham, 2003:90).

The essence of the focus group is to generate an environment which is ‘socially oriented’ and which mirrors everyday interactions (Wilkinson and Birmingham 2003:90). They can provide an open, supportive environment which can produce in-depth discussions even if the topic of discussion is of a sensitive nature (Braun and Clarke, 2013). Taking part in a group discussion which allows time for participants to consider their thoughts, opinions and answers, in comparison to being in a one-to-one interview, can have a ‘consciousness-raising effect’ (Braun and Clarke, 2013:111). This notion is supported by Wilkinson and Birmingham (2003), as they state:

> […] the intention is that the discussion will be richer, deeper and more honest and incisive than any interview with a single participant could produce (Wilkinson and Birmingham, 2003:92).

‘Heterogeneity or homogeneity’ is a divisive argument regarding focus group design. There are researchers who argue that heterogeneity of participants could produce more diverse discussion; whereas homogeneity is preferred by some, as participants who have familiarity with one another may be more at ease and comfortable (Braun and Clarke, 2013). The focus groups in this study are homogenous in make up because they consist of professionals with similar roles, and of professionals from the same local authority who possibly work alongside one another. However, this is not to claim that they all think alike, only that they work in the same local authority. It is hoped that a familiar and comfortable environment could be achieved to generate a quality of interaction whereby participants felt at ease to discuss, debate and disagree (Wilkinson, 2008).

In designing this research study, the inclusion of professionals from a children’s workforce was purposeful, in considering how different systems, contextual factors and professional roles influence and interact between

systems (Bronfenbrenner,1979). Three focus groups were attended by participants from the following departments:

- Focus group 1 - Education, professionals in pastoral (support) roles from primary and secondary schools
- Focus group 2 - Children's social care (statutory social work)
- Focus group 3 - Early intervention services for children (non-statutory)

The recruitment strategy for inviting professionals to participate in the focus groups is detailed below in chapter 11.3. The first focus group was attended by professionals in support roles from both primary and secondary schools. Professionals from schools were invited to participate due to the length of time they spend with children, being a universal service, and potentially being the first point of contact for children who are in need of support due to PSM.

The second focus group was attended by social workers from statutory children's social care, including social workers who were newly qualified, qualified senior practitioners, and social workers in a managerial role. The rationale for the inclusion of social workers was to understand their experience of supporting children living with PSM and the responses in practice where PSM is a significant safeguarding concern.

The third focus group was attended by professionals from early intervention (non-statutory) services who work directly with children and families affected by PSM. The inclusion of participants from this department was intentional due to the complexity and diversity of their roles. The aim of this focus group was to understand what they believe to be necessary to effectively assess and support children and their families affected by PSM in order to prevent cases needing to be escalated to statutory social care services.

11.2- Focus group sample size

When designing the focus groups, the number of participants invited to participate was an important consideration. The recommendations for focus group size can vary; however, to facilitate rich discussion, smaller groups of 3-8 which can be effectively managed by the researcher are advised (Braun and Clarke, 2013). Further, to ensure the researcher can encourage shy participants to speak, and to sensitively discourage participants who dominate discussion, group size is an important factor (Wilkinson, 2008). A smaller group size is also significant when considering how a researcher will manage instances of discomfort and disagreements, as it can help the researcher to handle these dynamics more effectively, with care and sensitivity (Wilkinson, 2008).

Further, the success of a focus group relies on the way in which people naturally engage in discussion on a topic of mutual interest. Too large a group and the honesty and richness may be lost; too small a group and the richness and depth of meaning may not be reached (Wilkinson and Birmingham, 2003).

The three focus groups for this research were each attended by 7-8 professionals. Six professionals attended focus group one (education) with an additional one-to-one interview with a participant who could not attend the focus group. Seven professionals attended focus group two (children's social care). Seven professionals attended focus group three, with an addition of a one-to-one interview. A total of 22 professionals participated in the focus groups.

11.3- Conducting the focus groups

In March 2019, I attended a senior leadership (service lead/manager) meeting within the North West local authority and presented information regarding this research project. This information (Participation Information Sheet and Consent Form - Appendix 9 and 10) was then cascaded to

frontline professionals via the senior leadership team and team managers. When frontline professionals contacted me, I provided further details of the focus groups over the phone and emailed them a copy of the participant information sheet and consent forms. Once I had acquired the required number of participants for each focus group, I informed the senior leadership team. I then emailed participants to confirm the date and time of each focus group and provide details relating to car parking and access to the building. One month and one week prior to the focus groups, I emailed a reminder to participants.

Three focus groups of 7-8 professionals were held between June and July 2019. At the time of the focus groups, I was aware (due to also being an employee of the local authority) that many of the professionals attending would have had, or would still be experiencing, considerable change due to service restructures. It was anticipated that the focus of conversations could lean towards more political discussions and so the needs of children affected by PSM could have been lost. To mitigate this concern, children's toys, emotion puppets, and children's books about worries and feelings were displayed in the middle of the room (see figure 3 below). This was a deliberate and planned design to support a subconscious focus on the child.

Figure 3 Focus group room

The focus groups lasted between one hour, and one hour and 45 minutes. All three focus groups began at 9:30am, with arrival between 9-9:20am. This was purposeful so participants could come straight to the focus group before beginning their working day, in order to avoid participants not being able to attend due to having to respond to a work matter or incident.

Upon arrival to the focus group the professionals were made aware of the pack of post-it notes on the arm of their chair. The purpose of the post-it notes was for professionals to write notes and questions they may wish to ask and stick them to the arm of the chair. This was a subtle means of informing me that they had something they wished to say but had not yet been able to do so. This tool was used not just for those participants who were maybe less confident and vocal than others, but also for those who perhaps felt the moment they had wanted to share something had passed.

The schedule for the focus groups was similar to the interview schedules for the creative interviews with children in that the questions were open-ended, beginning with broad questions which then narrowed in focus. Although similar in design, the schedule for focus groups (see appendix 11) differs as questions ‘act as prompts to elicit general discussion’ (Braun and Clarke, 2013:117). The focus group guide was designed with the research questions

and objectives in mind. In seeking to understand how professionals had experienced supporting children living with PSM, the challenges they had experienced and from their perspective what they believed to be the necessary changes in practice.

The focus group guide was also carefully designed to ‘stimulate’ participants to discuss with one and other, to agree, disagree and debate with one another, rather than just answering (Braun and Clarke, 2013:117). Throughout the focus groups the natural flow of conversation meant that, at times, participants had already addressed the next questions/prompt; rather than moving on, I made participants aware of this to allow participants the opportunity to add any further thoughts.

Immediately after each focus group, I compiled a reflective log; this was completed to capture the unsaid; the emotions in the room and those moments in the focus group which were felt to be significant but would not necessarily be captured in the recording. Examples included changes in the atmosphere, heightened emotions, strong reactions and visible displays of emotion by participants.

After each focus group, I emailed participants and thanked them for their contribution to this research and encouraged them to talk to their colleagues and line managers if they were affected by the content of the focus group discussions in any way. The participants from the education focus group all committed to emailing one another subsequently as they found the focus group to be therapeutic and a valuable way of sharing their experience and knowledge, as they often work in isolation within their school.

11.4- Analysis of focus groups

The adopted method of analysis for the focus groups is a latent approach to thematic analysis. Unlike IPA, which originates from the phenomenological and hermeneutic approaches in health and wellbeing research, thematic analysis has a ‘less coherent developmental history’ (Braun and Clarke, 2014). Thematic analysis is not ascribed to a particular epistemological or

ontological framework, ‘it really is just a method’ (Braun and Clarke, 2013:178). Its ‘theoretical freedom’ provides thematic analysis with a flexibility which can yield detailed and complex data (Braun and Clarke, 2006). In essence, thematic analysis is a method used by the researcher to identify themes and patterns within the data, in relation to the research question (Braun and Clarke, 2006). A definition of a theme is presented by Braun and Clarke (2006:82):

> A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set.

Thematic analysis can also allow the researcher to ‘delve deeper’ than a detailed descriptive account, and analyse data from a critical ‘constructivist paradigm’ in which concepts, meaning and assumptions of meaning can be identified which underpin the data (Braun and Clarke, 2013:178). Analysis of the focus group data will be inductive in nature, often described as a ‘bottom up’ approach, in that the endeavour is to generate an analysis which is driven by the data itself (Braun and Clarke 2013:175). As such, the data is not ‘shaped by existing theory’ (Braun and Clarke, 2013:175) or driven by a researcher’s theoretical or analytical interests (Braun and Clarke, 2006). Although this research is framed by ecological systems theory, this theory does not influence the data itself but will help to contextualise and make sense of the findings.

Thematic analysis is ‘common across many qualitative methods’ and can be identified by two types: semantic (explicit) and latent (implicit) (Braun and Clarke, 2013:174). The preferred type of thematic analysis for analysing the focus groups is the latter approach whereby the aim is to identify more implicit or latent meanings. Braun and Clarke (2013) argue that for a researcher to identify themes on a latent and interpretive level, they need to know their research topic well. A latent approach to thematic data analysis is also referred to as a reflexive approach (Braun and Clarke, 2013). As with reflexivity in IPA, the aim is to reflect the researcher’s understanding of the

depth of meaning (Braun and Clarke, 2013). A reflexive approach is not focussed on the number of times a theme has been identified within the data; rather it is focussed on the depth of engagement, developing understanding and interpretive analytical skills of the researcher (Braun and Clarke, 2013).

Although thematic analysis is similar to IPA on an epistemological basis, the notion of idiography is what separates the two. Due to the scale of this research study (seven interviews with children and three focus groups with 22 professional participants), and the time constraints for data collection and analysis, IPA was not conducive as a method for data analysis for the focus groups. Thematic analysis allowed for a reflexive approach, although only generalised themes could be included. Given the depth of data collected, I would have welcomed additional time to engage with the focus group data and be guided by the principles of IPA (chapter 9.4) in order to have achieved an even deeper level of understanding.

The focus group data was analysed following the six stages of thematic analysis as outlined by Braun and Clarke (2013):

Stage 1- Each focus group was transcribed verbatim; the initial transcription began on the day of the focus group.

Stage 2- Each transcript was cross-referenced with the original focus group recording and the reflective logs, providing increased familiarity with the transcript as well as ensuring transcript accuracy

Stage 3- Transcripts were coded using Nvivo 11 software; within the initial coding phase, 53 codes were identified.

Stage 4- The initial codes were then used to identify themes within the data. The themes identified were ‘data driven’ and therefore this stage of analysis was a ‘bottom up’ approach (Braun and Clarke, 2013:178).

Stage 5- When reviewing the themes, six themes were excluded as not being considered relevant to the research questions. The excluded themes included the relationship between adult treatment and adult mental health

services (dual diagnosis), generational cycles of addiction, and the perception that children living with PSM may have been misdiagnosed with conditions such as ADHD.

Stage 6- During the writing phase of this thematic analysis, themes which were similar were merged and further themes were excluded due to repetition or not being relevant to the research question. Of the initial 53 codes, 23 themes were identified and grouped to form 3 overarching themes and 23 sub themes.

11.5- Chapter summary

This section has presented the research design for the inclusion of adult participants. The adopted method of three focus groups and the rationale for the inclusion of participants from three departments across a local authority children's workforce have been presented. A descriptive overview of the stages of thematic analysis have been presented. The following chapter will explore and discuss the ethical considerations which were pertinent to this research. The chapter concludes by discussing the issues of being an insider researcher and ethical consideration is given to the issue of power and coercion.

Chapter 12

Ethical considerations

Ethical considerations are significant in this research because of the anticipated emotive content of experiences shared by both professionals and children participating in this research. In preparation for this research, it was anticipated that professionals in the focus groups would share emotive experiences of supporting children where PSM has been a safeguarding concern. The welfare of professionals taking part was explored in the ethical application made to both Manchester Metropolitan University and the North West local authority. I had also outlined clearly in the participation information sheet that there would be time to debrief with colleagues after the focus group, as well as providing information explaining how to access further support post-participation if required.

Ethical considerations were especially significant in relation to the children participating in this research project, in part due to their age (aged between 7-16 years) and due to their circumstance. The participating children were living with their parents who continued to misuse substances; this was not a retrospective account and children were living in the environment which the research project sought to explore and understand. There was a risk that, by taking part in the research project, their emotional vulnerability may increase due to sharing experiences that could evoke difficult emotions and memories.

As a registered and practising social worker, I adhered to the professional standards as outlined by the specialist regulator for registered social workers, Social Work England (Social Work England, 2020:online). Further, I adhered to the research ethics guiding principles of Manchester Metropolitan University. I took careful and considered steps, utilising both my social work practice and research knowledge to safeguard participants before, during and after they have participated.

As a social worker working within a specialist service supporting children and families affected by a loved one's substance misuse, I have over 12 years of experience supporting children to talk and explore difficult and emotive life experiences. My therapeutic practice in my role as a social worker utilises similar skills to those I used in the creative interviews with children.

This research project needed to be approached with care and sensitivity. As the literature review highlighted, the world for these children can be unpredictable and at times harsh. The emotional safety and wellbeing of child participants remained paramount throughout; they came first, not the research.

As outlined in my ethics applications, if a child was upset or distressed in any way prior to, or during, the creative interview, I ensured that the child had the choice to decide whether to continue to take part (Morrow and Richards, 1996). Further, if a child had been exposed to or suffered any form of abuse, such as physical harm, or had witnessed domestic abuse during the week their creative interview was scheduled, I took the lead from their specialist keyworker as to whether the interview needed to be postponed or cancelled.

Further, throughout the data collection phase, consideration was given to the needs of the parents. Through discussions with the keyworker from the specialist service supporting the family, consideration was given to the parents' emotional wellbeing and their access to support if required.

12.1- Parental consent and child assent

This is a sensitive area of research with a vulnerable participant group. Access to child participants was via a specialist support service where the child was accessing support and has an existing relationship with their keyworker.

The rationale for this was firstly to ensure that children had support prior to, during, and after, their participation in the research. Secondly, I engaged reflexively with the design and planning of this research study to carefully

consider how I could create the conditions for children to feel empowered, and ensure that obtaining their assent to take part is meaningful and not a tick box exercise.

Consent for a child to take part in research is given by adults who have parental responsibility; it is sometimes referred to as ‘parental permission’ (Oulton et al., 2016:589). The child, in addition to parental consent, gives assent; assent cannot stand alone and only consent has any legal standing. Nevertheless, it is essential to include children in decision making; this is a fundamental aspect of research with children (Oulton et al., 2016).

In seeking parental consent, the initial phase began with a phone call to parents by myself, or the child’s keyworker, to describe an overview of the research project. Following this phone call, parents had the option for a follow up phone call before deciding whether they consented for me to speak with their child. If parents were in agreement to learn more about the research and to meet with me face-to-face, a home visit was arranged so I could meet with parents and their child/ren. I accompanied the child’s keyworker to meet with the parents and their child/ren to talk through the participation information sheet, and to discuss consent. Parents were given a copy of the participation information sheet and children were provided with a child-friendly version (see Appendix 3/5) I encouraged children to speak to their keyworker after our first meeting and ensure they knew they had a choice whether or not to take part, even if their parents had consented.

Although consent by parents holds priority in terms of legal standing, in congruence with my epistemological belief, I have ensured that as far as possible, gaining assent was not simply a tick-box exercise.

12.2- Confidentiality and anonymity

The strength of the ‘draw and write’ technique lies in its potential to elicit deeper meaning, understanding and perspectives ‘not immediately visible to the researcher’; however, this approach does have its limitations (Sewell, 2011:178). The use of this method brings ethical challenges in relation to the

preserving of anonymity and confidentiality, as the drawings and contextual information could lead to the identification of the participant. Advocates for this method argue that drawing can provide access to different meanings and interpretations that are not possible through other methods (Sewell, 2011).

Using creative methods, as described in chapter 10, can make participating in interviews easier for children by engaging in 'storytelling' and making connections to their lives (Russo et al., 2006:231). The risk that confidentiality and anonymity could be breached through a child's drawing style being recognised is detailed in the child-friendly participation information sheet (see Appendix 5).

The only way to alleviate this risk completely would be to exclude the children's drawings in the final thesis and any subsequent publications, which would limit the impact of this research's ability to raise the profile and lift a child's voice and experience to the forefront. As such, children's drawings were used in the final thesis; no child requested that their drawing was excluded.

Children and their parents were made aware of the circumstances when confidentiality may have to be breached during the initial home visit. Prior to each interview with children, I revisited their child-friendly information sheet to confirm their understanding of confidentiality. Prior to conducting the creative interviews with children, I sought relevant information from their keyworker, such as known persons of risk to the child and their family. This was important should a child mention a name which in the context of the interview may not have been considered a safeguarding concern. Being aware of named persons of concern who posed a significant risk to the child and the safety of their family enabled me to make an informed assessment of the risk and decision to breach confidentiality.

Confidentiality is outlined in the participation information sheet for professionals attending the three focus groups (see participation information sheet, appendix 9). The data collated from the focus groups was completely

anonymised; however, there was a risk that direct quotes used in the final thesis and subsequent publications may lead to the professionals being identified by the people present in the focus group. This risk of anonymity being breached is outlined in the participant information sheet (appendix 9).

12.3- Insider positioning

As this research is taking place in the borough in which I am employed, and with the support of the specialist service where I continue to practise, the issue of insider researcher requires consideration. Conducting social research within communities and groups in which the researcher is also a member is referred to as being a 'native researcher', as (Kanuha, 2000:441) illustrates:

> The native researcher often arrives at a project from an emic perspective. Emic suggests a subjective, informed and influential standpoint, contrasted with an etic perspective that is more objective, distant, logical and removed from one's project. Therefore, the native researcher chooses not only a project in which she is deeply situated, whether by geography, tradition, or simply "inside" experience, but also one in which she is invested in those factors and others as they inform the "act" of research.

Positive aspects of insider research include having a pre-existing knowledge of, and a familiarity with, the context of the research. Further, insider researchers have the experience and knowledge of exploring difficult and emotive topics, using meaningful questions, reading of non-verbal cues, as well as the ability to understand the subject area being studied (Greene, 2014). Greene (2014) cites the work of Aguiler (1981) who writes that insider researchers have a natural ability to interact and are less likely to stereotype or pass judgement on the participants under study.

Regarding potential safeguarding concerns and disclosures from children where confidentiality would have to be breached, my insider knowledge and years of practice experience in responding to safeguarding concerns

informed my response. Being an insider researcher also meant that I had detailed knowledge of local safeguarding procedures and the infrastructure of support for the families participating in this research.

Within this research study there was a possibility that participants may use ‘coded’ language and terminology which was less known to those outside of the research topic. As an insider researcher, having prior knowledge of language and common terminology can provide an environment in which there is a shared empathic understanding (Kanuha, 2000). This notion is further supported by Taylor (2011) who outlines the advantages of being an insider, in that there is the potential to elicit a deeper understanding which is ‘afforded by prior knowledge’ and ‘knowing the lingo’. Insider positioning also provides an opportunity to establish ‘rapport’ and ‘trust’ between participant and researcher perhaps more quickly than that of an outsider researcher (Taylor, 2011:6).

The positionality of being an insider researcher has the potential to enhance a ‘depth and breadth of understanding’. However, there are questions which need to be asked and explored in relation to the authenticity of the research, as Kanuha (2000:444) outlines:

> …questions about objectivity, reflexivity, and authenticity of a research project are raised because perhaps one knows too much or is too close to the project and may be too similar to those being studied.

Being an insider should not be viewed as a position which allows for complete way of knowing. Insider researcher positioning should therefore not be privileged, as there will undoubtedly be differing and multiple views that arise within the research (Taylor, 2011). The insider researcher position does not equate to a totality of knowing and nor is it a position of either inside or outside. Rather, the positioning of being an insider researcher may be best viewed as a continuum, as insider views are multiple, and positions/ boundaries are ‘permeable’ (Taylor, 2011:6).

12.4- Power imbalance and coercion

A further consideration regarding insider research is the risk that participants may feel obliged to take part in the study (Costley et al., 2010). Participants invited to take part were not children I had worked with directly, although there was a possibility that they would recognise me simply from being in the same building or from group activities I have been involved in.

To mitigate the risk of children feeling obliged to take part, children were initially told about this research by their keyworker with whom they have a trusting relationship. Then, only when parents had provided initial verbal consent to their child participating did I have any direct contact with the children. Children were informed by both their keyworker and me that they could change their mind and did not have to take part.

It was anticipated that parents may feel pressure or obligation to agree for their child to participate, especially if they declined and felt their decision would reflect negatively on them or that services would have been reduced or removed. Parents were reassured that this was not the case and their conversations with me and their child's keyworker about the research would remain confidential. Parents were made aware (see appendix 3) that confidentiality would have to be broken if their child mentioned something which could suggest harm.

Potentially feeling obliged to take part also applies to adult participants; whilst professionals invited to participate were not colleagues from my team, I had worked alongside the professionals in supporting children and families affected by PSM. To mitigate against professionals feeling that they were obliged to take part, I did not approach professionals directly to request their participation. Instead, a generic email with a brief outline of the study was sent to all relevant teams/services via senior leaders and team managers. Only when participants had opted in and their contact details had been sent to me, did I contact them directly to provide the participation information sheet and confidentiality form.

12.5- Part 3 summary

The methodological chapters have outlined the guiding philosophical and theoretical underpinning principles upon which this research project is built. The chapters have provided a clear rationale for the chosen research methods undertaken, that seek to understand the needs of children living with PSM and the experience of professionals in their endeavour to support these children. The research methods were presented in two parts; part one outlined the research design and the use of creative interviews with children, and part two outlined the research design for the inclusion of professional participants. Both parts concluded with an exploration of the chosen approaches for data analysis and the analytical process. I have provided detailed reflections on the ethical considerations for this research study, including the anticipated challenges and planning to mitigate those challenges. Through thoughtful and reflexive planning, I have endeavoured to safeguard the emotional wellbeing of children, their parents and of professional participants. The proceeding chapters present the findings from the creative interviews with children and focus groups with professionals. It is hoped that the careful thought and planning in the design of this research study can be seen in the depth and richness of the findings presented.

Part 4- Presenting the findings

Chapter 13 - Introducing the findings from creative interviews with children

In seeking to understand the support needs and experiences of children living with a PSM, this chapter provides an interpretive phenomenological analysis of the creative interviews with children.

Between August and December 2019, seven children participated in creative interviews. Of the seven children, there were two sibling groups of two. The children who participated were between 7-16 years of age. Five of the children were living with parents who were misusing substances, and one sibling group were, between the time of recruitment and the interview taking place, placed in the care of their father due to their mother's increased substance misuse.

The sample profile of the seven children is presented in Table 3 below. One child identified as gender neutral and requested that they were not referred to by their gender. To respect this child's wishes and protect their anonymity, none of children in the presentation of findings are referred to by their gender. Each child is referred to throughout this findings chapter by their gender-neutral pseudonym. In the absence of a prescriptive list of gender-neutral names, the chosen names are subjective and were chosen by me.

The sample profile of child participants outlines each child's age, ethnicity, family member who misuses substances, the substance itself and level of safeguarding. The level of safeguarding (see appendix 2- glossary of terms) is included in the sample profile as it highlights the severity of safeguarding concerns and risk of harm posed to the child due to their parent's substance misuse.

Sample profile of participating children

Table 3 Child participants, sample profile

Child Participant	Age	Ethnicity	Parental Substance Misuse	Identified substance	Level of Safeguarding (see appendix 2- glossary of terms)
Kit	7	White British	Mother	Alcohol and unknown substances	Child Protection Plan
Charlie	16	White British	Mother and older sibling	Alcohol and Cannabis	Team Around the Child
Taylor	14	White British	Father	Alcohol	Universal services
Rowan	12	White British	Mother	Alcohol and unknown substances	Child Protection Plan
Roux	8	White British	Mother	Alcohol, crack cocaine, possible multiple substances	Child Protection Plan and Public Law Outline
Cody	11	White British	Mother	Alcohol, crack cocaine, possible multiple substances	Child Protection Plan and Public Law Outline
Quinn	8	White British	Mother and Father	Alcohol	Child Protection Plan and Public Law Outline

To encourage children to share their lived experience, two creative methods were used, as outlined in chapter 10. An exercise called ‘If alcohol or drugs could turn into an animal what would it look like?’ was used, alongside the semi-structured interview questions for primary school-aged children. The creative method allowed children to tell their story through their drawings and supported those children who found talking alone, too difficult.

A second exercise using the drawing of a tree, to assist children to share their worries, support needs/ coping strategies and support networks, was chosen primarily by secondary school aged (11-16) children. As with the exercise above, the use of the resilience tree exercise was used to facilitate conversation, alongside the semi structured interview questions for secondary school aged children (see appendix 7&8). As shown in the drawing by Kit, the resilience tree relates to three parts of a child’s life, their worries (branches), what helps them to cope and feel strong (trunk) and who are their trusted adults and support networks (roots).

Figure 4 Creative method example- the resilience tree

I did not presume that younger or older children would have a preference for either exercise, nor did I presume that all children would want to draw. Children were given the choice both at the start of the interview and throughout, in case they changed their mind. Two children preferred to talk without drawing, of those two children one child did not draw but wished to refer to the different parts of their resilience tree in a virtual sense, by verbally describing what worries were on their branches.

The themes were grouped into superordinate themes which related to the overall research questions, this resulted in four identified superordinate themes and a total of 24 subordinate themes, as presented in table 4 below:

Table 4 Superordinate and subordinate themes from creative interviews

Superordinate Theme	**Subordinate Theme**
Children's emotional responses to parental substance misuse	If alcohol or drugs was an animal
	Feeling angry
	Feeling sadness
	Feeling in danger and scared
	Feeling isolated
	Feeling anxious and uncertain about the future
	Self-harming to cope
Children's experience of living with parental substance misuse	Witnessing substance-related injuries
	Parental physical and emotional absence
	Young caring role
	Lost childhood
	Money and limited resources
	Living through ups and downs
	Loyalty to parents

Understanding children's support needs within their immediate environment	Non- substance misusing parent
	Grandparents and extended family
	Importance of friendships
	Importance of family pets
	Need for a stable home
Understanding role of professionals in responding to the support needs of children living with parental substance misuse.	Children's experience of school
	Absence from school
	Support needs in school
	Needing support from professionals
	Longevity of support needs

Throughout the children's narrative I explored the breadth and depth of the shared experiences by children to ensure all experiences were highlighted, even if an experience was unique to one child.

In the next chapter, the superordinate and subordinate themes will be presented and explored in turn. Pictures drawn by the children will be presented, providing a visual representation to support their written voice. As well as extracts from the original interview transcripts, to support the prevalence of each subordinate theme. Though the themes identified are presented individually, many are intertwined and this is apparent throughout.

Chapter 14

Superordinate theme 1: Children's emotional responses to parental substance misuse

This superordinate theme encompasses the reflections and emotional responses from children about their feelings of living with parents who misuse substances. Children's drawings will be used to further illustrate and elevate their voice and experience. This superordinate theme is accompanied by six subordinate themes which are listed in table 5 below, each subordinate theme is presented in turn.

Table 5 Children's interviews Subordinate themes 1.1-1.7

Subordinate Themes
1.1 If alcohol or drugs was an animal
1.2 Feeling angry
1.3 Feeling sadness
1.4 Feeling in danger and scared
1.5 Feeling isolated
1.6 Feeling anxious and uncertain about the future
1.7 self-harm to cope

14.1.1- If alcohol or drugs was an animal

To support younger children to explore their thoughts and feelings during the interview, they were asked, 'If alcohol or drugs could turn into an animal what would it look like?' This subordinate theme explores the findings from children who chose to use drawings of animals to support them to share their experience.

The group of children who took part in this research project were a homogeneous group, as they were all children who were living with (at least until two months prior to the interview) a parent who misused substances. Whilst PSM creates a sense of homogeneity, the children were all unique; their reflections, memories, worries and feelings were both similar and uniquely different.

Through their descriptions, it was apparent that talking about (PSM) and exploring their own thoughts and feelings was a real struggle. During Kit's interview, the level of distress this child felt was clear throughout; at times, Kit was close to tears and their voice tapered off into a soft whisper.

Kit chose to draw a donkey. Through their drawing, they described witnessing their mum drinking alcohol. Kit reflected on how their mum's eyes changed and they could tell their mum had been drinking as her eyes were 'blurry'. As Kit talked about alcohol, they looked close to tears and kept their head bowed to the floor:

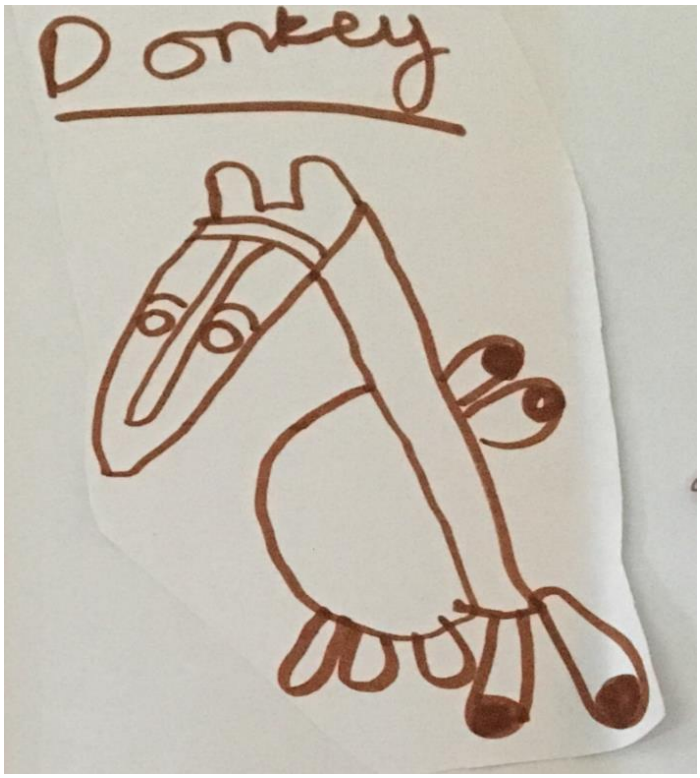


Figure 5 If alcohol and drugs was an animal by Kit

> When mum walks normally, it's properly normally erm her eyes go like blurry a bit maybe erm well she hasn't really done it like in the past month (Kit)
>
> Erm just like the way she's acting because when she's drinking, she'll act like […] it's hard to explain, like, just like not the same (Kit)

In preparation for the interview, I had visited Kit and their siblings at their dad's house. The children had recently moved and were all living with their dad due to mum's alcohol misuse and increasing safeguarding concerns (the details of which I was not aware). During the interview, Kit shared with me that they were going to see their mum that afternoon. It could be possible that Kit was experiencing emotional turmoil and pressure during the interview. They may have believed that by sharing with me a detailed reflection of their experience of PSM, they would no longer be able to have time with their mum that day. Kit attempted to explain the difference when their mum was drinking alcohol and not, sharing with me that mum was happier when she was not drinking alcohol:

> Like happier, she's happier and she's more like just, feels […] it's not that I don't want to say it, it's just hard to explain (Kit)

As Kit drew how they felt, it became apparent as the interview progressed that Kit was struggling emotionally and it was no longer ethical for me to explore further questions with Kit relating to substance misuse:

> This is really tough talking about it isn't it? (Interviewer)

Kit replies in a whisper;

> Yeah (Kit)

Roux chose to draw a number of animals in their pictures, each animal representing a different substance and portrayed differently in relation to Roux's description of the character of the animal.

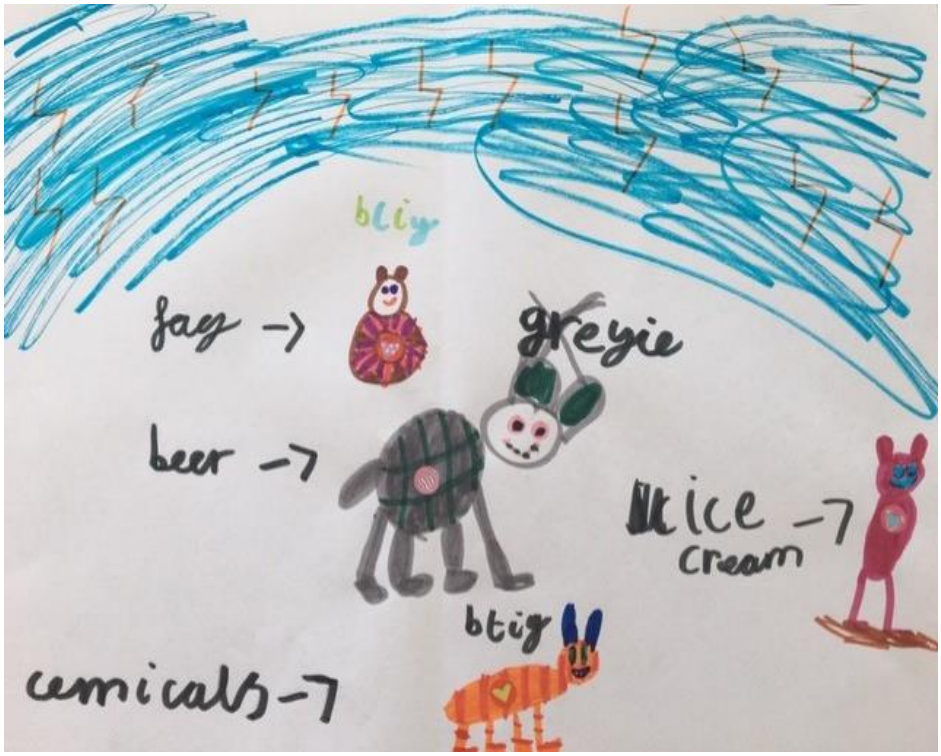


Figure 6 If alcohol and drugs could turn into an animal, by Roux

Roux began by drawing a cat which represented a ‘fag’ (cigarette). Roux drew confidently and spoke in jovial tone, joking that the cat called ‘Bluey’ who ‘stole other animals’ food. Roux also depicted ‘Bluey’ as an animal which could also be protective:

> So, like if somebody hurts his friend then he’ll go mad (Roux)

Through Roux’s description of ‘Bluey’ the cat, there was a sense of pride from Roux in the way the animal was conveyed. It is possible that Roux was thinking about their mum whilst drawing the cat, as mum smokes cigarettes (‘fags’) and I was aware from my first meeting with the family that mum was immensely protective of her family.

I first met with Roux and their family two weeks prior to the interview. We met in maternal grandparents’ home where Roux’s mum was batch-cooking meals for her children as the bed and breakfast they were staying in had no cooking facilities. The family had had to flee their home because of threats

made against their lives. I was informed prior to the interview by Roux's keyworker that this was possibly due to drug debts.

In contrast, in the next two pictures Roux drew an elephant and a tiger, which represented both 'beer' and 'chemicals', Roux was less jovial and their tone of voice at times changed to a whisper. Perhaps this was because they felt they were disclosing a secret which needed to be whispered or it may be because describing the behaviour and how these animals made them feel was much more difficult.

As Roux drew the second animal (an elephant), they whispered that the elephant was 'beer'. When asked what 'Greyie' the elephant was like, Roux whispered 'scary'. The third animal Roux drew was a tiger, which they named 'Chemical Tiger'.

Roux appeared much more considered in their description of the tiger; there were longer pauses of breath and Roux used fewer words and more sounds. Roux made a 'grrrr' sound to describe how the tiger sounded, before sharing with me that the tiger was a 'bully tiger' and 'bites' people.

Roux also shared their memory of seeing the tiger:

> When he hurts people err he puts, into people's mouth and the people fall asleep […] When they're sleeping and then they wake up and feel oh I feel dizzeeee and then they fall and go back to sleep. He's a bully tiger (Roux)

The emotional response from Roux in sharing this memory was apparent through their whispered voice and visible sadness. The use of the word 'bully', coupled with the description of the tiger putting something into people's mouths without overtly naming what it was, could signify Roux had witnessed their mum being forced to take a substance. Roux's description when referring to 'people' could suggest there were multiple adults in the family home who were using substances.

Roux drew the weather around the animals in the picture as rain and lightning. When I explored this further to understand what Roux had drawn and why, Roux shared with me:

> It would be rainy, because it would be raining and you could hear stomps from the elephant (Roux)

Roux's older sibling Cody also took part in the research project. Cody's presentation throughout the interview was starkly different to that of Roux. Roux was calm, considered, often pausing for 10 – 15 seconds at a time. Roux took their time to answer questions and explore their reflections through the use of drawings and appeared confident.

In contrast, Cody appeared agitated and couldn't get comfortable. Cody moved on and off the chairs/ beanbags and spoke with speed. Cody would often go off on a tangent and share with me details of their friendships, school life and dreams of the future such as having a gold house with an indoor swimming pool. It is possible that Cody was using such story telling as a diversion tactic, as talking about PSM was simply too hard to do. It is also likely that, due to being older, Cody was perhaps more aware of the potential consequences of sharing information with me.

During my visit to meet Roux and Cody, both mum and maternal grandma were very open about children's social care involvement about not being able to move back to the family home, due to continued concern by both the family and professionals of the threats made against their lives. Perhaps Cody felt the potential consequence of me sharing their information with social care and the risk of not being able to remain in mum's care was simply too great a risk to take.

As the interview progressed, I revisited the topic of confidentiality to offer reassurances to Cody. Cody asked to draw and proceeded to lead the interview through the use of their drawings and descriptions.

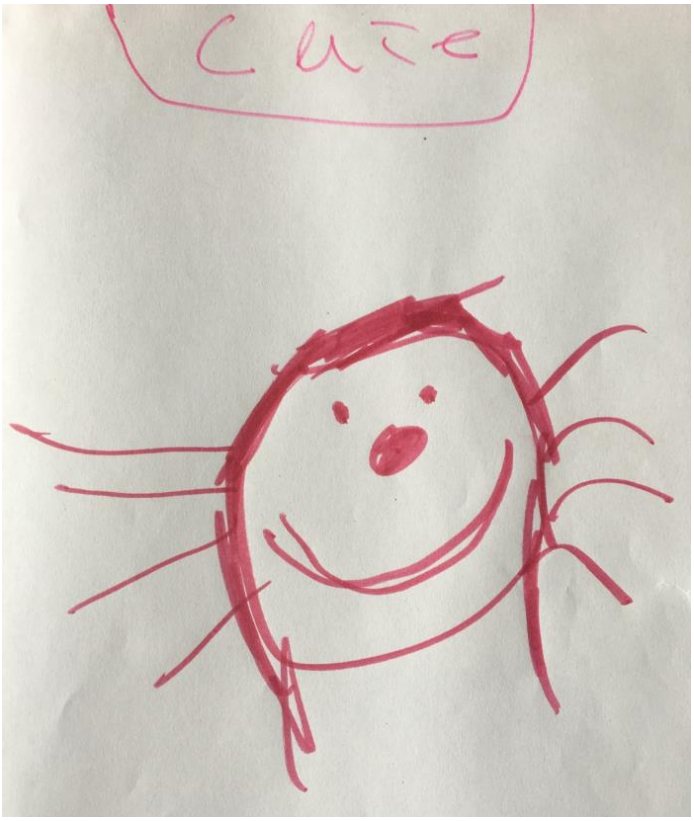


Figure 7 If drugs could turn into an animal by Cody

> Erm let me think, probably a fierce and cuddly animal like a big cat because like […] I really can't draw. I'll draw fear like when it's aggressive, I can draw its fur like when it gets into ya and its aggressive […] so that's like a cute pig spider an it's got really long hair and it's really cute pink hair an you fink oh my god that's so cute an if it was real you'd want to stroke it wouldn't ya and then it gets into ya and then you see the angry aggressive side of it. So, it looks all cute and then, well basically don't judge a book by its cover (Cody)

Cody's account of alcohol or drugs being an animal appears to depict a sense of experienced unpredictability, a sense of not knowing whether they were going to experience a 'cute side' or an 'aggressive' side to their parents.

Cody also repeatedly used the word ‘aggressive’, perhaps signifying their experience of witnessing or hearing violence within the family home. Unlike their younger sibling, Cody identified the substance they were referring to:

> Cos I know this sounds really weird but it could be cute to people because like its crack and cocaine an everyfin and they think ahh yeah this is going to be so good an then afterwards they’re like oh what av I done innit. That’s what I think anyway (Cody)

After drawing the spider pig, Cody then began to draw how aggression and anger looked, when crack cocaine took hold:

> So, basically this is like fire, its grabbing onto ya and it’s taking ya to places, I don’t know (Cody)

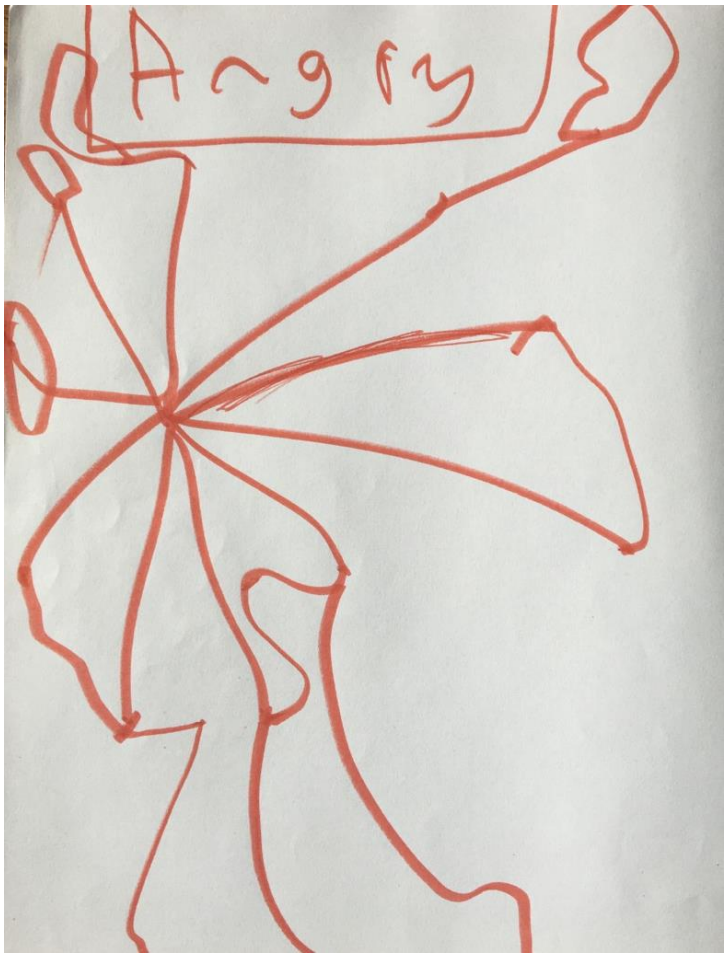


Figure 8 What would crack cocaine look like by Cody

> […] basically it's like, cocaine is like anger soooo it don't really have a cute side to it, anger, but it has an aggressive and angry side because like when you're angry you just flip out like you fink oh my god and it just all comes out and it's like fireworks are exploding inside ya and you get really mad and stuff like that. (Cody)

As soon as Cody had finished their drawings and shared with me that they had been crying in lessons at school, they swiftly changed topic and diverted away from the drawings. Cody looked agitated and fidgety and was unable to share with me why they had been crying and they diverted any further questions away from the picture. They had appeared to be engrossed in their drawing and sharing of their story but perhaps they felt they had disclosed too much. Cody did not revisit the drawings again.

All but one child who participated had been accessing support from the specialist service for between 3-18 months. Quinn had only recently been allocated a keyworker from the specialist service and had only had two one to one sessions with their keyworker. At the start of the interview Quinn sat ready with their felt tip pen poised to begin, as though they were excited to be able to share their story. Quinn took their time throughout the interview, there were long pauses (often 30-35 seconds) between questions as Quinn appeared to carefully consider their answer and what to add to their drawing. It is possible Quinn was apprehensive about how much to disclose, but it may also be the case that due to Quinn's speech and language difficulties, they simply needed more time to communicate.

Quinn described their drawing as a half human and half animal which fell down the stairs and had blood coming from its mouth:

> Ok I know it look like half human but it not it like half human and this lump is actually animal and that is the tail […] yeah it the eyes, the red eyes and alcohol when it's bad, you fall over and you bleed (Quinn)

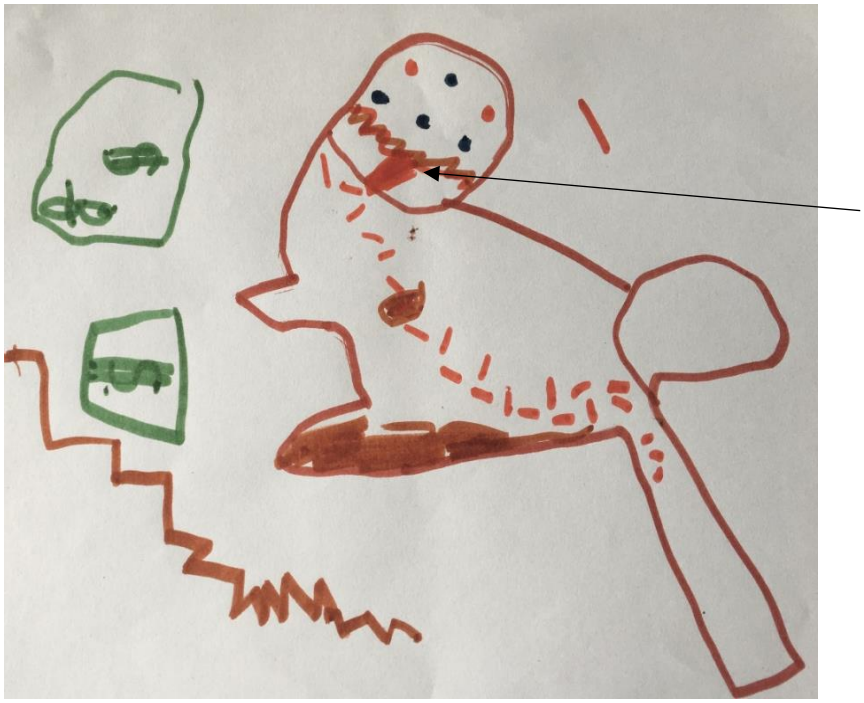


Figure 9 If alcohol could turn into an animal by Quinn

Quinn referred to the animal as ‘evilly’ and explained to me that it was alcohol that made it behave ‘evilly’

> It do something like evil, to somebody (Quinn)

Quinn struggled to explain their feelings towards alcohol, their description below indicates the direct impact PSM is having on Quinn, in relation to hearing or receiving ‘horrible’ comments. As Quinn shared their reflections, the tone in their voice was notably softer, they spoke with less animation and appeared visibly saddened.

> Like it makes you fall over and it make you say horrible things like say it can even make you deal things […] Yeah so it comes out like swearing, you say anything and you don’t mean it (Quinn)

Quinn was unable to share with me what they meant about ‘deal things’. It is unclear whether this is something Quinn has experienced or has associated with substance misuse through other means such as the media or talk amongst friends.

Quinn differentiated substances and described their mum smoking cigarettes and how for them, this was ok. But mum drinking alcohol was a worry and something they didn't like to see:

> Really, I just don't like it, I think actually it can really hurt you, I don't mind mum smoking outside yeah but not drinking […] Another reason it makes you sound weird and it makes your words sound weird (Quinn)

Quinn's reflections highlight the burden of worry Quinn holds and their feeling of responsibility for the safety of their parent:

> I worry she'll hurt herself, If I hear a bang I'll go downstairs and see if anyone is hurt. (Quinn)

For all of the children, both the younger ones and older children, describing their experiences of being exposed to PSM led to strong emotive reflection, with reference to feelings of anger and sadness.

14.1.2- Feeling angry

The experiences of each child who participated differed; even children who were siblings, who had the same parents and lived in the same house had their own unique account and story to share. Despite children's unique experiences, there were shared themes related to emotional responses.

Feeling angry was something Kit identified when they knew mum had been drinking alcohol:

> Angry, I'm angry when mum drinks (Kit)

As Kit described their feelings of anger their body language changed. Kit looked visibly sad and close to tears. In response to Kit's visible sadness, we moved on to explore a more generic topic of support networks.

Charlie similarly described feelings of anger when exposed to PSM. Charlie's reflections of feeling angry appeared to be in response to their feelings of abandonment. Charlie described their feelings of anger when their mum left

the family home to drink alcohol and had not returned until the following morning:

> Sometimes a bit angry that she's gone out and got into a position where she knows she can't get hold of us (Charlie)

Reflecting back on these memories of their mum being absent for periods of time, Charlie described feeling angry upon mum's return, perhaps because of the repeated cycle of behaviour and repeated position Charlie had been left in, alone at home, caring for their siblings:

> I can get a bit angry with mum when she gets back, or not get angry but feel a bit angry because it has happened a few times. (Charlie)

Although Taylor didn't specify directly how they felt, it was clear from their tone of voice that there was a sense of anger. Taylor spoke with a stern tone and looked increasingly angered as they described the direct impact of their dad's alcohol misuse. Taylor reflected on being displaced within the family home due to their dad choosing to drink and sleep in their bedroom, leading to feelings of anger and sheer annoyance:

> It is really annoying though because like, it wasn't pre-talked or pre-negotiated that he could take my room and so all my stuff was in there and I didn't wanna to go in and get my stuff, plus he also stained all my Nintendo Switch games with beer so that wasn't great […] he doesn't put the beer away he just leaves the cans everywhere. (Taylor)

Throughout the children's interviews there were emotions and feelings which were intertwined, feeling anger and sadness were often connected.

14.1.3- Feeling sadness

For many of the children, living with a parent who misused substances had a direct impact on their emotional health and was evident in their descriptions of feeling sad.

Rowan, who is Kit's older sibling, described their feelings of sadness. There was a sense from Rowan's description that the sadness could have been a feeling of guilt, because Rowan relied on Kit to seek support from family and professionals:

> Erm sad because [Kit] she's the one who will tell someone when she's really sad or she'll you know just speak to somebody whereas like I just like to wait until later (Rowan)

Similarly, to Rowan, Charlie found it difficult to talk about their feelings and seek support when they were feeling sad. Charlie described how they were unable to confide in their parents:

> I'm sort of not very expressive so if I'm upset, I don't go to mum and say I'm upset I just sort of keep it in, which is fine because that's just how I cope. (Charlie)

Charlie's reflections of their mum's substance misuse portrayed not only sadness but mixed emotions, a sense of emotional turmoil. Charlie not only had to manage their own emotional responses but protect their younger sibling's emotional wellbeing:

> It makes me feel a bit bad sometimes because [sibling] will be like oh don't be mean to mum, when it's me that's trying to let her know that what's she's done isn't really ok and that it's had a big effect on us (Charlie)

For some children it was hard to make sense of their feelings or identify what it was they were feeling when exposed to PSM. Quinn appeared to struggle to make sense of their experience in relation to how this had made them feel,

perhaps indicating that, for the younger children in particular, they experienced a number of differing emotions and therefore it was difficult for them to distinguish one from another:

> I don't know, really just worried (Quinn)

Kit preferred to express their emotions through a drawing:

> Yeah, can I just like draw a sad face (Kit)

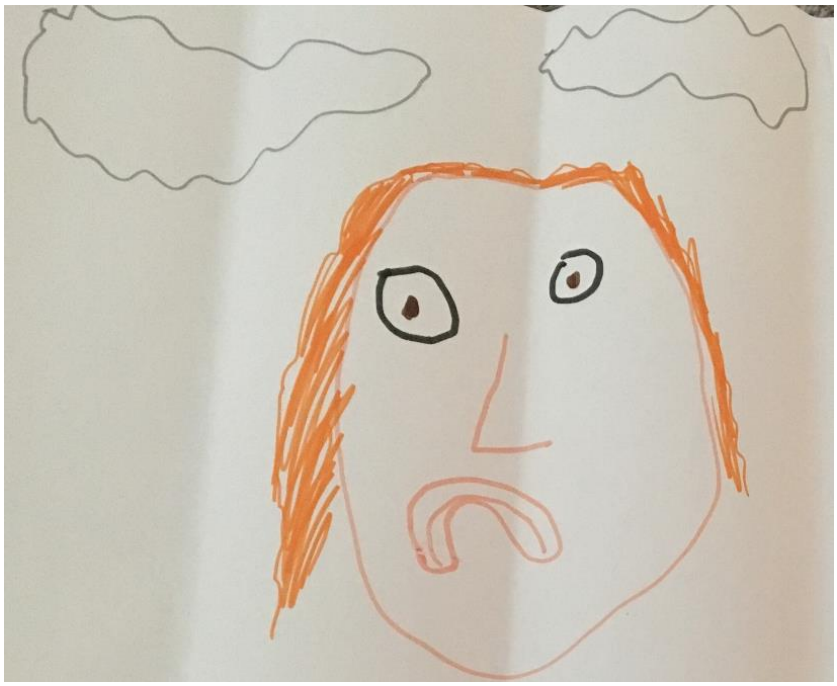


Figure 10 Expression of feeling sad and miserable by Kit

> Sad… Cloudy… miserable, is that a word? (Kit)

Taylor shared detailed descriptions of their experience of PSM, although they did not overtly specify the emotion, they were feeling at the time:

> As bad as it sounds, the first thing that pops into my head is death because every time my dad's done it, he's got sick (Taylor)

> He was on the phone upstairs and the first thing I heard was, he wasn't shouting but you could definitely hear him and he was saying we're both going to die on the same date […] and I just sat there listening. (Taylor)

Based on Taylor's reflections, it is possible to assume that the worry of death, and overhearing their dad saying to Taylor's maternal grandmother they were going to die, would have undoubtedly caused Taylor emotional distress and sadness.

Through their emotional reflections it is clear that for these children, being exposed to their parent's substance misuse provokes negative emotive responses. For some children the emotional impact is felt in a physical sense, a feeling of being in danger and feeling scared.

14.1.4- Feeling in danger and scared

The children shared many experiences of PSM including feelings of being in danger, feeling scared, as well as direct exposure to threats of violence within the family home.

Quinn's immediate response when exploring thoughts of PSM and, in this case, alcohol, was 'danger'. Quinn's experience and feelings of danger stemmed from hearing violence, hearing 'bangs' and perhaps hearing swearing and 'horrible things', as described in subordinate theme one. Quinn's description below shows they had developed their own way to cope during these incidents of danger and also, in a sense, the unpredictability of PSM:

> Just staying out of it, don't get involved, just not going downstairs, I just stay and watch YouTube until they calm it down (Quinn)

For some children, the sense of danger and feeling scared is not linked to their parent's behaviour directly but the associated danger of substance misuse. Children described associates of their parents coming to their house

and making threats. Roux shared during the interview that their older sibling had stolen a motorbike and attributed this behaviour to the reason their family had received numerous threats. Roux had been directly exposed to threats of violence, evident in their description of feeling scared:

> Scared, because he stole a motorbike, we're getting the blame for it and people are chasing after us with guns and knives and guns. (Roux)

It's not possible to know for sure whether the threats to this family's lives and the stolen motorbike are drug and/or drug debt related. That said, Roux's reflections as presented within superordinate one of the 'tiger' and of multiple adults within the home misusing substances, depict a sense of chaos within the home. It could therefore be possible that the danger experienced by Roux and sibling Cody was related to drug debts owed by their parent and/or older sibling:

> […] a person came into my house with a baseball bat and he had beer in his hand and it was really scary. (Roux)

Roux described feeling 'scared' when witnessing this incident and profoundly stated:

> A bit scared […] because erm I'm seeing it and I'm only little. (Roux)

At the time of the interview, Roux was living in a bed and breakfast out of the area due to threats to life made to their family. It was evident as Roux shared their experiences that the feeling of danger was ongoing. Despite being out of the family home and in another town, the feelings of being scared and in danger had not gone away:

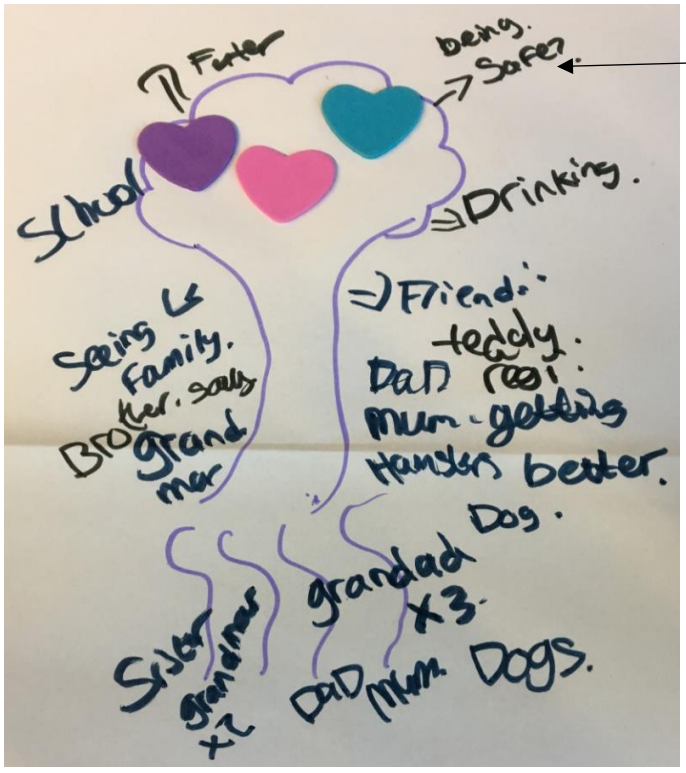
> I'm scared in case he comes and hurts me. (Roux)

In contrast, Roux's sibling, Cody, did not mention the baseball bat incident. However, they did recall another incident where their family had received threats. Cody's reflections and description of events were spoken with less

emotion than Roux; Cody appeared almost blasé about what they had experienced. Perhaps Cody felt the need to describe events in this way to lessen the seriousness, for fear of the consequences (interview confidentiality having to be broken) or perhaps they felt the need to play down their experiences due to loyalty to their parents and family. Cody described moving between their mum and dad's house due to further threats made to the family:

> So basically, I was living with my dad […] an then what happened is I moved back with my mum then we was in the house for a bit then erm I fink these guys were threatening to petrol bomb the house or something. (Cody)

Rowan recalled memories of their mum drinking alcohol and how this often led to Rowan and Kit being in situations where they were not safe. Rowan attributed feelings of sadness to feeling unsafe:



Rowan wrote their worries on the top of the tree;

'being safe'

Figure 11 Rowans resilience tree

> Being safe because when she drinks a lot like she forgets about me and 'Kit', sometimes, a couple of times I've had to like go out in the middle of the night and phone Grandma and it's like one o'clock in the morning or something. And erm she, she used to hang out with like the wrong people and things and that's why she started drinking and things (Rowan)

Similarly, to Roux and Cody's shared experiences of PSM and associated adults, Rowan identified that the adults their mum associated with was a source of worry and made them feel unsafe. For Rowan, their experience of feeling unsafe extended beyond their family home, as they described being taken to houses where they didn't want to be. This further conveyed their vulnerability and exposure to their parent's chaotic lifestyle:

> Erm like, it's like a normal house but then erm there's drinks on the table and things and like loads of glasses and erm sometimes I went to this house and there was a little baby as well and things and I felt really sad. (Rowan)

On this occasion Rowan's vulnerability and sense of isolation was apparent; Rowan had been unable to contact their grandma to come and collect them:

> we like get worried sometimes if erm our mum drinks […] like when am I going to see my family again if I'm somewhere else. (Rowan)

Rowan also wrote on their drawing of the tree, that the future was a worry for them. This was in relation to their mum's alcohol misuse and the impact this would have on whether they saw their family. Rowan's reflections suggest that PSM ignites a sense of anxiety, which relates to their feelings of being unsafe and experience of the unpredictable behaviour of the adults around them. This is further highlighted in Rowan's memory of a family holiday:

> We were at [a holiday park] one time and erm we were with my auntie and my cousin […] and my mum's friend was there as well and he was drinking. I don't know if my mum was drinking but my mum's

> friend came drunk already and then he smashed the window and then erm I just remember that ever since and erm it's just made me sad. (Rowan)

The feelings of danger, being scared and experiencing unpredictable adult behaviour were undoubtedly frightening for these children. As with Rowan, Quinn identified that 'to be safe' and in a way to be protected was hugely important for all children experiencing PSM:

> We all need this in this world, somebody to follow you around, every single day, protect you and if anyone is bothering you, they can go after them and teach them a lesson. (Quinn)

Quinn's description of needing to be protected, highlights the probable feelings of danger and uncertainty experienced because of PSM. Quinn's description also implies violence is necessary to be protected, perhaps signifying the normalisation of violence in Quinn's life.

14.1.5- Feeling isolated

Through their emotive recollections and reflections of experiencing PSM, the complexity of emotions felt by the children was evident. The feelings of danger, being scared and not being safe highlight the struggle these children have faced and continue to face. Linked to these experiences, the children who participated also identified feelings of isolation as a direct consequence of their parent's substance misuse.

Quinn shared their experiences of PSM and their learnt coping strategy to self-isolate. Quinn described how they would save money, buy food and store it in their bedroom. In the event of their parents misusing substances, this meant Quinn could stay in their bedroom and not have to go downstairs for something to eat:

> All I do when I see alcohol, I stare at it doing this (cross intense stare, signifying stare to parents) and then I just go upstairs […] I stay

> upstairs me; I don't go down […] I get a fiver sometimes for helping my nanna and I get food, take it upstairs and hide it and I get to eat that then I don't have to go downstairs. (Quinn)

Quinn indicated this was something they would have to do that evening:

> And then I can just go to sleep, like probably when I get back from here tonight, I probably just watch YouTube, get in my bed and just chill out. (Quinn)

Whilst Quinn's description could signify a level of resilience and ability to be resourceful in the face of adversity, it also highlights a sense of loneliness.

When asked how this made them feel, Quinn's response was 'scared'. Quinn had been allocated a keyworker (specialist support service) the week prior to the interview and when asked how having somebody to talk to made them feel, they responded by saying 'More nicer'.

Kit also attributed feelings of isolation to children who shared the same worry as them. Kit felt it was important that children who worried about PSM had somebody to talk to:

> […] if other children had the same problem, I think like they would just feel like they don't have anyone to talk to. (Kit)

Feeling isolated was also described by Taylor. Their description also conveyed the impact PSM had had on their daily family life:

> We don't always have family time anyway, but that's beside the point. So, I don't like talking, well not that I don't like talking, I'm just isolated because I want to be isolated, I just want to be alone. (Taylor)

Taylor was visibly sad as they described their increased isolation due to being the only child now at home, as their older sibling was living away at university.

Feelings of isolation were also felt by Charlie whose descriptions and reflections of their family life suggested they were isolated at home and that this was not something they were content with:

> I don't really do anything, like I don't really have any clubs that I go to or anything. (Charlie)

Outlined previously in this chapter was Charlie's description of caring for a younger sibling due to their parent's substance misuse. It could be possible that Charlie's feelings of isolation were linked to their caring role and was the reason they were unable to access community resources such as youth clubs.

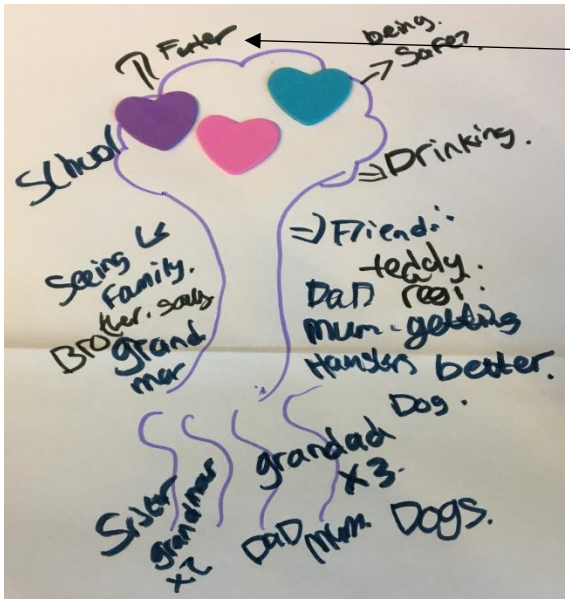
14.1.6: Feeling anxious and uncertain about the future

Throughout the interviews, the children's narrative of their experiences highlighted the complexity of emotions they felt when exposed to PSM. The experiences described by the children, were of the past and present but inextricably linked were their feelings about their future:

> Like what's going to happen in the future […] like what's going to happen if she drinks again. (Kit)

Due to increased safeguarding concerns related to their mum's substance misuse, Kit and Rowan were temporarily living with their father. At the time of the interview, they had been living with their father for almost two months. Neither Kit or Rowan knew how long they were going to be there and what would happen if they went back to live with their mum and she drank again.

Rowan's description alluded to the fact that they were also worried about the potential for dad to misuse alcohol as well, leaving Rowan with increased anxiety about what would happen if both parents misused alcohol. Rowan wrote the word future on the top of their tree, to show this was one of their worries:



I don't really know […] I get worried at my dad's as well because […] I don't know like if that (substance misuse) was going to happen again or if it was going to be with both of my parents as well […] I feel ok I just like want to know where I'm gonna be and things so that I know what's going on (Rowan)

Figure 12 Rowans resilience tree

In contrast to Kit and Rowan's reasons for feeling uncertain and anxious about their future, Cody's anxiety about their future was not related to adult behaviour but their anxiety about how they themselves would behave in the future.

Cody's description of not wanting to smoke when they are older but feeling a sense of inevitability was a clear cause of personal struggle for Cody:

> […] the thing I hate the most is smoking, like I hate the smell of it and I hate it, an I think it's disgusting and I really don't want to do this when I'm older but I feel like…I'm gonna end up doing it and I really don't want to smoke. (Cody)

The internal battle Cody was experiencing appeared to relate to the uncertainty of their current circumstance. At the time of the interview, Cody was living in temporary accommodation due to fleeing their family home. Cody's descriptions show a belief by Cody that smoking is what people do when stressed, Cody appeared to have no alternative positive coping strategy. This internal battle of not wanting to smoke, smoking being inevitable and the anxiety this caused about their future health is apparent:

> Yeah cos I know this girl and she lives in the B&B and she's only 15 and she smokes an like I feel like I'm gonna be under a lot of stress that I might start smoking […] I might get peer pressured into it […] I don't want to die I want to have a long life […] I know it sounds stupid but I don't wanna die. (Cody)

When the topic of positive coping strategies was explored, including discussion around what might help Cody to feel less worried about their future, there was a long pause before Cody stated:

> I don't know mmmmmm I really don't know (Cody)

The negative impact of living with PSM and the experienced complexity of emotional felt by children is evident. The direct negative impact on a child's mental health is depicted below.

14.1.7- Self-harming to cope

For one child, their mental health was so profoundly impacted due to their parent's alcohol misuse, they had self-harmed and contemplated taking their own life:

> I don't want him to drink but I can't stop him, the thing that is upsetting me was I had like a suicidal episode in school, so obviously they had to phone up my parents for that and then he was like well if I stop drinking will that make you feel better, and I was like probably not but I'm not going to tell him that and that yes it would make me happier because I don't want him to drink, but a month later he starts drinking again […]. I can't remember how I felt because at the time I wasn't in the best state anyway because I was self-harming, suicidal and so I was more focussing on myself than I was dad. As bad as that sounds, I was more focussing on the fact that I was trying not to kill myself rather than going back to see him in hospital all the time. (Taylor)

This powerful account from Taylor highlights the profound impact PSM had had on their mental health. Taylor reflected on this time in their life and how they had not had support from outside of their family up to this point. Taylor shared with me that they had since been accessing specialist support regarding dad's alcohol misuse for almost two years and they no longer self-harmed or had thoughts of suicide.

14.1.8- Superordinate theme 1: Summary

This superordinate theme has highlighted the emotional impact on children who are living with, and have experienced PSM. Children were often unable to fully share their lived experience due to not being able to find the words and at times being too sad and close to tears.

The shared accounts from children witnessing parents under the influence of, and taking, substances portray the complex experiences and emotional burden placed upon these children.

Alongside feelings of anger, sadness, being isolated and anxious about their future, children also shared their experiences of substance related behaviours, of possible drug dealing, domestic abuse and parental absence. The following superordinate theme will present in greater detail the experiences of children living with PSM.

Chapter 15

Superordinate theme 2: Children's experience of living with parental substance misuse

The previous chapter highlighted the emotional responses the children felt and experienced when exposed to PSM. Whilst there was a shared consensus from the children around the complexity of emotions felt, it is important to recognise that not all children experience PSM in the same way. As such, this chapter will explore additional factors related to PSM which children shared throughout their interviews. Each subordinate theme, as shown in table 6 will be presented and analysed in turn;

Table 6 Children's interviews subordinate themes 2.1-2.8

Subordinate Theme
2.1 Witnessing parental harm
2.3 Parental physical and emotional absence
2.4 Young caring role
2.5 Lost childhood
2.6 Money and limited resources
2.7 Living through ups and downs
2.8 Loyalty to parents

15.2.1- Witnessing parental harm

The interviews did not explore children's experience of witnessing parental injury, yet, despite this, children's reflections of their experiences evoked emotional descriptions of seeing their parents in poor health and/or injured due to their substance misuse.

The severity of the impact substance misuse had on parents' physical health

was clearly outlined by Taylor. Taylor had witnessed their dad having an alcohol-related seizure at home; this was undoubtedly a distressing incident for Taylor to see. Seemingly, at the forefront of Taylor's memory was the change in their dad's behaviour during this time. This change, perhaps due to damage caused by the seizure, had unnerved Taylor and they no longer wanted to visit their dad as frequently:

> He had a seizure and got taken to hospital, I didn't know until the next day. We went to visit him a couple of times and I don't understand why he was doing this but he was trying to force me to play with his phone […] I didn't want to visit him that often. (Taylor)

Alcohol appeared to be linked to parental poor health and injury; no other substance was mentioned by the children. For Quinn, when reflecting on their worst memories of PSM, their initial response appeared to be blasé, as depicted here:

> Me I don't mind if, I just think this […] if you want to drink it, yes you can, but it's her fault if she falls over for drinking it […] If I hear a bang I will go running and see what it is, I'll go downstairs racing, I'll probably break my bloody neck by falling down the stairs too. (Quinn)

However, when asked how they felt when alcohol was around them, Quinn's tone changed. In a whisper, Quinn replied 'worried'. Quinn's confidence and blasé approach quickly became increasingly emotive:

> I do remember […] I was sleeping at Nana's and I had a headache, yeah, my tummy hurt actually and I was sleeping over. I'm not allowed now an I, I don't mind. Erm an then my mum came around and she was drinking […] I was just playing on the PS3 an then, she came around with a nosebleed yeah and said she had fell down the stairs. (Quinn)

Quinn's recollection of hearing bangs and earlier reflections of needing to isolate themselves until parents calmed down, poses the question of how

Quinn's mum had sustained her injuries. It could be possible that Quinn's mum is the victim of domestic abuse and had had to flee the house to maternal grandmothers, on the evening when she suffered a nosebleed. Whilst Quinn had not witnessed the injury being sustained, to see the injury would have undoubtedly been emotionally distressing.

Charlie had also experienced witnessing substance-related injuries:

> Because there have been instances, there was one incident where she drunk too much and had fallen over and really hurt her eye and ended up having to go to hospital and have stitches and then have an operation because she really damaged the muscles in her eye. So, there's always a worry of something like that happening again […] Also, with mum one night she had been out and fallen over and then came home all black and bruised and cut and…that was quite scary as well. (Charlie)

The emotive account by Charlie of seeing the extent of their mum's injuries and the fear they felt not only in the moment but also the fear of repetition links back to previous identified feelings of anxiety regarding the future.

Charlie's description of their mum coming home and the description of mum being 'black and bruised' could suggest that mum's injuries were not sustained because of a fall whilst intoxicated, but that Charlie's mum had been the victim of an assault or the victim of domestic abuse.

Throughout the interviews, children reflected on their memories of seeing their parents injured. As outlined above, whilst children had described substance-related injuries, it is possible to assume from their descriptions that injuries may not have been sustained from a fall or an accident. Children had not identified domestic abuse explicitly; however, their accounts of hearing bangs, parents shouting and swearing, and injuries suggest children living with parents who misuse substances are also exposed to domestic abuse:

> I can hear it and it keeps getting in my head, does my head in and so I put my PS4 on and put my headphones, put loud music in my headphones and then all I can hear is my music. (Quinn)

Quinn's description of hearing noises downstairs when they are in their bedroom further supports the analysis that domestic abuse is a significant factor in the lives of some children living with PSM.

Quinn's thoughts, given below, clearly illustrate that the complexity of PSM and associate factors such as domestic abuse have a significant impact on the lives of these children:

> You need more help to stop, like say stop drinking, to stop parents from drinking because it's not very nice or right for a kid to see it. (Quinn)

Taylor shared their experience of hearing arguments between their mum and dad which were substance-related. Taylor described hearing arguments because their dad wanted 'more beer' and mum was refusing to go to the shop for him. The emotional impact on Taylor of hearing this conflict was evident in the interview, as they spoke with an apparent anger and sadness at this situation.

A further impact on Taylor was that following the conflict, Taylor's mum would not allow dad into their bedroom and so he then slept in Taylor's bedroom. This meant Taylor had to sleep either on the sofa or share their mum's bed. Taylor spoke of regularly being displaced because of their parent's arguments:

> Mum and dad argue mainly about my dad wanting mum to get him more beer (Taylor)

At the start of this chapter, Roux's drawing of the chemical tiger and their reflections of seeing this tiger put things into people's mouths, as well as being a 'bully' tiger, could suggest that Roux had also witnessed and experienced domestic abuse. It is not clear from Roux's reflections who the

bully tiger is; however, it is possible that Roux has witnessed their mum being coerced into drug taking. Roux's use of the word 'hurt' is also significant and signifies they may have witnessed violence.

Although children did not explicitly identify being exposed to domestic abuse, as outlined above this is a very real possibility. Their reflections and recollections of memories but also of current and future concerns have been linked to feelings of anxiety due to the unpredictable nature of PSM. Children experiencing unpredictable behaviour is further depicted in the next theme which explores the experience of children when their parents are absent.

15.2.3- Parents physical and emotional absence

For children living with parents who misuse substances there were times when they didn't know where their parents were and if they were safe. The anxiety this caused is illustrated by Charlie:

> […] my mum […] a lot of the time the worry is she'll go out and probably be drinking and then her phone will end up running out of battery or she'll put it down somewhere and I won't be able to get hold of her an I don't know where she is and so I'll be at home, usually on my own with [sibling], erm, not knowing where she is and not knowing if she is coming back, if she's gonna get back […] that's when I really worry (Charlie)

Charlie reflected on times when they had been left overnight, due to mum staying with friends or her boyfriend. It wasn't until the following morning or day that Charlie knew if their mum was ok and where she had been.

The pressure on Charlie to cope during these incidents of mum being absent were evident through Charlie's reflections of needing to reassure their younger sibling that everything was going to be ok. Charlie's descriptions highlight the emotional maturity Charlie had to present to their siblings; in essence Charlie was putting on a brave face, perhaps to the detriment of their own emotional health.

A further concern for Charlie during these periods of absence was the impact of trying to cope with their older siblings' behaviour with mum gone. Charlie's older sibling (aged early twenties), had been hospitalised on a number of occasions in recent years because of struggling with their mental health and continued cannabis use. Charlie's mother's absence resulted in additional caring responsibilities not only for their younger sibling but also being left in a position of responsibility to care for other substance users in the household.

Rowan shared similar accounts of being left for periods of time and not knowing if or when their mum was going to return. Rowan's memory of being poorly and needing their mum, highlighted the increased vulnerability of Rowan, not just because of their age, but also due to having been left alone when unwell:

> Then the other time was when I was poorly […] it was in the morning and my mum took [Kit] to school and then I was left by myself for like 4-5 hours and I didn't have any credit on my phone and I couldn't ring anyone. But then I went to my neighbours and erm asked to use the phone to phone my grandma and she came and picked me up […] I thought she had just gone shopping but she was being a really, really long time and I, that's why I had to phone grandma […] it was like making me really sad because I was just looking out the window and she wasn't there and so it made me a bit upset. (Rowan)

Rowan also recalled a time when they had been waiting at their dad's house for mum to collect them, as they were going on holiday. The excitement of going on holiday was dashed when their mum came to collect them and it was then too late to make the holiday:

> It just happened when my mum forgot to take us on holiday and we were at our dad's and she came back late, well she didn't come back to take us to our holiday. (Rowan)

Parents being absent from their children due to misusing substances away from the family home could indicate parents' attempts to shield their children

from their substance misuse. Whilst this may be the case, it is clear from the descriptions of these two children that parents being absent has a profound impact on their emotional wellbeing.

For some children the impact of their parents misusing substances is not the physical absence but more so the emotional absence and inconsistency in their behaviour towards their children. Taylor shared their emotional reflections of their dad's substance misuse and the changes in behaviour they endured during his relapses.

Taylor spoke with heightened emotion; they were visibly angry and teary-eyed as they shared their reflections with me. Taylor explained that they had come home from school to find the door to the house open. Taylor was angered that they were in trouble for leaving their house keys in the door, despite dad having been 'drunk', asleep and having left the door wide open. There was an apparent frustration shown by Taylor, that it simply wasn't fair that they had been shouted at for a mistake:

> […] not only had I left the key in the door when I'd left that morning, he was pissed off at me for that despite the fact that it was only a mistake and he'd left the door open, despite the fact that he was drunk and clearly could not defend the house if you know someone tried to break in. (Taylor)

Taylor explained that, when their dad was not drinking, he was very 'touchy-feely', he was always wanting to give cuddles whilst watching TV. Taylor laughed at how annoying this could be and how when dad was drinking this gave them some respite, as dad would isolate himself to drink. However, Taylor was beginning to notice that even when dad was not drinking, he appeared to no longer want to spend time with Taylor:

> It's like my dad's really touchy-feely so it's a slight positive because it means my dad stays upstairs and he isn't going to start asking me to stay with downstairs or anything like that. Even then he doesn't really

> try any more anyway…he doesn't make a massive deal about it anymore. (Taylor)

Like Taylor, Quinn had also experienced inconsistency from their parents in relation to their emotional availability. Fortunately for Quinn, their dad had recently reduced his alcohol misuse and Quinn now felt that they could confide in dad. Had Quinn's dad not been able to achieve a reduction in his alcohol use, it is possible that Quinn would not have had a parent who was able to be emotionally available for them or able to ensure their day-to-day needs were met.

This is even more significant given Quinn's difficulty with speech and language, suggesting that at times when both parents were misusing alcohol, there would not have been an adult available at home to support Quinn with their school work and exercises to encourage speech and language development:

> Well my mum drinks alcohol all the time as you know and she's trying to calm it down you know, I trust my dad […] Her drinking say now yeah, well I'd rather talk to my dad and then if my dad's drinking, he used to but now he don't, I'll talk to mum, yeah. (Quinn)

Similarly, to Quinn, Cody had experienced inconsistency in relation to their parent's availability for them. Cody's use of the words 'most of the time' suggest there are times when they are unable to confide in their mum. If Cody's mum, as with Quinn and Taylor's parents, are not approachable, then it is possible that these children are at times unable to not only confide in their parents but seek comfort, guidance, receive appropriate supervision and receive consistent emotional warmth:

> Well say like it was about drugs or anything it would be a bit weird to talk to her about it but most of the times I can tell my mum. (Cody)

The reflections from the children illustrate the impact PSM has on their parents physical and emotional ability to respond to their care needs. When

parents are not able to fulfil their parenting role, the role of caring fell to their children.

15.2.4- Young caring role

It is evident from the children's reflections that due to parents' physical absence and inconsistent parenting due to their substance misuse, children were frequently taking on a caring role to young siblings.

As outlined previously, Charlie and siblings had experienced periods of neglect due to their mum's physical absence. For Charlie, this meant being in a position or role where they were the one having to comfort and care for a younger sibling. Charlie described that this had happened on school nights, suggesting that they were not only having to meet their own needs in getting themselves ready for school but having to ensure their sibling was ready for school also (this is explored further in subordinate theme 4.1):

> It's sort of trying be a bit brave so [sibling] doesn't get upset, and having to look after [sibling] (Charlie)

Charlie also described their increased caring role and need to offer comfort to their younger sibling in an attempt to lessen their worry. Especially when their mum had been absent and returned home with visible injuries and when their older sibling had also been misusing substances or their mental health had declined:

> A bit worried and a bit scared seeing mum and my brother like that erm a bit trying to keep [sibling] not worried so erm looking after her a little bit […] An then maybe also sometimes [sibling] can be very forgiving [...] When sometimes erm I can be less forgiving on mum if she's done something and left me and [sibling] alone in the house and I've had to look after [sibling] (Charlie)

Despite being only 8 years old, Quinn had learnt how to care for their younger sibling when parents were misusing alcohol. Quinn had learnt

strategies to safeguard themselves in terms of not picking up drinks in the house without smelling them first. Quinn had learnt the difference between 'fizzy pop' and fizzy pop that had alcohol in it. Quinn was teaching their 6-year-old sibling to smell the drink first and not just to drink it:

> They get different ones, they get dark ones and they put coke in it […] I need to sniff it to see if it's coke, if they hold it for a minute, whilst they're not looking I sniff it to see if it just coke and then I get a whiff of it and then I do this (holds nose and shakes their head). (Quinn)

As they were sharing with me their learnt strategies to test the drink, Quinn looked full of pride as they explained how they were keeping their sibling safe and teaching them to smell the drinks:

> And does [sibling] know to sniff it and not just pick it up, because she's only little. (Interviewer)

> Yeah we are trying to tell her that […] if she wants coke I'll go and get her some (Quinn)

The children's reflections of their caring role highlight both the physical aspect of keeping young siblings safe but also of helping to ensure their siblings emotional safety through comfort and reassurance. This undoubtedly places a heavy burden of responsibility on these children to undertake roles, perhaps associated more so with adulthood. The following subordinate theme explores in further detail the sense that for many of these children they had to become mature beyond their years.

15.2.5 Lost childhood

As the shared experiences from children illustrate above, PSM had a significant impact on children and their increased caring role. The children's descriptions also illustrated the maturity they had had to develop, during times when their parent's substance misuse had increased.

For Charlie their caring role had meant they had grown up quickly, perhaps more so than their peers, with their perception being that due to PSM they had had to become ‘a bit adult’:

> I think it’s probably made me quite responsible, because I have to be a bit adult and look after [sibling] sometimes and be quite mature about it. I think that’s a good thing in a way that it’s made me more mature. (Charlie)

At aged 16, Charlie had begun to notice a difference between themselves and their peers. Their caring role and precocious maturity appeared to set Charlie apart from their friends. Perhaps not simply due to Charlie being mature beyond their years but because of their negative experiences of substance use, Charlie was finding socialising with friends increasingly troublesome:

> Sometimes, because of the experiences I’ve had, can make me a bit […] bit worried and a bit angry about people using drugs and alcohol because obviously I’m thinking about the long-term effects it can have, seeing people being irresponsible […] so I’m at a party and people are drinking, sometimes I feel a bit like well that’s irresponsible because you don’t know the effects that can have on you in the long-term. (Charlie)

Similarly, knowledge of substance misuse appeared to influence Cody’s advanced maturity. Cody shared a belief that all children should have knowledge of substances, as there was a risk they could take a substance, mistaking it for a sweet:

> Like see I’m not stupid, I know stuff like this, like some kids don’t know and they’re like oh my god I don’t know what that is […] I think like kids should know about it because someone could give it to em and they’d be like ahhh thanks for the sherbert. (Cody)

Cody spoke of parents trying to protect their children from seeing drugs, but felt strongly that children needed to know what drugs were and the dangers. Cody's (aged 11) description outlined previously of crack cocaine, coupled with a belief that children needed to know about drugs, suggests Cody's has knowledge beyond their years, as a consequence of the adversity they have experienced due to PSM:

> Yeah like I think more kids should know about it. (Cody)

Cody's description and sense of self in relation to their advanced maturity could be perceived to be a positive attribute. As with Quinn having learnt to test drinks before drinking them, Cody's knowledge of substances appears to be an internal safeguard. Whilst Cody and Quinn may have developed strategies and knowledge which could demonstrate a certain level of resilience, this does not address the emotional impact of what they are seeing and hearing.

15.2.6- Money and limited resources

It became apparent through the children's reflections and emotive talk that living with a parent or parents who misuse substances had increased the children's need to act and respond, 'to be a bit adult' (Charlie). Being mature beyond their years and needing to develop strategies was apparent when resources at home were impacted on.

Charlie identified money was a significant factor when their mum had lapsed, leaving the family with little monetary resource:

> I'd probably say money, money has been a little bit because if mums using all her money in the wrong way. (Charlie)

For Rowan their parent's substance misuse had also impacted on family finances. Prior to moving to live with their dad, Rowan and Kit had experienced being unsettled and had had to move home. It is not clear why this was the case, but it may have been related to substance misuse. Rowan

and Kit's mum may have been unable to pay rent on their home as their mum had lost her job, but Rowan was keen to mention that she had started work again:

> An then we moved to a flat and it was cheaper and erm like now she works more, well she doesn't work more but like she works. (Rowan)

As depicted previously, the children's experiences of PSM had forced them to become resourceful, to develop ways to survive in the face of adversity. For Quinn this was evident in their description earlier of hiding food in their room. Quinn had also come to learn that if there was little food at home, then going to their nana's house was an option.

> Well no but they do worry about food […] say like we haven't got enough food I'll go to my nana's and get fed. (Quinn)

Whilst this is positive for Quinn, it is unclear whether Quinn's siblings were also able to get to and from nana's house if they had gone without food. This raises the question of whether Quinn was having to care for their siblings and ensure that they too had eaten.

Linked to lack of food and financial hardship, the financial impact of PSM also meant that children were often unable to experience positive activities. This is evident in Cody's description of their love of sports and sheer excitement for the future:

> Oh my god if somebody took me swimming, I'd love that. I love swimming I just love it. I could stay in the pool for hours and hours and hours […] yeah, I love cricket and rounders as well (Cody)

Cody had been promised by their dad that they would take them to martial arts classes (MMA). This was something that Cody felt would help with their feelings of anger. Although the promised classes had not yet materialised, there was a sense that Cody believed this would happen one day:

> Yeah my dad's well don't tell anyone but my dad's gonna try and look for MMA places for me and see how much money it is and then he's gonna try and pay for it if he can but he said he doesn't want anyone to know. (Cody)

Cody also shared their knowledge of local activity centres; perhaps they had overheard of such places from friends. Cody began to describe a trampolining centre but from their description it appeared Cody hadn't been there, although this was something, they felt they would enjoy:

> I don't know but like there's this place called Jump Heaven an it's so cool and when I go places like that […] (Cody)

When asked why this place and activities were important to Cody, they confirmed it would take their mind off things. Other children were more fortunate, in that when they experienced hardship, they had family members whom they could rely on for practical support (this is explored in further detail within superordinate themes 3 and 4).

Charlie was able to contact their dad during times of crisis and hardship. They also had the opportunity to be able to have a break from their home life to have weekends at their dad's house:

> I'm quite lucky at the weekends to be able to go to my dad's and to be in a completely different environment and to be completely out of it an have a break. So, I'm really lucky I have that and also my dad's quite supportive as well when things are happening, he's always at the end of the phone. (Charlie)

Similarly, Rowan also had extended family who offered support and enabled Rowan and their sibling Kit to have opportunities to experience positive family activities:

> my uncle he didn't take it too well at the start because he went and he shouted at mum and things but now like they're best friends and I'm

> actually going to see him with my mum and having Japanese food in town. (Rowan)

The impact of PSM on the lives of children has been identified in relation to their caring role, early maturity and experienced hardship, which has limited the availability of food and positive life experiences. Through their shared stories and reflections, it is clear that the negative experiences are not persistent and there are times when family life is less worrisome.

15.2.7- Living through ups and downs

Through the children's reflections of their experience of living with PSM, it was evident they experienced 'ups and downs' in relation to whether their parents were misusing substances or not. For some children, not experiencing PSM persistently may allow for some respite and, in a sense, some time to re-charge their batteries. Yet, for some children, having to experience ups and downs depended on whether their parent was misusing substances or not and could increase their anxiety. Not knowing whether their parent was going to relapse would understandably create uncertainty and unpredictability and perhaps would be even more difficult for younger children to comprehend:

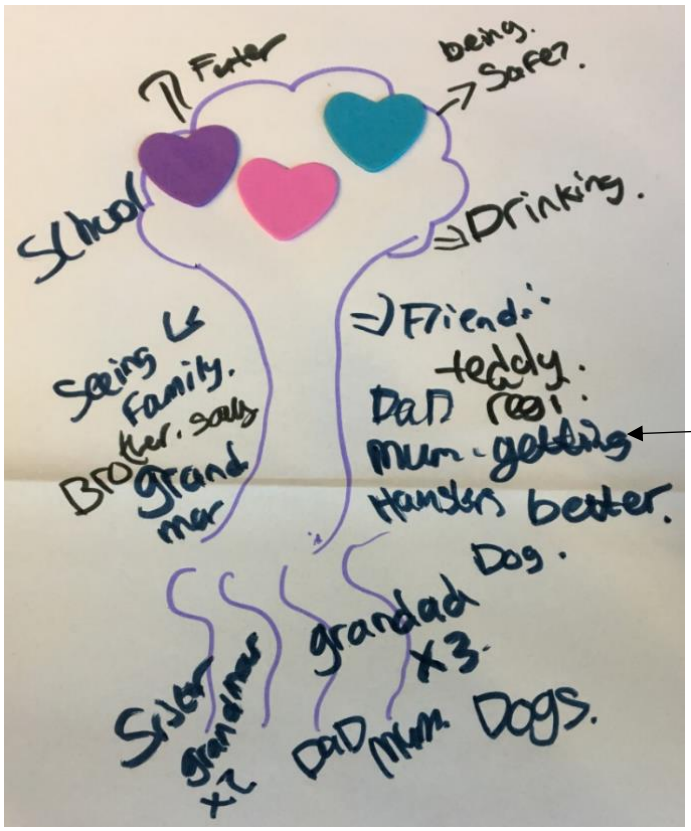
> It's usually the good times, like Christmas or birthdays, that he starts drinking and then doesn't stop […] At first, when I was younger, I didn't understand what was going on. Then when I got older I started to understand it. (Taylor)

Rowan had experienced significant ups and downs and had recognised the six-monthly cycle their mum seemed to follow:

> It stopped for like 6 months and then the first time it happened it was a couple of years after, actually it happened when my mum and dad first split up she just like drank a lot but then she stopped […] because she was just like getting over my dad and mum breaking up…so like 6-12

months it stops and starts again that's usually when it happens. (Rowan)

When talking about the ups and down of their mum's cycle with alcohol misuse, Rowan wrote on the trunk of the tree, they wanted their mum to get better, as this would help them to feel strong: (Rowan)



mum getting better (Rowan)

Figure 13 Rowans resilience tree- mum getting better

Alongside the differing levels of substance misuse, Charlie linked their mum's absence to increased concern. Charlie highlighted that although mum being absent happened 'every so often', it is without doubt that when incidents of increased substance misuse occurred, these would have had a significant impact on Charlie's emotional wellbeing:

> There's like drinking when mum will have just like a few drinks and that's not an issue at all but sometimes if its erm, she'll go to her boyfriend's house and erm and every so often we won't be able to get

> hold of her. Probably because she's been out and that's only like, that's only happened a few times in the past few months. (Charlie)

Charlie's experience of ups and downs were not just in relation to their mum's substance misuse but their older brother's as well. This meant not only Charlie living with two adults misusing substances but having to endure two different cycles or patterns of substance misuse:

> With my brother, it was quite a big worry because he was using drugs and then he was actually in hospital and was sectioned, probably a lot to do with his drug use. He had a manic episode, so then he was sectioned and ended up staying there for about a month. Erm, after that his behaviour has sort of been very different, erm, so a lot of it is about worrying about if he starts using alcohol, using drugs again, if that could happen again. (Charlie)

The impact of continued ups and downs was evident for Taylor as their family had, in a sense, given up hope of change being sustained. From Taylor's emotional account it was clear that the continued ups and downs of dad's alcohol misuse had led to family conflict and a strained relationship between Taylor and their mum:

> I wasn't that worried, it wasn't as bad as previous times and to be honest it's just got to the point where I can't care about it and if he wants a drink and to kill himself then he can do that. Sure, I don't want him to die but if he's going to drink and if he's going to continue, if he's gonna continue that way we can't stop him so what's the point in worrying about it. He has to stop on his own. (Taylor)

The impact on Cody of their parent's substance misuse also appeared to be an up-and-down experience. PSM was not persistent in Cody's life, however, what was apparent was Cody's experience of an anxious wait, not knowing if their mum was going to relapse. Cody described how they felt when waiting to move to temporary accommodation and their dread that due to the stresses of their circumstance this would lead mum to misuse substances:

> Well, I thought when we got there that mum was gonna be like doing loads of alcohol and everything cos she was too stressed but she didn't…I thought she was gonna be drinking an everything and doing alcohol but she's not (voice tapers off to a whisper) an she's doing that for her kids I guess. (Cody)

Cody was also keen to tell me that their mum's substance misuse was no longer a worry for them. Cody appeared guarded and didn't want to explore their thoughts and feelings about substance misuse any further. Cody's mum may have achieved abstinence but it may also be that Cody's awareness of professional involvement was heightening their awareness of the potential consequences for disclosing information:

> Was a big thing but it's not anymore…it's like it gets around like she's on stuff but she's not like that anymore, she's fine now (said sternly). (Cody)

Experiencing the ups and downs of parents misusing substance and, at times, being able to remain abstinent, demonstrates a further emotional layer for affected children, compounding their experience of life being uncertain and unpredictable.

15.2.8- Loyalty to parents

Despite the negative impact of living with a parent who misused substances and the complexity of the emotional roller-coaster these children had endured; it was clear throughout the interviews that children were loyal to their parents. As children shared their reflections of PSM and associated experiences, they often stressed that their worries were in the past and parents had made positive changes.

As Kit began to share their story using their drawing of the donkey, their sadness was visible and their story changed quickly, from that of describing their mum's alcohol misuse to stressing that this hadn't happened for a long time and mum was still able to take care of them;

Figure 14 If alcohol or drugs could turn into an animal by Kit

> Ermmm it's still quite like looking after me, it's just different […] You know about the last question about the donkey, well erm like the last time she drunk it was probably, actually like I can't remember, not like a long time ago but like just she's not done it for like 5 months. (Kit)

Kit's need to tell me that their mum had not 'done it' for '5 months', despite having to move to live with their dad only two months previously due to mum's alcohol misuse, suggests Kit felt compelled to protect their mum. Kit struggled to verbalise their thoughts and feelings about alcohol, their voice often tapered off into a whisper and, at times throughout the interview, they looked close to tears.

Similarly, Kit's older sibling Rowan shared information about their mum's substance misuse before quickly stressing how well their mum was doing:

> Oh wait yeah yeah and she volunteers an things as well like she helps the homeless and is err she's doing [charity] projects or something and she goes to alcohol meetings everyday or something I don't know

> about it […] but she hasn't been drinking for like well like months or something. (Rowan)

During the first half of the interview it was clear Cody was struggling emotionally. Their communication was closed; Cody would answer a question about substance misuse with the words 'nothing' and 'No'. Perhaps for Cody the stakes were just too high; it's possible that Cody understood the seriousness of the involvement of social care and the consequences for their family should they disclose too much information. Or it is possible they were simply being loyal to their mum and finding it too difficult to talk openly, as talking openly would test this loyalty. Only through exploring their support networks, and towards the end of the interview, did Cody appear to let their guard down:

> Yeah, cos she like used to go out every night and as soon as I was waking up she'd be coming in an going to bed and my dad had to, like don't get me wrong mum would clean the house still and she was still like helping my dad get clothes ready even when she was drunk, but she wasn't a nasty mum or owt like that. I used to always ask my dad what was wrong an he was like mummy's just tired because that's what you do in't it. But she's not like that anymore. (Cody)

Throughout their interview, Charlie had been notably more descriptive and open about their experiences in comparison to younger children who participated. Despite this level of openness and detailed reflections, Charlie appeared compelled (as with the younger children) to stress that their worries were not in the present:

> Probably more past worries, but a little bit ongoing. (Charlie)

15.9- Superordinate theme 2: Summary

This superordinate theme has presented the detailed and emotive accounts from children, of their experiences of living with parents who misuse substances. Children's reflections and shared experiences highlight the often-unpredictable nature of PSM.

Emotive descriptions from children highlight what they see, hear and endure in relation to domestic abuse, inconsistent parenting and the impact on family life. The findings highlighted the uncertainty in children's lives, the impact PSM had on children's caring role and their need to protect and care for younger siblings. The need to care for younger siblings and their apparent maturity, highlighted how children had little choice but to be older than their years. The children's reflections and shared accounts also highlighted the financial hardship they felt as well as having limited resources. Meaning children appeared to have little respite from their home life and worries of PSM.

Table seven (below), illustrates the complex and multiple risk factors each child experienced due to their parent's substance misuse.

The children's lived experience also highlighted their strength, maturity and strategies to cope. The following superordinate theme presents factors that support children to cope and to feel supported.

Table 7 Identified risk factors associated with PSM

Child Participants	IDENTIFIED RISK FACTORS																					
	Parental Substance Misuse (PSM)	Parental Mental ill-health	Absent parenting	Abandonment	Parental separation	Witnessing/ hearing Violence	Domestic Abuse	Family conflict	Multiple adult substance misuse	Physical neglect	Emotional Neglect (low warmth)	Young caring role	Parent hospitalised/injury	Child self-harm	Isolation- limited support	Financial hardship	Homelessness	Not in Education	Lack of positive activities	Threats to life	Victim of Bullying	Perceived Maturity	Communication difficulties
Kit	●	●	●	●	●	●		●	●														
Charlie	●	●	●	●	●			●	●	●		●	●									●	
Taylor	●	●	●								●		●	●	●								
Rowan	●	●	●	●	●	●		●	●	●		●										●	
Roux	●				●	●	●		●						●	●	●	●	●	●			
Cody	●				●	●	●		●						●	●	●	●	●	●	●	●	
Quinn	●					●	●		●	●		●	●		●	●					●	●	●

Chapter 16

Superordinate theme 3: Understanding children's support needs from within their immediate environment

The previous two superordinate themes have identified and explored the emotional responses and experiences of children living with PSM. This superordinate theme identifies the concept of support from within the family and protective factors. The subordinate themes as shown in table eight below, will explore what children feel they need to feel supported and able to cope.

Table 8 Children's interviews subordinate theme 3.1-3.5

Subordinate Theme
3.1 Non-substance misusing parent
3.2 Grandparents and extended family
3.3 Importance of friendships
3.4 Importance of family pets
3.5 Need for a stable home

16.3.1- Non-substance misusing parent

The uncertainty and unpredictability that children living with PSM experience have been highlighted in previous superordinate themes. Throughout the interview's children spoke of the importance of trusted adults in their lives, adults whom they could turn to in a time of need. For many children, having a parent who didn't misuse substances was a critical lifeline, for both practical and emotional support.

Kit had struggled throughout the interview to explore their thoughts and

feelings about substance misuse itself. As previously outlined, this was perhaps due to the fear of sharing too much information and the possible consequences this would have for not being returned to their mum's care. When exploring support networks and what would help Kit to feel they could cope, Kit appeared to find this topic much easier to explore.

As shown on the drawing of the roots (support network) below, Kit shared with me the importance in their life of their dad and dad's partner:

My dad […] and probably my sister, I'm just gonna write sis. (Kit)

Figure 15 Kit's resilience tree

Similarly, Charlie explained that although they did not live with their dad, they saw him every weekend and as well as being able to provide practical support for the family, he was always at the end of the phone for Charlie:

> Obviously, there's my dad who works away in the week […] I see him at the weekends, erm, he's quite good. Him and mum were married for quite a while and so he does understand, my brother and me have different dads but my dad took a big role in raising him so he knows us all quite well. He's very supportive with [older sibling] he helps my mum with money and stuff, keeping organised, he's very good at that. Even if I can't see him every day he's always at the end of the phone. (Charlie)

The importance of having a parent who doesn't misuse substances is evident from Charlie and Rowan's accounts. However, Charlie's reflections highlight the reality of parents being able to offer support when they no longer live in the family home. For Charlie it was clear that due to their mum and brother having been hospitalised due to substance-related physical and mental health needs, Charlie was understandably anxious about how they would respond and what they would do in an emergency scenario:

> If he's not there then I have to be responsible and so obviously if I didn't know what to do, then that could be really, really dangerous. (Charlie)

Charlie identified a gap in their knowledge and stated that if they had been taught first aid then this may have alleviated some of their anxiety in the event of an emergency at home:

> I think if people understood more, they'd be able to know how to help. For example, if like a first aid was to do with alcohol and drugs, a bit more like widely taught. (Charlie)

For Taylor, their mum was the non-substance misusing adult in the family home and whilst it is likely Taylor's mum was responding to Taylor's practical day-to-day needs, Taylor's emotional health needs were not being met. Taylor's account of having to keep their dad's alcohol misuse a secret, suggests they were placed under unnecessary pressure and unable to confide in trusted adults:

> My mum's not helpful, she wants me to keep it a secret and not tell anyone and just keep it to myself. (Taylor)

On the surface, it may appear that these children have appropriate support but what is evident from their descriptions is that support within the family home may not always be reliable and appropriate.

16.3.2- Grandparents and extended family

Children's reflections of their support networks highlighted the important role grandparents played in their lives, both for practical support and for emotional comfort, during times of need. Taylor described the importance of their relationship with their paternal grandad and his close proximity to where they lived:

> […] they don't live with me, they visit a lot…my grandad is probably the person I have the closest bond with in the family […] he lives on the opposite side of [town]. Grandad and [cousin] I feel like they're the only people I can really trust. (Taylor)

This meant that Taylor could walk to grandad's house after school if needed. Taylor shared that this was something they had to do on a number of occasions when their dad had been drinking and mum was still at work.

Taylor also reflected on their relationship with extended family. Of particular importance to Taylor were their older siblings and their partners, who Taylor had been able to learn to trust and confide in.

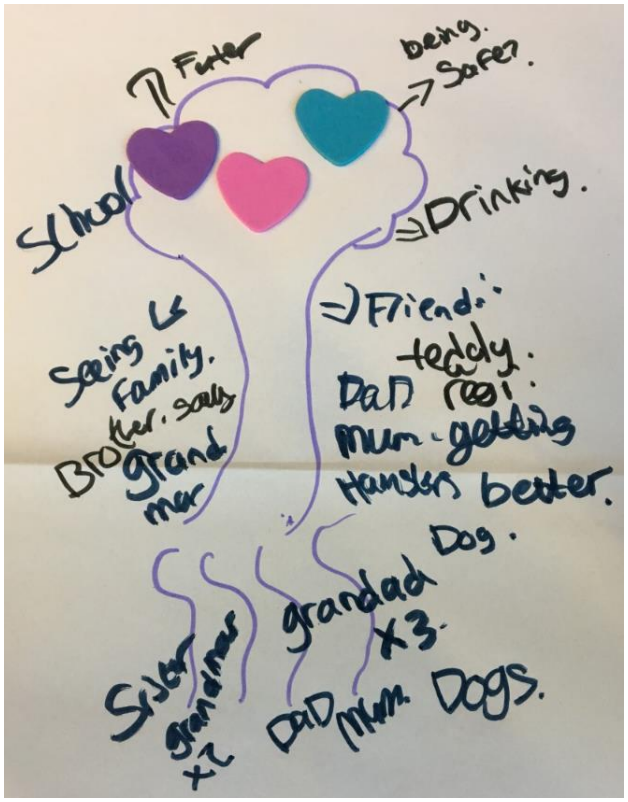


Figure 16 Rowans support network

Rowan also reflected on the importance of family relationships, in particular their relationships with their grandparents. On the roots of Rowan's tree (figure 16), they wrote 'sister', 'Grandma x2', 'Grandad x3'. 'Mum', 'Dad' and 'dogs'. Rowan appeared keen to tell me all about their family and most noticeable was their animation as they shared with me the characteristics of each grandparent.

In times of crisis, such as being taken to houses where adults were misusing substances (outlined in subordinate theme 1.4) or their parent being absent and being left alone, Rowan knew which grandparents to call upon. Rowan identified one grandma for cuddles and one grandma who could help in an emergency. It was this latter grandma who Rowan phoned to come and collect them:

> Yeah and also my grandma [A], my dad's grandma she has started to like erm like ask me stuff. She like is the cuddly one because my grandma [B] just helps, she doesn't really like the cuddly one. (Rowan)

Rowan spoke positively about their family's response to mum's substance misuse; this appeared to please Rowan as it was clear from their descriptions that they didn't want anyone to think badly of their mum:

> I think they're quite supportive of erm mum because they know that she has troubles and things and that she gets depressed really easily and things (Rowan)

Rowan was keen to tell me about lots of people in their family. Although there were many adults in their family, from Rowan's description there was a sense that the presence of many adults didn't necessarily equate to having a robust support network. Perhaps Rowan's honest reflections of their experiences were an attempt to reassure me that they had support. However, from Rowan's descriptions of their family, it appeared there was only one grandma whom they could rely on in a time of crisis:

> […] I have like 3 or 4 grandads […] He doesn't really like responsibilities of people to have to look after […] my other grandad is err he just plays and things my great grandad well he's a bit cuddly. (Rowan)

Quinn also shared during the interview that their nana was especially important to them. However, Quinn also shared that they were no longer able to stay overnight with them and she didn't come to the house as often anymore. Prior to the interview, Quinn's keyworker had informed me that maternal grandmother had been supplying Quinn's parents with alcohol and drinking with them.

The complex nature of PSM in relation to associated risk factors such as domestic abuse, threats of violence and the complexity of emotions experienced by children has been outlined. The complexity of substance misuse also runs into family relationships. As depicted above, children, through no fault of their own, are often in the middle of these conflicts and have no control as to whether trusted adults can be relied upon. Perhaps because of this level of uncertainty of the availability of adults, children find themselves building their own network. For many children, friendships appeared key to their emotional wellbeing.

16.3.3- Importance of friendships

From the youngest to the oldest child participant, friendships were a significant, and much needed, source of comfort and escape. Not all children needed to be able to confide in their friends; for some children their friends not knowing their circumstance was their preferred choice as they wanted their friendships to be just about fun, as shown by Quinn:

> All my mates do is we just have a laugh […] I got my friends, my mate yeah, I got three mates, like my best mate, he is so the best and a very fast runner. My mate can do anything, he don't hurt them, he just tell them to go away. (Quinn)

Rowan was extremely excited to tell me they were having a friend to sleep over that Friday. It's possible that Rowan was unable to have friends to stay whilst living with their mum, due to mum's substance misuse, and this would explain why they were so excited to now be able to have a friend to stay:

> [they] might be staying over at my house on Friday (Rowan)

For some children, their friendships were a valuable source of support, as their friends were children who they could trust and who they could confide in. Kit shared their friend's name and wrote it on the roots of their tree; having a friend who knew their mum and their circumstance was important to Kit:

> This is another friend who knows my mum, a friend in school (Kit)

During family conflict or strained relationships with trusted adults, friendships were a valued lifeline. Taylor explained the difficulties in the relationship with their parents. It seemed Taylor's mum was beginning to isolate herself and was emotionally detached from Taylor, meaning friendships were even more important:

> I don't think she's ever really shown any proper love or anything, so of course I told my friends because I needed the support…Yeah and like it's not like my friends are gonna think or bring shame or anything, they

> just wanna help me […] even if I don't talk to them about it, just being there with them, makes me happy. (Taylor)

Friendships for Charlie appeared to support their sense of self, to be more than a young carer and their mum's child. Time spent with friends allowed them to be their own person:

> I know I can talk to them if I needed to, so I'm quite lucky in that respect […] I have them if I need to talk, if I need to but then again it's nice to have that separate to be able to be sort of just being me without having to be like my mum's [child]. (Charlie)

The only two children who didn't mention their friendships were siblings Roux and Cody; both these children had only just returned to school after months of absence and continued to live in temporary accommodation. It is likely that moving home, school moves and poor school attendance had meant they were separated from friends or did not have stability for long enough to form strong bonds with friends.

16.3.4 Importance of family pets

When exploring support networks with the children, many shared their view that their pets were sources of comfort. For some children, having a pet was as important as having a trusted adult in their life:

> They're family, a teddy or a dog or like a pet you can hug, they're like mum and dad, or social workers…because they can help (Rowan)

> Dad, my annoying sisters and my annoying brother […] an then maybe erm my wabbit and my tat and that really it (Quinn)

Children's ages did not appear to be a factor in whether pets were seen to be important; children of both primary and secondary school age identified their pets as being important in their lives, especially when they needed comfort:

> The cat he's just a cuddle monster, he used to be really, really feral not like massively feral but he would jump at my face a lot and now he's just a cuddle monster and he's adorable (Taylor)

Rowan's pet hamsters had died just before they moved to live with their dad, Rowan was visibly upset when sharing this. The uncertainty of where they were going to live meant they couldn't have a new pet at the moment, but this was something they hoped for:

> My hamsters, well I don't have hamsters anymore but erm they died just before I moved to my dad's, but I'm getting another one when I go back to my mum's, well when I visit even if I don't live there, I might still get one. (Rowan)

Through the children's reflections of their experience of living with parents who misuse substances, the importance of a robust support network and additional protective factors such as friendships and pets was evident. For some children the instability of their living arrangements impacted on the availability of such protective factors.

16.3.5- Need for a stable home

The impact of the uncertainty and unpredictability of living with parents who misuse substances is documented throughout this chapter. Further compounding children's feelings of isolation, the uncertainty and inability to seek support is identified within this theme. Children shared their experiences of being uprooted and not knowing where they were going to be living.

Kit and Rowan had recently gone to live with their dad due to mum's alcohol misuse. Rowan, being the older of the two siblings, was aware that there was a court hearing looming and they shared their anxiety about not knowing what was going to happen:

> Because I don't really know who I'm living with, I live with my dad at the moment but I don't know when they go back to court, I might go back to mum I don't know (Rowan)

Kit shared the same anxiety about their future, Kit described not knowing what would happen if they went back to live with their mum and she drank alcohol again:

> I'm living with my dad now […] like what's going to happen if she drinks again (Kit)

Siblings Roux and Cody shared their experience of living in a bed and breakfast and their struggles to adapt to life, which was so different to being at home. Roux, Cody, their mother and siblings had fled their family home due to threats made against their lives. Professionals involved in supporting the family, including the police suspected that the threats to the family were related to drug debts and theft.

As outlined previously, the family had had to flee because of threats made to their lives; the family didn't know how long they would have to live out of area, in the bed and breakfast (B&B):

> I live with my mum, [siblings] erm and a lot of other people […] It's like a hotel it has upstairs and a downstairs (Roux)

> I live with my mum now an we live in a B&B erm it's alright but the thing that's really annoying is, you're not allowed in the dining room past 10 you're not allowed outside past half 8. You're not allowed to use this bathroom because you're not in the same room or something and you're not allowed out by yourself or anything basically. You have to go everywhere where your mum is basically it's like she has to be stuck to you like glue (Cody)

Although the security of being in the B&B appeared appealing for Cody, they were struggling with the change in lifestyle and the apparent endless list of rules they had to follow:

> […] I'm just like a bit mad because there's loads of rules. I'm not worried about where I live, I feel really safe an real secure an everything, it's just annoying that the rules, but you got to have rules I guess. (Cody)

16.6- Superordinate theme 3: Summary

The impact of living with parents who misuse substances undoubtedly has a significant impact on the lives of children. This superordinate theme has presented the support needs of children living with PSM, within their immediate environment.

Children have shared their experiences and their support needs, most noticeably was their need to have both practical and emotional support. Children identified support from a non-substance misusing parent, grandparents and extended family. Support from family was needed to support children, especially in times of crisis. However, their family support network was negatively impacted due to conflict within the family.

Alongside the need for family support, children also shared their need for friendships, a vital source of laughter and relief from their often unpredictable and uncertain home life. To enable children to utilise support from their family and to build friendships, it was apparent that children needed to have a stable home. The following superordinate theme builds on the support needs of children living with PSM and presents the children's experiences with various professionals.

Chapter 17

Superordinate Theme 4: Understanding the role of professionals in responding to the support needs of children living with PSM

Previous superordinate themes have highlighted the significance of informal support for children experiencing PSM. This superordinate theme identifies the protective factors which support children to cope in further detail. The subordinate themes outlined in table nine, explore children's experiences and views of their support needs in a formal context, by way of support from professionals;

Table 9 Children's interviews subordinate themes 4.1-4.6

Subordinate Themes
4.1 Children's experience of school
4.2 Absence from school
4.3 Support needs in school
4.4 Support from professionals
4.5 Needing somebody to talk to
4.6 Longevity of support needs

The first theme begins by exploring children's experiences of school, before presenting themes relating to formal support. The purpose of this opening theme is to understand how children's unique experiences have shaped their support needs.

17.4.1- Children's experience of school

Given how much of their childhood is spent within school, it was not surprising that children's experiences of school featured throughout the interviews. This theme explores the experiences of school life for children living with PSM. For Cody, school was not just a place to learn, but a place which formed a sense of identity, where they were known, and where they had friends:

> I do kinda like being at school cos erm not just like learning an stuff, like I was friends with the people […] so just you know, known. (Cody)

For some children, school appeared to be a place that encouraged and motivated them to achieve, in order to reach their goals and ambitions:

> I want to work at like DreamWorks or something like that as an animator (Taylor)

> I am like quite motivated in that way. I'll want to get more schoolwork done and like when I'm at home I'll want to get that done and that's quite good having that to do. (Charlie)

Prior to taking part in the research, Cody (who was living in temporary accommodation) used their time with their keyworker from the specialist service to complete their maths homework. It is possible that Cody had needed support from their keyworker, as there was no adult at home that they could seek support from. They were so excited their keyworker had been able to help them and that they only had six more questions to go:

> I've just done my maths homework with [keyworker] I've done 10 questions and just 6 more to go and I was gonna do some more and then you called. (Cody)

Children wanting to do well and living with a parent who misused substances highlighted the additional pressures these children experienced. Children

shared their reflections of their time in school and how difficult this was for them to manage at times:

> Like at the time doing my GCSE's and having to come into school maybe after something had happened and get on with it because if I didn't get on with it, it would have a knock-on effect then on my learning. (Charlie)

> […] because at school sometimes I can't concentrate or sometimes I just don't do my work or sometimes I just really don't want to go into school. (Rowan)

For many children, school was not a positive experience. Children shared their experiences of being bullied and how this was directly linked to their parent's substance misuse. As children shared their experiences, there was a mixture of emotions, of visible anger and sadness. As Rowan shared their experience, their voice tapered off into a whisper; it was clearly an emotive memory and difficult for them to share:

> I told [friend] about it because she's had problems as well, then she told her cousin who goes to my school whose like a bit of a bully and then he told everyone at school and he liked posted things on social media about it and he like made everyone against me in school […] then it just kept on spreading […] it's been like a year but erm I still remember it. It's made me feel kinda sad because then everyone's gonna think that I'm with my mum and she's all crazy and my mum's not crazy but that's what they'll probably think. (Rowan)

> I changed my friendship group because my old friendship group in primary school bullied me a lot. (Taylor)

Cody recalled memories of being bullied by pupils from their school and how the bullying didn't stop at the school gates, but continued into the community. It appeared other children knew of Cody's circumstances at home and this was used as their ammunition to bully:

> I was getting bulled every day an when I was walking to the shop people liked punched me in the chest…then when I was walking home they'd pop my crisps and throw them at me […] Just made me really angry an then one day I turned around and punched him in the face… they started bullying me again […] always picking on me with the littlest things like ya probably get ya clothes dead cheap from Cheetham Hill or someat because ya mum's on stuff. Ya mums on drugs (Cody)

The reflections from Cody and their sibling Kit, highlighted the complexity in the lives of these children. Neither home nor school were places of emotional and physical safety due to being victims of bullying in school and their experience of what appeared to be a chaotic home life, before moving to the B&B. Despite all of this, Cody was still wanting to do well as evidenced by asking their keyworker to help them with their homework. Similarly, Taylor wanted to do well and achieve, despite disliking school:

> I hate high school just in general but erm, an I feel bad saying it, I wanna do well but at the same time I hate it. (Taylor)

Children's reflections of their time in school highlighted both positive and negative experiences. For some children, school was, in a sense, a sanctuary, a place to be with friends, to form identifies and work towards their ambitions. Yet, for some children school was a place which further compounded their struggles of living with PSM and understandably evoked strong emotional responses.

17.4.2- Absence from school

Three children highlighted their absence from school and the impact this had had on them. One child had completed school and was adjusting to this significant change; namely that the staff in school whom they had received support from, they could no longer see.

Charlie had described positive experiences of school, of achieving well and

having access to emotional support. Sadly, for Charlie this support had come to an end because they had finished school; at the time of the interview Charlie had started college and was approaching their seventeenth birthday. Charlie reflected on what had helped them to cope over the years:

> School a little bit, maybe not so much anymore because obviously I'm not there anymore. (Charlie)

For other children, the choice of attending school was taken from them as a direct consequence of their parent's substance misuse. Due to having to flee their home because of threats made to their family's lives, Roux and Cody were unable to go to school.

> I don't really know to be honest I can't say off the top of my head but it was quite long. (Cody)

At the time of the interview, Roux had just had their first two days back in school after approximately two months of absence. Whilst some children may view absence from school as a positive, it was undoubtedly a difficult time for Roux, especially being in a new town, living in a B&B, away from anything familiar and isolated from friends and teaching staff.

> It was kinda like weird cos I was normally getting up early and like getting up and going to school […] I've only been in for two days. (Roux)

Not only did Roux have to adapt to life back in school but they also had to face the challenges of starting a new school, making new friends and learning to navigate a whole new environment.

Fortunately for Cody, they had started back at a high school at which they had friends who attended; they came to the interview one evening after school. They had their new uniform on and appeared excited and happy. As outlined above, Cody was keen to get back to learning and had been receiving help from their keyworker with their maths homework.

The direct impact of PSM on children's access to school, ability to learn due to the emotional strain and not being able to concentrate has been highlighted. The following themes will explore children's experience of receiving support and, from their perspective, what they feel they need from professionals.

17.4.3- Support needs in school

Each child has shared their own unique experience of living with a parent who misuses substances and the complexities of those experiences. Whilst a child's experience is unique to them, the thread running throughout all of their shared accounts is the unquestionable emotional impact. For children experiencing PSM, school can be both a haven for much needed respite but also a place where their emotional wellbeing is tested even further.

Cody's reflection below appears to illustrate their exposure to the unpredictability of their parent's substance misuse and the impact this had on them in school. Cody stated they didn't know why they were crying in lesson. It's possible they were experiencing difficult times at home and being in school was simply overwhelming:

> I was crying in lesson today and yesterday […] Cos I was just really upset and I don't know why. (Cody)

When exploring support networks with Kit, they looked visibly saddened as we talked about school and when asked if they had anyone they could talk to in school they simply replied, 'No'.

Taylor described having an 'episode' in school because they didn't want to go home. It's unclear what Taylor meant by 'episode' but as they talked, they lowered their head and their voice began to break. Taylor's experience of being in school, and not wanting to go home, illustrates the gravity of the emotional impact of PSM on children trying to make it through their school day:

> I did have an episode in PE when he was drinking because I didn't want to go home. (Taylor)

For both Cody and Taylor, they described needing to have support in school. For Cody the support they felt they needed was a time-out pass, so if they began to feel tearful, they could leave the lesson without anybody seeing they were upset. Cody also felt any child who was worried about their parent's substance misuse would need a time-out pass:

> Do you know what I think I should have in school, I think I should have a time-out pass but they're not gonna give me one. I need a time-out pass because whenever I get upset, I just need to cry and I can't do that in lesson when everybody is there. Cos they'll ask me what's wrong an then it's kind of personal int it. So, I think they would like need a time-out pass in school an erm and like just like when they go out for time out just for someone to check and come and see that they're alright. (Cody)

Given the complexity of the experiences Cody had endured, including exposure to violence, possible domestic abuse, living in temporary accommodation and having been absent from school, it is little wonder they had been overwhelmed and cried in lesson, yet they didn't feel they had any support in school.

Taylor experienced similar difficulties in school; for Taylor, support was 'promised' but they had to wait before being able to access any support in school:

> The safeguarding officer and Mrs […] make too many false promises, she said she would get me a time-out pass, never did […] I eventually got one and a wellbeing pass to go to the wellbeing group. (Taylor)

Taylor felt it was important for staff in schools to know about the needs of children living with PSM, Taylor's description below illustrates how confiding in a member of staff in school could be the first point of call for children who

need support due to their parent's substance misuse. Enabling schools to then coordinate a response to the presenting needs of the child;

> I feel like the schools they go to should know because in case something's happened so they can call up [support services] and be like… come over right now (Taylor puts arms in the air as if to signify a catastrophe). (Taylor)

The view that schools needed to know a child's circumstance was not shared by one child, whose description suggests they preferred some level of anonymity:

> Yeah, there's new teachers now so nobody really knows about it which is like, which I'm quite happy about because I don't like being treated differently in school or anything. (Rowan)

For one young person their experience of school and receiving support had been a positive experience:

> I think probably support in schools because for me I think if I didn't have that support it would have affected my education and whole learning. (Charlie)

> Yeah definitely having someone with school I can talk to like in my case my head of year and having someone out of school coming into school, and being able to take a little break and go out of lessons for half an hour and having someone to talk to, and then my head of year would also pass on to my teachers so they all know what was going. I got more support in lessons then without having to use anything as an excuse an then obviously my learning wasn't affected as much and I could just get on with it. (Charlie)

The reflections shared by the children, evidence the value they placed on having a trusted adult in school. A trusted adult in school meant they had somebody who could respond to their educational and emotional health needs.

17.4.4- Needing support from professionals

Children living with parents who misuse substances have shared their views regarding their support networks, the need for family support, support from friends and the need to be understood and supported in schools. This theme explores children's perspectives of their support needs outside of their family and school. Towards the end of the interview, children were asked what their views were of the support needs of children who shared similar worries to them, the children's responses are included in this theme.

The description and reflections from all of the children who participated indicated that having support from professionals was important to them, especially when children were not able to confide in family. Although Cody couldn't remember the name of the professional who came to support them and their family, their account below illustrates the importance of this support:

> […] I can't remember who it is an I know who it is in my head but I can't remember […] say like if I had no one like no social worker or anything and I was really like depressed or something like that […] I don't know how to say it but they should, I think they should be able to have support workers that will help them. (Cody)

Taylor also valued having support from professionals outside of school and their family and the need for professionals to show care and warmth to children in need, by offering comfort in the form of a 'brew' and 'snacks'. Perhaps Taylor was prompted to say this because they had a cup of tea and their favourite snacks for the interview:

> I feel like just having someone to talk to in general…And if they've had like I don't know like something traumatic and someone in their family drinking again, having snacks and something like a brew really does help as well […] it always helps me be more relaxed an just knowing that there is someone there. (Taylor)

The importance of being understood, having the opportunity to talk openly and for their confidentiality to be upheld was of significant importance to Charlie. Their detailed account illustrates the support they have received from specialist services and how the specialist keyworker, (referred to for the purpose of confidentiality as keyworker) was at times their single point of contact to coordinate support and respond to their presenting needs:

> If I need to, I can call [keyworker] or after something's happened, I know that I have someone that I can talk to after if I want to […] that's been really helpful, even if I've been seeing her when something hasn't been happening it's just nice to have a chat […] then I have her number so I know I can contact her if I need her as well… quite a relief that I can talk to someone and have it confidential so I know it's not going to get back to my mum and whatever I say, it's private and I can say what I want […] because if I said something to my mum or sister it could upset them and so having someone totally separate to talk to…I don't really know how to put it into words, they understand and so I know I can talk to them. (Charlie)

Children's reflections of their support networks and the need to have professionals; whether that be Social Workers or keyworkers from specialist support services was clearly of importance to Charlie and Taylor. Their reflections illustrate that support was not just needed in response to a crisis but was ongoing.

The importance of having professional support was echoed by the younger participants; although their reflections were less detailed, their choice of words and short statements demonstrated the importance and significance of professional support in their lives.

Quinn had only just started receiving support from a specialist service and when they spoke of the support they needed, they whispered that they needed somebody to 'talk to'. Quinn's need to have a professional to talk to

was even more evident when they said their new family worker and added: ‘and you’.

Roux also shared their excitement about participating in the research interview. Having been isolated at home due to living in temporary accommodation and not having been at school for weeks, Roux appeared excited to speak to someone:

> When Mum said I was coming to see ya and then I was like you’re lying and then she said she wasn’t and I was like yaaay. (Roux)

Kit shared their feelings about the need to have somebody to talk to outside of their family. Using the drawing of their tree (see figure 17 below), the trunk represented what helps them to feel strong, they wrote:

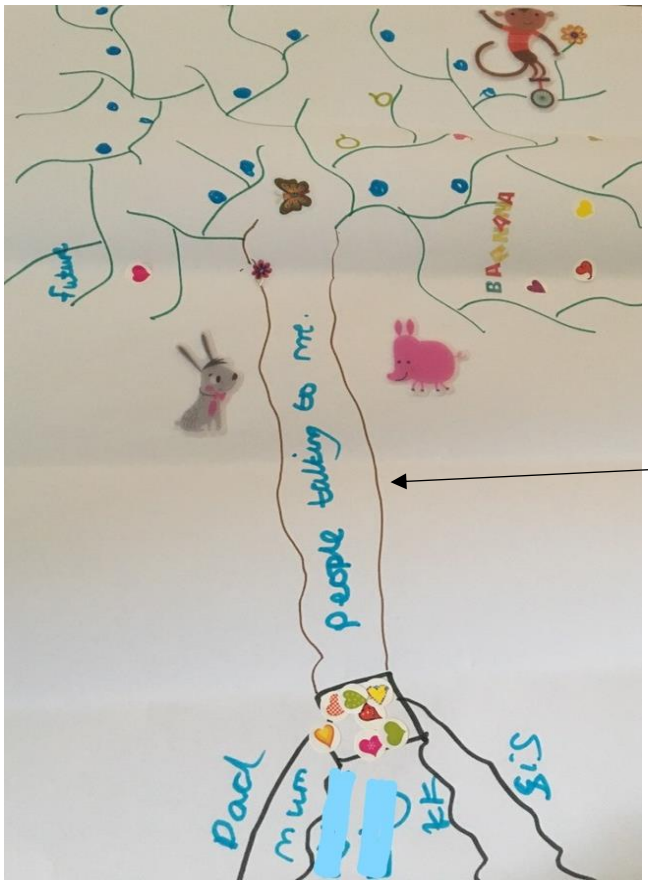


Figure 17 'People talking to me'

Kit shared their views about the importance of having somebody to talk to, but not only talking, ‘drawing it’ was important for Kit. This is perhaps a reflection of the difficulties children face, when trying to put their experiences into words.

Having professionals to talk to about their family life, and their worries about their parent’s substance misuse is reflected in Kit’s words:

> I know I’ve said this loads of times but just talking to people. You know, otherwise you just feel like dead deflated […] like if I couldn’t talk, probably just be upset all the time. (Kit)

The perspective from children that they need professional support, to ensure they have somebody to talk to, is evident from their emotive and descriptive reflections. Children also shared their views of how long their support from professionals should be in place for.

17.4.5- Longevity of support needs

The lives of children and their families are not stationary and as shown throughout this chapter, the lives of children living with PSM are often unpredictable. The reflections and shared accounts from children convey the importance of professional support, both in and outside of school. Children also shared their perspectives of how long they needed professional support.

For Rowan, the message was clear, they needed support from professionals for as long as they were experiencing uncertainty:

> […] until like my mum gets better, I think or until I know where I’m going to live. (Rowan)

The perspective that support from professionals was needed for a sustained period of time, or at least until their circumstances improved, was echoed by Cody:

> I don’t really know I think it’s like a long time. (Cody)

Taylor appeared apprehensive about their support coming to an end, despite having had one-to-one support for two years. Taylor explained that they had a plan with their keyworker, who would phone them after their sessions had come to an end. Taylor's description suggests that they were unsure whether their dad was going to relapse due to their paternal grandmother being unwell. Taylor suggested they needed a phone call within a week or two, clearly showing their anxiety regarding specialist support coming to an end:

> Well, I suppose give it a week or two because my dad's mum isn't very well and yesterday, he was quite sad and he ended up sleeping on his mum's couch. (Taylor)

The messages conveyed by children of their experience of receiving specialist support from a professional was that this support was of significant importance to them. As each child's support needs differed from another, so too is the length of time that each child would need support for. This suggests that professionals' responses to children living with PSM need to be consistent and tailored to each child's presenting and changing needs.

17.4.6- Superordinate theme 4: Summary

This superordinate theme has explored children's experience of school and of receiving professional support. Children's experience of school was both positive and negative. Some children found school to be a sanctuary and a welcome respite, yet for other children school was a place that compounded their misery. For some children school was a place where they could pursue their ambitions and look towards a brighter future and for others it was a place of continued struggle due to being bullied and feeling misunderstood by school staff.

Although children's negative experience of PSM differs from one child to the next, what this superordinate theme has illustrated is the value all children placed on receiving professional support both in and outside of school. Children's reflections highlight the importance of trusted professional relationships, somebody who can respond to their needs in a crisis, be a

listening ear and a source of comfort for all the times in-between. As with the identified risk factors presented in table seven, table 10 below illustrates that no two children are the same and their protective factors all differed.

Table 10 Identified protective factors associated with PSM

Child Participants	**IDENTIFIED PROTECTIVE FACTORS**													
	Non substance misusing parent	Older sibling	Positive friendships	Grandparent- practical support	Close bond with grandparent	Family occasions celebrated	Engaging in positive activities	Specialist PSM keyworker	Support from children's social care	In full time education	Emotional support in school	Support in a crisis	Positive ambition for the future	Warmth and care by parent when abstinent
Kit	●	●	●	●	●	●	●	●	●	●				●
Charlie	●						●	●		●	●	●	●	●
Taylor	●	●	●		●			●		●		●	●	
Rowan	●		●	●	●	●	●	●	●	●		●	●	●
Roux		●		●				●	●			●		●
Cody		●		●				●	●			●		●
Quinn		●	●		●			●	●	●				●

17.7- Part 4 Summary: Creative interviews with children

The findings presented have illustrated the complexity and severity of children's experiences when exposed to PSM. PSM was rarely experienced by children in isolation and the negative impact of PSM was compounded by associated behaviours such as violence, family conflict and domestic abuse. Although children did not overtly identify domestic abuse in their emotive reflections, their descriptions of parental injuries and hearing conflict, suggests domestic abuse was prevalent.

The negative impact of PSM on children's emotional health as a consequence of children seeing their parents use substances and being intoxicated was presented. The findings also illustrated how waiting with uncertainty and heightened anxiety for the next incident, had a profound impact on children's emotional health.

The children's shared experiences have illustrated that the reality of living with PSM is at times harsh and enduring. PSM negatively impacted on their school work, their time with friends and their opportunity to be children, as described in chapter 15.2.5 (Lost childhood).

In spite of the harsh and enduring cycles of ups and downs, the children's shared experiences demonstrate that their support networks both familial and professional could help to lessen the negative impact of PSM. Children portrayed a strong message that they needed somebody to talk to and when this support was not available within their immediate family, support from professionals was needed. Without specialist keyworkers, social workers and/ or support in school, when informal support networks are not available, children are likely to continue to experience PSM in isolation and carry the emotional burden alone.

The proceeding chapter will present the findings from three focus groups, exploring the needs of children living with PSM from the perspective of professional who endeavour to provide support.

Part 4- Presenting the findings

Chapter 18 - Introducing the findings from focus groups with frontline professionals

One of the key objectives of this research was to understand the needs of children living with PSM and investigate the experiences of professionals across a children's workforce in responding to PSM. This chapter presents the findings from three focus groups relevant to those aims.

Professionals from three specialist fields were recruited through one North West local authority. The fields included, professionals in pastoral/support roles within schools, professionals from early intervention children's services (seeking to prevent the need for families to be referred to statutory social care), and social workers in a statutory child protection role.

In June and July 2019, three focus groups took place; of the 22 professionals who volunteered to participate, all but two attended the focus groups. The two participants who were unable to attend on the day, still wished to participant. Both participants attended one-to-one interviews which followed the same focus group interview schedule and their transcripts were added to the transcript of their respective focus group.

An overview of the participants in each focus group and of the professional role of each focus group participant can be found in the sample profile in Table 11 below.

Table 11 Focus group participants, sample profile

Focus Group 1 Professionals from Education	Participant Identification	Professional Role
	PE-1	High School Year 11 Pastoral Lead
	PE-2	Primary School Pastoral Lead
	PE-3	Primary School Pastoral Manager
	PE-4	Primary School Pastoral Manager
	PE-5	Primary School Pastoral Lead
	PE-6	High School Year 9 Pastoral Manager
	PE-7 (attended 1:1 interview)	Primary school Pastoral/ Learning Mentor
Focus Group 2 Professionals from Children's Statutory Social Care	Participant Identification	Professional Role
	PSC-1	Children's Disability Senior Social Worker
	PSC-2	Newly Qualified Social Worker
	PSC-3	Senior Social Worker
	PSC-4	Newly Qualified Social Worker
	PSC-5	Senior Social Worker
	PSC-6	Senior Social Worker
	PSC-7	Social Care Team Leader
Focus Group 3 Professionals from Early Intervention services;	Participant Identification	Professional Role
	PEI-1	Family Support Worker
	PEI-2	Family Support Worker
	PEI-3	Team Around the Family, Support Coordinator
	PEI-4	Sex, Relationships and Education Youth Worker
	PEI-5	High School Drugs/Youth Worker
	PEI-6	Family Support Worker
	PEI-7	Youth Offending Service Officer
	PEI-8 (attended 1:1 interview)	Parenting Team Practitioner

The following chapters present each overarching theme and relevant subthemes, as shown in table 12 below;

Table 12 Focus groups; Overarching and subthemes

Overarching theme	**Subthemes**
Understanding Children's Experience of Living with Parental Substance Misuse (PSM) from the Perspective of Professionals	Impact of PSM on children's emotional health
	Children suffering from physical neglect
	Parental inconsistency and availability
	PSM and domestic abuse
	Factors increasing the risk of significant harm
	Contextual safeguarding
	Children's experience of living with secrecy
	Children experience of fear, shame and stigma
	Longevity of exposure to PSM
	Lost childhood
	PSM and the impact on children's education
Parental Substance Misuse- Understanding Protective Factors and Children's Support Needs	Gaining children's trust takes time
	The need for children to have a safe space
	The importance of trusted adults
	Trusted adult relationships in school
	Specialist child-focused support
	Responding to the needs of older children
Understanding Challenges in Practice in responding to the Needs of Children Living with Parental Substance Misuse	The impact of austerity measures on service provision
	Changes to adult treatment services and the implications for children
	Parental denial, stigma and shame
	Parental mental ill health and substance misuse
	PSM: Knowledge and training

Chapter 19

Overarching theme 1: Understanding children's experience of living with parental substance misuse (PSM) from the perspective of professionals

This overarching theme presents the findings from the discussions across the three focus groups in relation to the experiences of children living with a parent who misuses substances. Professionals shared emotional accounts and reflections of their experiences in practice, of observing the direct impact of PSM on children. This overarching theme is accompanied by 11 subthemes, as listed in Table 13 below;

Table 13 Focus groups; subthemes 1.1-1.11

Subthemes
1.1 Impact of PSM on children's emotional health
1.2 Children suffering from physical neglect
1.3 Parental inconsistency and availability
1.4 PSM and domestic abuse
1.5 Factors increasing the risk of significant harm
1.6 Contextual safeguarding
1.7 Children's experience of living with secrecy
1.8 Children's experience of fear, shame and stigma
1.9 Longevity of exposure to PSM
1.10 Lost childhood
1.11 PSM and the impact on children's education

19.1.1- Impact of PSM on children's emotional health

This subtheme explores the impact of PSM on a child's emotional health from professionals' perspectives. The need for professionals to be mindful of a child's emotional health, as well as their physical health and safety, was echoed by many participants. Participants identified that whilst the physical safeguarding concerns may be more easily identifiable, there remains the need for professionals to understand the emotional needs of children:

> You can keep children physically safe but actually it's the emotional side […] and actually how crap it is for a child to live with a parent who isn't there for you […] or may be horrible to you and maybe disappear for days on end. They may become a very different person and may become aggressive (Focus Group 3: PEI8).

The negative impact on children's emotional health and wellbeing due to PSM was implicit within all three focus groups. Many participants reflected on their experiences of supporting children who were experiencing 'anxiety on a deep level':

> I think when they wake up in the morning and they don't know what that parent is going to be like, that's got to have a massive impact on your identity and your confidence and your self-worth […] from a child's point of view that's got to be quite scary (Focus Group: PEI 8).

The unpredictable nature of PSM and the impact this had on children's emotional health was evident. One participant explained how a child they were supporting would feign 'seizures' to be allowed to go home, as waiting in school, knowing that parents were at home misusing substances, was unbearable. Participants' recollections of children experiencing uncertainty and the direct impact this had on their emotional health, feelings of anxiety and fear, was a theme that ran throughout all three focus groups. One participant shared their experience of supporting a child in school who was

consumed by anxiety due to their fear of leaving their parent at the school gates in the morning:

> …he's terrified that dad might not be alive to come and pick him back up from school (Focus Group 1: PE3).

A further consequence for children living with PSM was identified by participants in relation to how children feel different from their peers. Participants shared their experiences of supporting children and how they portrayed their sadness, and perhaps shame, of their home circumstances:

> […] he wrote 'why can't I have a family like others' (Focus Group 3: PEI6).

Exposure to PSM was linked to children presenting with often challenging and difficult behaviour. Participants shared their experiences of witnessing children's emotional health fluctuate, dependent on their circumstances at home. Some children would become withdrawn, other children more dominant, angry and in need of attention and for some children their behaviour was described as 'really bizarre':

> We have other children who come in and you would not know from how they physically present but you can tell from changes in their behaviour that situations have escalated at home […] their behaviours change, you can see them becoming less resilient or more dominant sometimes or they can become withdrawn. It depends on the child (Focus Group 1:PE7).

Participants reflected on their experience that children understandably presented with negative behaviour and feelings of anger, given that children's emotional needs were often unmet due to PSM and the confusion this would create especially for younger children:

> …the anger that would then be present and how confusing must it be when they mistrust their main attachment and the anger they have

> towards them, that's so emotionally damaging when that is all of the time (Focus Group 2: PSC3).

Whilst for many participants their reflections were focused on children presenting with challenging and aggressive behaviour, one participant highlighted the need for professionals to be vigilant and in tune to the needs of children who were less visible:

> […] non-verbal signs, looking out for if a child is a little bit quieter than normal. It's the quiet ones I really worry about (Focus Group 3: PEI8).

For children who have been removed from their parents' care due to significant safeguarding concerns, or where the parent who misuses substances was no longer in the family home, the emotional impact on children was ongoing. Participants described their experiences of witnessing the continued emotional suffering of children, in instances when children had to watch parents being turned away from contact centres:

> There were occasions where mum would come to see them at the contact centre and she was turned away because she smelt of alcohol and the children were there and they saw that (Focus Group 2: PSC7).

The participants discussed at length the impact of being separated from their parents and the emotional weight bearing down on children, who from day-to-day do not know if their parent will be there for them. Participants also discussed the consequence of the longevity of exposure to PSM on children's emotional health. Of particular concern was the emotional health of children as they enter their teen and young adult years, especially when they have learnt to be independent and meet their own needs at too young an age:

> […] when she's sober, she's a fantastic, an amazing mum, but when she's drunk, she erratic, she's abusive, forgets to pick them

> up. And on paper these girls are described as resilient, and in a way, they are, but I worry about the long-term effect. Not so much now but when they start to have to go into the wider world, when they become independent. Already at 13 and 14 they've learnt to be independent (Focus Group 3: PEI8).

This subtheme has detailed the emotional impact PSM can have on children due to the unpredictability they experience. Intertwined within the discussions of the emotional impact on children were reflections from participants of their experience of seeing first-hand the direct impact of PSM on children in relation to neglect. The following subtheme explores professionals' experiences and perspectives of the correlation between PSM and children experiencing physical neglect.

19.1.2- Children suffering from physical neglect

Neglect can be defined as both emotional neglect and as a child's physical day-to-day needs not being met by their primary caregiver (please see appendix 2- glossary of terms).

Participants categorised neglect into two key themes - one of immediate risk of significant harm, linked directly to PSM and the risk of children picking up substance paraphernalia. The second theme related to unmet needs, parents not having money to meet the basic day-to-day care needs of children, such as funds for electricity and children not having enough or no food to eat.

The immediate risk of harm linked to drug misuse (not alcohol) is described by one participant who recalled his experience of a teenage child sharing his early childhood experiences:

> […] working with families with drug issues has been the neglect side, because they are shooting up with heroin, they're just leaving the needles around and you know that was happening for the young person I was working with (Focus Group 3: PEI7).

Participants shared their experience of supporting children who had additional needs due to having a disability or a medical condition that required parents to administer regular medication. The participants outlined the increased anxiety experienced by professionals about the needs of these children not being met due to PSM, and of the responsibility to respond to the needs of children with additional needs falling to professionals in school:

> There were high levels of cocaine, it was awful, it was chronic case of neglect. With the complication was that there was a child with a disability in the family […] the first thing the child said to the foster carer was where are you going to get the money for gas and electric and have you got enough money for food. She was thinking her basic needs weren't being met constantly (Focus Group 1: PE5).

Participants from primary and secondary schools shared their heartfelt and emotive reflections of seeing children experiencing neglect:

> I've started a food bank, a clothes bank, a shoe bank, and it's the basic needs. We've got children coming in smelling of urine, and holes in clothes, holes in shoes […] parents will choose the substance over those things […] children are coming in, they've not eaten […] they haven't had breakfast, they are deathly thin these children, it breaks your heart and it's awful (Focus Group 1: PE2).

The experience of professionals in schools seeing the very visible signs of neglect was echoed within all three focus groups, in that at a safeguarding level 'It's the whole sphere of the child's world isn't it that's completely dominated by, at that level anyway by drugs' (PSC7). There was a consensus across the three focus groups that PSM equated to children experiencing neglect with parents struggling to meet the very basic of needs such as providing a home with electricity, gas, food and children having appropriate and clean clothing.

Participants reflected on their experiences of witnessing very young children with 'nappies that dangle around their ankles' (Focus Group 2: PSC6)

because their nappies had been left unchanged for too long and of children who were ‘left in pushchairs and cots’ (Focus Group 2: PSC5). This suggests that children were left without stimulation because parent’s priority at that time was their need to misuse substances. The interconnection between physical and emotional neglect intertwined throughout and across focus groups.

Neglect was also identified by participants as something that children living with PSM experience because of parents being absent: a feeling of ‘being abandoned’ and of parents not having the ‘time to deal with their children’ (Focus Group 3: PEI5). This links with the previous theme of the impact on children’s emotional health and the safeguarding concern of children learning to be independent too young, because adults are not consistently in their lives to meet their day to day physical and emotional care needs. Intertwined with professionals’ accounts of children suffering emotional and/ or physical neglect was the theme of parent’s inconsistent responses and availability to meet their children’s day to day needs.

19.1.3- Parental inconsistency and availability

Participants discussed and recalled their experiences of supporting children and their families affected by PSM. As with previous themes of neglect and the impact on children’s emotional health, their accounts and experiences were underpinned by a key theme of inconsistency and parental availability for their child. The unpredictability and inconsistency children experience because of PSM and parents’ availability for meeting their needs was identified across all three focus groups:

> I think that the biggest safeguarding issue is that the parent becomes unavailable to the child and children end up having to fend for themselves and having to look after themselves and the parent is not aware of what is going on (Focus Group 1: PE7).

> The impact substance misuse has on relationships stroke attachments, I’ve so many examples of children that have had

> parents who are alcoholics, binge drinks, parents that are using cannabis, cocaine, heroin, although whatever drug it is, this is where I define misuse, where it's about a parent's ability to be the consistent caregiver is impacted on […] from all the years of work in outreach, parenting team, underneath all that when substance misuse impacts on that caregivers ability to be there for their child, that for me is misuse (Focus Group 3: PEI8).

One aspect of PSM and the impact on children was parents' struggles to meet the day-to-day physical and emotional care needs of their children. PSM was also attributed to a parent's inability to prioritise the needs of their children over their need to misuse substances, as the 'priority ends up being the substance':

> Routine, parents can't get up in the morning because of use the night before and that has a knock-on effect on school attendance and nursery (Focus Group 2: PSC6).

Participants reflected on their experiences that the impact of PSM on children did not simply occur when parents were under the influence but throughout the cycle of substance misuse. This was identified by participants when describing the behaviour of parents in reference to mood swings prior to, during, and after, they had taken a substance:

> I think one of the key things we talk about is consistency and if parents aren't consistent at home because they are drinking or taking drugs and their moods are up and down and then their kids are going to feel really insecure because they haven't got those boundaries (Focus Group 3: PEI1).

Participants shared experiences of the impact of inconsistent parenting where children experienced parents' 'short temperedness' and 'limited' or 'lack of attention' (Focus Group 2: PSC5). Participants also highlighted their concerns that this style of parenting would lead to children developing negative behaviours and coping strategies:

> […] anxiety kids feel from inconsistent parenting I think does kind of lead to their own behaviours and maybe experimenting with drug and alcohol abuse themselves (Focus Group 3: PEI3).

The complexities surrounding PSM were narrated by participants who identified that inconsistent parenting was not solely due to substance misuse itself but the knock-on effect this had on family relationships. When parents experienced conflict within their relationships due to substance misuse, this had a direct impact on children. Participants identified adults becoming focused on their own problems and not the emotional needs of the child, which had an 'impact' on their 'relationship with their child' (Focus Group 3: PEI2).

Participants identified the impact of both PSM and parental separation on children. Due to children being caught up in conflict, as parents' focus shifted from their child to focusing their energy on responding to and making allegations against one and other.

The long-term impact on children's emotional development because of prolonged inconsistent parenting and a lack of emotional availability from parents was also identified by participants:

> The impact it has on the relationship, attachment, for want of a better word, and actually how without that secure relationship we're just going to potentially create another generation of parents who are going to repeat the same mistake (Focus Group 3: PEI8).

A key theme running through each focus group is the uncertainty and unpredictability children experience when living with PSM. Participants shared their experience of supporting families affected by PSM and additional factors which contribute to children's experiences of unpredictable adult behaviour. As outlined above, children living with PSM can often be exposed to conflict within the family. The following subtheme explores in greater detail the complexity of PSM and children's exposure to domestic abuse.

19.1.4- PSM and domestic abuse

Participants across all three focus groups identified that domestic abuse was often inextricably linked to PSM. Participants articulated that such uncertainty and unpredictable behaviour was linked to children being exposed to violence and high levels of conflict within the family home:

> I think violence, that's common isn't it. Fear of violence
>
> (Focus Group 3: PEI3).

Participants associated domestic abuse more so with parental alcohol misuse than parental drug misuse. Participants identified the difficulty in implementing safety plans with children when both parents were misusing substances, especially when parents' substance misuse was 'co-dependant' (Focus Group 2: PSC1) and domestic abuse was present:

> […] when you look closely there's DV so it's not just the alcohol misuse but the impact of the DV and how that effects the child and how that child then sees their main caregiver who can't keep them safe (Focus Group 3 participant: PEI1).

Children growing up in households where PSM and domestic abuse co-existed were felt to be at risk of developing learnt behaviours, learning to control the adults around them to secure their needs. This was highlighted by participants who described the child-on-parent abuse they had been aware of:

> … he's very controlling with mum, so he'll say well you need to buy me a new PC is his latest one because you didn't complete rehab so you need to buy me this, you owe me (Focus Group 3: PEI7).

Participants also identified the risk of children being physically harmed due to children attempting to intervene to protect their parent from domestic abuse, in particular older children:

> Intervening in altercations, I can think of countless number of families who I have worked with where a child has been injured because one of the parents has tried to assault the other one under the influence and the child has tried to stop that (Focus Group 2: PSC7).

Domestic abuse and PSM were identified across all three focus groups as being inextricably linked. The impact is both in terms of a child's immediate emotional and physical safety, and of the long-term impact on their emotional development and learnt negative coping strategies. The following subtheme details additional factors that were identified within the focus groups, as potentially increasing the risk of significant harm to a child.

19.1.5- Factors increasing the risk of significant harm

This subtheme explores factors which increase the likelihood of significant harm (see appendix 2- glossary of terms) to children, due to parents' chaotic lifestyles, parents receiving threats due to drug debts and of the risk of children suffering physical abuse. For many participants, discussion of PSM elicited memories of supporting children when safeguarding concerns had increased, leading to a child being at risk of significant physical harm.

One participant shared their experience of receiving information from an anti-social behaviour team regarding one of their pupils (aged seven at the time) who had been seen out in the community past 11pm 'running around the estate' (Focus Group 1: PE2). The participant shared further details relating to the significant risk of harm to these children, including reports of domestic abuse, and the house being unsecure due to the front door being 'smashed'. The participant shared their frustrations and, in their opinion, the presenting risks were not acted upon by statutory services (police and children's social care) soon enough:

> The police went in [police and professionals] shouting and it wasn't until they went into the bedroom, did the parents sort of spring into life […] it was very clear [parents] were drug induced […] we know there's domestic violence, we know there's serious issues and yet this child is

> still with this family and dad, he's such a serious concern' (Focus Group 1: PE3).

Children experiencing chaotic lifestyles due to PSM and the imminent danger this placed them in was evident from participants' detailed accounts. Children being exposed to drug dealers coming to the family home and the negative consequences to families when drug debts are not paid, is evident in the following accounts from professionals of their practice experience:

> People coming into their lives, you know when you're scoring you know the kind of impact on the relationships, the abuse that's inherent. The reliance on a person to provide you drugs, which you know, the risk of this becoming abusive. The passage of people through the property (Focus Group 2: PSC5).

> You know we've had dealers around here; we've had people putting grows [cultivating cannabis plant] on in the loft to pay off debts and pay bills […] then when they don't do that, they set fire to the house' (Focus Group 2: PSC6).

Participants considered that children being at risk of significant harm due to their home environment was attributable more so to drug misuse. In part, this was due to children being exposed to drug dealing, the consequences on families of not paying drug debts and paraphernalia.

Participants across all three focus groups had a shared consensus of the correlation between drug misuse and significant harm in relation to a child's exposure to environmental factors. In contrast, parental alcohol misuse was associated more with the risk of a child suffering from significant harm due to physical abuse:

> For me it's fear, especially the young person I'm working with at the moment where his mum's drinking quite a lot, he's scared of […] what's going to happen to his mum and on the flip side what's she going to do to him (Focus Group 3: PEI7).

Children suffering physical abuse was also linked by professionals to situations in which children tried to stop their parents from using a substance; this was described by participants in reference to the safeguarding needs of older children where it was felt that older children are more likely to intervene and attempt to stop their parents from misusing substances:

> […] older children are more likely to intervene […] in terms of maybe stopping their parent for reaching for the bottle […] (Focus Group 2: PSC7)

The overarching consensus from participants is that PSM is inextricably linked to children experiencing emotional and physical neglect, as parents struggle to manage their need to misuse substances and the needs of their children. Participants highlighted the factors relating to PSM within the family that increased their concerns for the immediate safety of children. The following subtheme explores the risk of significant harm in relation to a child's wider environment.

19.1.6- Contextual safeguarding

The definition of contextual safeguarding (see appendix 2 for full definition) is outlined in the 2018 '*Working together to safeguard children*' UK Government guidance:

> As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. (H.M. Government 2018:22)

Across the focus groups, the impact of PSM in relation to contextual safeguarding was identified. Participants shared their reflections of supporting children and families where PSM was a safeguarding concern and the risk of children, in particular older children, seeking comfort and support outside of their family home. Participants shared their concern for the safety of older children due to the increased risk that they would become victims of both sexual and criminal exploitation:

> The risk, as these children grow older, [is] the risk of child sexual exploitation and missing from home because of parental substance misuse and neglectful parenting (Focus Group 1: PE5).

> A teenager may not be needing to be fed on a four-hourly basis like a baby might, but the need for love, attention and seeking that elsewhere from people who want to exploit them is certainly a risk for them (Focus Group 2: PSC7).

Participants shared their experience of supporting children who, due to a lack of appropriate supervision and availability from parents, had developed negative coping strategies. One participant shared their experience of supporting a child whose mother misused substances and, in an attempt to escape the direct impact of his mum's substance misuse, he spent as much time as he could away from the family home, began smoking cannabis and became involved in a gang:

> […] he doesn't want to be anywhere near the house so he'll stay at dad's as much as possible, he'll go out on the park and [he] started smoking cannabis, he's hanging round with groups he shouldn't be hanging round with and that's how he's got involved with me (Focus Group 3: PEI7).

Participants discussed the issue of a child's environment outside of their home and raised concerns about a child's wider environment/ community and the potential risk of increased harm linked to children being exploited. A further risk identified by one participant is the culture within families and the expectation that younger generations continue the 'family line of dealing':

> I have a young lad, and he is just now carrying on the family line of dealing on the estate. And the fall out, he's only 15 and he's having a child and they'll be in the process of child protection. But it's such a culture in that family to just deal on that estate and hand it down [the generations] (Focus Group 2: PSC5).

The themes presented above have largely explored the experiences of children living with PSM and associated physical safeguarding concerns. The negative impact PSM has on a parent's ability to respond to their child's day to day physical care needs and the risk of a child sustaining a physical injury are presented. The themes have also drawn attention to the needs of all children living with PSM and the importance of professionals not losing sight of the needs of older children. The themes so far illustrate the complexity of the impact of PSM on children and the correlation between PSM and contextual safeguarding concerns.

The following subthemes draw attention to the emotional wellbeing of children and explores the impact of PSM due to the burden of secrecy, experienced stigma and the impact on children of prolonged exposure to PSM.

19.1.7- Children's experience of living with secrecy

This subtheme explores the reality for children living with PSM and the pressure children experience to conceal PSM. Participants' narratives of children needing to conceal their parent's substance misuse and their mistrust of professionals was evident within all three focus groups. Participants shared their experiences of attempting to support children and the barriers they face due to children's mistrust and entrenched secrecy within families:

> I think the mistrust that parents have and that children feel, is probably the hardest thing to overcome (Focus Group 2: PSC2).

Participants described the confusion children must experience when being told by parents not to tell professionals anything about their home life:

> The impact on the kids when their parents can't (be honest), because they see it play out and they must see evidence and have to cover it up. There must come a point for the children when they think just admit it, let's get some help (Focus Group 2: PSC5).

Participants' reflections of their experience in practice highlighted the complexity of the lives of children living with PSM and the pressure they must feel to live with secrets. The pressure on children is evident from one participant's account of a child they were trying to offer support to:

> I have one particular girl and I pass her every morning, I ask 'how are you?' and she goes [participant whispers] 'I'm not allowed to say' (Focus Group 1:PE2)

Children's experience of needing to conceal PSM and the pressure they experience to keep PSM a secret was evident. Coupled with experiencing pressure to maintain secrets, participants also identified that children must be left feeling confused:

> […] he was confused because his mum would still say you know don't tell the social worker and so on. So, it was a big mess really in this child's head, and so that was tough (Focus Group 2: PSC7).

Participants also reflected on the consequence's children experience when they do share their worries with professionals. In particular, when disclosures led to safeguarding concerns and statutory intervention by social care leading to further mistrust and children being told by parents 'don't talk to her', 'don't trust him' (Focus Group 2: PSC3).

Participants clearly articulated the impact secrecy and mistrust can have on a child's emotional health and the mixture of emotions children experience, through fear of the consequences of accidentally letting slip any information about their home life.

> There's often feelings of guilt and shame [children] very loyal to their parents, not wanting to hurt their parents […] a mixture of embarrassed, embarrassment, loyalty to parents, fear of intervention, fear of social services (Focus Group 1:PE6).

Participants from focus group 2 debated whether there was a difference between parents who misuse alcohol and those who misused drugs, in their

perceived need to conceal their misuse from professionals. The agreement among participants was that secrecy was prevalent regardless of the substance but that the extent to which parents attempted to conceal their substance misuse differed.

From the experience of participants in this focus group, it was felt that parents misusing drugs were more likely to overtly deny and conceal drug misuse. While parents did attempt to conceal their alcohol misuse, this was more in relation to the amount they were drinking as opposed to complete secrecy and denial:

> I would attach more secrecy with drugs than alcohol (Focus Group 2: PSC2).

> I think the lower the drugs are considered so in terms of crack, heroin, being at the lower end. I think there's more secrecy (Focus Group 2: PSC4).

For children living with PSM, the themes presented so far, highlight how complex their lives can be both in terms of their physical safety and wellbeing, and of the complexity of emotions which are undoubtedly felt by children. This can be especially so when children are living with secrecy and the pressure on children to conceal their home life to the outside world and most notably to professionals seeking to support their family.

19.1.8- Children's experience of fear, shame and trust

When discussing secrecy and trust, participants talked about the emotional health of children, leading to reflections of how children may feel shame, embarrassment and stigma when living with parents who misuse substances:

> I think the shame that children often feel and embarrassment, you know friends seeing their parents, or coming to their house. That whole shame that parents probably feel and that's probably why they

> hide their drug use, and that gets carried through to children (Focus Group 1: PE5).

A further concern raised by professionals was that of trying to build a relationship and gain the trust of older children, namely teenagers. Participants identified a child's age as a particular barrier and the need to work even harder to invest time in older children who may have lived with parents who misuse substances for many years:

> When I worked in outreach, you're just taking them for a game of pool, no I'm not, well you're right I'm playing pool but that game of pool allowed that child to feel a bit less pressurised and most of the best conversations I've had with young people about anything are generally when they are feeling safe and cared for (Focus Group 3: PEI8).

One participant recalled her experience of supporting a 15-year-old child, who had been able to trust and confide in them. But, through fear of the consequences of what might happen to her, her social worker had to attempt to navigate how to keep her safe whilst attempting to protect her confidentiality. This further highlights the complexity for professionals when supporting families where PSM is present:

> You know children have seen texts on a parent's phone that categorically says there's dealing going on but she was 15 at the time and she doesn't want me to tell, and you have to navigate all of that (Focus Group 2: PSC5).

The shared accounts and reflections from participants of their experience in practice, of supporting children and their families where PSM is a safeguarding concern has highlighted the complex reality of the lives of children living with PSM. The following subtheme explores the notion of longevity and the impact on children of living with PSM over a prolonged period of time.

19.1.9- Longevity of exposure to PSM

Participants across all three focus groups identified that the length of time for children living PSM is significant in terms of the long-term impact on their emotional health, physical health and development.

> What happens if you don't protect these children what are they going to be like when they become the adults of the world, […] what are their behaviours going to be, what's their take on life going to be, are they going to be a fully functioning independent responsible adult themselves if they have been damaged (Focus Group 1: PE7).

The impact of children being exposed to PSM over a prolonged period of time was identified by professionals and the 'damage' especially when considering the emotional impact on teenage children.

> I think expectations in life, their self-esteem and self-worth is so flawed by the time they are older, from how they have been treated and not prioritised (Focus Group 2: PSC5).

The knowledge of adverse childhood experiences was highlighted, with reference to one of the adversities being PSM. Participants' reflections suggest that the accumulation of safeguarding concerns as outlined previously in this chapter, coupled with prolonged exposure to PSM is likely to have a profound impact on children's ability to reach their full potential:

> […] if we think about things on a service level and that child, that teenager, will then become the next family and it's a huge risk to our society that we are not dealing with (Focus Group 2: PSC3).

Underpinning participants' concerns regarding longevity was their experience of generational safeguarding concerns. The narrative from many participants was that for children who do not receive support, or where their needs go unmet, they are at risk of becoming the next generation of adults struggling to meet the needs of their children. The impact of longevity for children living

with PSM can be lifelong:

> I suppose for that child trying to explore how they feel when actually, why should they feel any different when that's just normal life experience for them. You can't help but think they have such a normalised view of the world, they then go down that path (Focus Group 2: PSC1).

The long-term impact on children as they enter into adulthood was articulated by many participants. One aspect identified was in relation to children's ability to form positive relationships in adulthood because of the absence of a secure attachment or relationship with a trusted adult in their childhood:

> […] I would say and it impacts on their relationships, because that's how they've perceived their childhood because they've not developed those attachments (Focus Group 3: PEI2).

Longevity of exposure to PSM, and of prolonged emotional and physical suffering, was raised by participants throughout the focus groups. A frustration which was articulated by many participants was the risk of children 'going down that path'; children believing that to misuse substances was a normal coping mechanism and developing negative learnt behaviour because they know no other way:

> They know that they're suffering or dealing with mental health issues […] it's normalised and substances are a way of dealing with stuff [...] (Focus Group 3:PEI5).

This theme has highlighted the accumulation of risk over a prolonged period of time and the negative consequences this can have on a child as they enter their teen years and adulthood. The impact on the lives of children has been presented both in terms of their immediate safety and the long-term implications for their emotional safety and development. The following subtheme explores the impact of PSM and the notion of lost childhoods.

19.1.10- Lost childhood

Through discussions of the complexity of safeguarding concerns due to PSM, participants identified that children living with PSM often had to adopt roles that were far beyond their years. Participants said that children often had to care for family members, including younger siblings or to support and care for their parents when they were misusing substances. Participants' reflections identified that children were not always necessarily undertaking a physical caring role but that they felt a sense of responsibility and that it was their role to ensure the safety of their parents:

> Mum had very serious problems with alcohol, when he was little, he'd done things like, when she hadn't woken […] he had to ring for an ambulance (Focus Group 1:PE4).

Participants shared accounts of families they had supported where parents had poor physical health as a result of their substance misuse and parents struggling to cope with poor mental health. One participant recalled her experience of visiting a family and having to call an ambulance; the participant reflected on their feelings of anxiety and how the children in the family took it all in their stride:

> […] dad with a severe drinking problem who was always in and out of hospital because he was self-harming and I looked and thought they've done this so many times […] they know exactly how to look after each other (Focus Group 3:PEI3).

The impact of PSM on children and of losing their childhood, especially in relation to children not having a consistent adult or secure attachment, was echoed by participants. Participants identified that, for children who do not have a stable adult in their lives, who are having to endure unpredictable adult behaviour, and in the absence of a caregiver who can meet their emotional needs, the impact for children is far-reaching:

> […] from a practical point of view he was resilient, he was doing his exams, he was a nice lad, never in any trouble, at 15 he was his mum's carer and on the surface it felt ok but underneath he had no caregiver that was there for him […] he's looking out for his mum he's scared of going to school in case mum drinks herself into a coma' (Focus Group 3:PEI7).

When considering the impact on children who have experienced and endured adversity due to PSM, participants' reflections identified the need to understand the long-term consequences for children in terms of their physical and emotional health and wellbeing. A further implication of prolonged exposure to PSM, is the impact on their education.

19.1.11- PSM and the impact on children's education

This subtheme explores the impact of PSM on children's childhoods in relation to their time in education. Participants identified how school could further compound feelings of anxiety for a child living with PSM, especially for children who felt a responsibility to stay at home and care for their parents:

> I find that I've got children that don't go to school and have always got tummy-ache, or headaches and don't feel well and it's because they want to be at home to look after mum or to look after dad, because they're not sure what state mum or dad will be in when they get home. It stops them from going into school and feeling scared of what mum or dad are doing (Focus Group 3: PEI6).

The accounts from participants also suggest that being in school increased a child's anxiety as they wait all day not knowing what situation they will go home to. Participants' reflections highlight the pressure on children in school to learn and the burden of worry they have to endure throughout the school day:

> I suppose if you're there and you're seeing, then you can kind of prepare yourself for it even as a child but if you're at school and you're coming home and you don't know what you're coming home to, it can be quite scary (Focus Group 3: PEI1).

Participants from all three focus groups, unanimously spoke of their experiences and understanding of the impact that PSM has on a child's ability to enjoy and learn in school. Participants' reflections identified that life in school for children is a struggle; through fear of what might be happening at home and because of being hungry and emotionally overwhelmed, it's a struggle to concentrate and to learn:

> […] children not having breakfasts becomes an issue, children are saying that they've got themselves ready in the morning, they say things like erm 'mummy was asleep on the sofa and I couldn't wake her up last night' […] (Focus Group 1:PE7).

As participants recalled their accounts and understanding of the impact PSM had on children's education. Participants detailed their frustrations that the needs of children living with PSM was often not understood by professionals in school, particularly in high schools where children are not as well known. This was evident in one participant's account of a child who was suffering from neglect due to PSM and the effort it took for them to get into school, yet they were turned away for not having the correct uniform:

> It's the classic, they've got the wrong shoes on so send them home but what they're not actually understanding is the child has come in, […] you know, they've come in, can you not just, and you're thinking what message are you giving, […] (Focus Group 3: PEI2).

One aspect the impact of PSM had on children's education was falling attendance, often through repeated lateness into school which affected their attendance record:

> It's heart-breaking because the kid's never in school, but on her bedroom wall it was covered in post it notes of revision notes. She wants to learn but her attendance is about 18% but she clearly wants to learn (Focus Group 1: PE1).

Participants described their worries for children when they are not in school, knowing that children were probably meeting their own needs. But crucially, were not having a break from their home life. Participants believed that, for many, school was a safe place and they needed time in their safe place to support positive emotional health:

> Attendance in particular is a huge safeguarding issue, particularly when parents have substance misuse issues, they need that safe place and the more they get that the better they are (Focus Group 2: PSC1).

Participants articulated that there was a greater need for schools to understand the impact of PSM on children and for children's individual needs to be understood. This was echoed by many participants who felt that schools often took a 'punitive' approach to responding to children affected by PSM who didn't have the correct equipment for school. This resulted in children experiencing further negative consequences because of the impact on PSM.

19.12- Overarching theme one: Summary

This overarching theme has explored the lives and experience of children who are living with PSM, from the perspective of professionals. The emotive accounts from participants highlight the complexity of the lives of children living with PSM. Throughout the subtheme's the plight of the lives of children living with PSM highlighted significant safeguarding concerns in relation to children suffering emotional and physical neglect, as well as exposure to additional risk factors. The subtheme's identified additional risk factors associated with PSM such as witnessing domestic abuse, exposure to drug related crime and contextual safeguarding concerns. The needs of older

children were identified in relation to the longevity of exposure and the potential lifelong impact of prolonged exposure to PSM in relation to children's mental health and negative behaviours taken into their adult years.

Intertwined through the shared reflections from participants was the shared consensus that life for children living with PSM was unpredictable and isolating due to family conflict, mistrust of adults and the burden of having to maintain secrecy. The following overarching theme draws attention to the needs of children living with PSM and of the protective factors which help to lessen the negative impact.

Chapter 20

Overarching theme 2: Parental substance misuse- understanding protective factors and children's support needs

The previous overarching theme explored the lived experience and impact of PSM on children. The emotive responses from participants identified safeguarding concerns relating to PSM and the impact these have on children's emotional and physical health, both in the immediate and the long-term consequences. This overarching theme presents the findings from the three focus groups which focus on protective factors. The subthemes, as shown in Table 14 below, identify from the perspective of professionals, factors which lessen the impact of PSM on children, and of children's support needs.

Table 14 Focus groups; subthemes 2.1-2.6

Subthemes
2.1 Gaining children's trust takes time
2.2 The need for children to have a safe space
2.3 The importance of trusted adults
2.4 Trusted adult relationships in school
2.5 Specialist child-focused support
2.6 Responding to the needs of older children

20.2.1- Gaining children's trust takes time

To understand the needs of children living with PSM, participants recognised the need to understand that life for these children is complex. The previous overarching theme identified that life for children living with PSM is often fraught with the burden of secrecy. Participants described the value of investing time in children to gain their trust so that when they are ready, they can confide in trusted adults and that this was something that did not happen overnight:

> I think it's a huge amount of work for a practitioner or a support worker from any agency to break down those barriers […] it's time-consuming, we need the resources for someone to be able to build that relationship up so that they have someone they can talk to, someone that they can trust. And I think that can be a huge piece of work before any child will even begin to [share their experience of parental substance misuse] (Focus Group 2 participant: PSC1).

> We need to be given the time to build up relationships with children, so they can trust us and that just doesn't happen in an 8-week piece of work. (Focus Group 3: PEI6).

Participants reflected on their understanding that children who have experienced neglect, abuse and who have developed a strong mistrust of adults, need time to learn to trust professionals. The importance of time was identified in relation to providing a child a safe space, for professionals to offer comfort but without placing any pressure on a child to talk:

> Whatever has happened they're not in the mood for learning, sometimes it's just to sit in the office, you don't even need to say anything, just sit there for this lesson get your head together, that's all they need. A safe space essentially (Focus Group 1: PE1).

One participant described their frustrations at knowing children were being asked questions about their home life when professionals were already

aware of the concerns. Participants identified the value of allowing children time and the importance of professionals simply listening:

> We know their parent's a heroin user, not asking loads of direct questions because in my experience it just doesn't work and sometimes […] So, people just having an understanding how to communicate with children, how to listen actually […] someone for them that can listen and help them work through and just reflect and just be (Focus Group 3: PEI8).

Understanding the needs of children living with PSM led to many reflections not just about the time needed to gain a child's trust but of the importance of offering a nurturing response to children. Participants identified that children living with PSM need not only time, but they needed to feel nurtured, to feel understood and, most importantly, valued and cared for:

> The little boy, the only way I can describe him is he's feral. You know where he lives, smashing the estate up, up on garages, putting himself at risk constantly. But whenever I go into his classroom he approaches me with a book and says 'will you read a story to me', and so I sit you know in the corner and he puts his head on my shoulder, all he wants is for me to just read him the book […] you know if you saw him out on the estate, you'd never know that. But he misses that nurture because he doesn't get it at home' (Focus Group 1: PE2).

The importance of professionals taking time to get to know children and understanding children's fear of talking openly about their experience has been presented in this subtheme. Participants recognised the need to allow children time and that children who have experienced neglect and abuse due to PSM need to feel nurtured. The following subtheme builds on the notion of time and nurture by exploring the need for children to have a safe space.

20.2.2- The need for children to have a safe space

When prompted to reflect on the factors in children's lives which would support them when living with a parent who misuse substances, participants identified the need for children to have a space to retreat to:

> When your home may be very unsafe, that feeling of safety is absolutely key […] Focus group 1: PE5).

Participants emphasized the impact on children living with an unpredictable home life and the need for them to have stability, a place of safety, somewhere where they could feel safe and a place where they had a trusted adult to confide in:

> I think a safe place, whether that's the wider family, just somewhere where they can go when things have gotten to the point where they are frightened. Because that inconsistency of not knowing what state parents might be in, are they hungover, on a come-down, using drugs, under the influence. It can be really unsettling not knowing what state you're going to find your parent in (Focus Group 2: PSC1).

Participants reflected on the feelings of uncertainty and fear children experience when living with parents who misuse substances. One participant identified the need for children to be supported and have a place of safety, especially when PSM and parental mental health co-exist:

> It's when a child has got to deal with a parent who has tipped over from drug misuse into a psychotic episode and you're into dual diagnosis and it all gets very messy (Focus group 2: PSC6).

When children are faced with increased uncertainty, unpredictability and fear, having a place of safety was identified as a fundamental source of protection. The provision of such solace, whether in school or in their community, was significant in reducing the negative impact of PSM on children.

Linked to places of safety, the following subtheme explores the importance of children having trusted adults in their lives, whom they can seek solace from.

20.2.3- The importance of trusted adults

This subtheme explores the importance of children living with PSM having a trusted adult whom they can confide in during times of need. Participants identified that trusted adults can be from both the child's family and wider networks:

> Sometimes it's just that one trusted adult, whether that's school, grandma, [key]worker, I think it's really dangerous if that child is exposed to what they are exposed to and they don't have one person available to them to explore what they're going through (Focus Group 2: PSC1).

Participants described the importance of the relationship between children and their parents. Even if parents were misusing substances this did not mean that parents could not have a 'strong relationship' and provide emotional warmth and care. Participants reflected on their experience that just because a parent was misusing substances did not mean that they did not love their child:

> […] a strong relationship with the caregiver, if that child, despite all the, what we're talked about… if they still have a strong relationship with that caregiver then that's really important and that's going to give them that inner ability, strength (Focus Group 3: PEI8).

In circumstances when parents were unable to respond to their child's emotional and physical needs due to their substance misuse, participants identified the importance of a wider family network in stepping in to support children. Despite the recognised importance of wider family members such as grandparents, professionals raised concerns that, when completing assessments, professionals did not always include family

members from outside of the family home in their assessment and care plans for children:

> We need to be mindful of wider family and the extra layers of protection they can provide (Focus Group 2: PSC5).

Participants' descriptions and insight into the world of children living with PSM has highlighted the enormity of the impact on children's emotional health and wellbeing. In circumstances where family support is absent or where children feel they cannot talk to their family, the need for children to have the option for outside support was identified:

> It's those therapeutic interventions that are really important (Focus Group 1: PE3).

Where children are able to access and receive support from professionals, participants outlined the need for this support to be consistent. The narrative from participants was linked to previous themes of secrecy, trust and time. Participants stressed the importance of investing time in children who have little trust, of being consistent, and of not causing additional uncertainty for children by changing 'workers' (Focus Group 3: PEI3):

> Providing emotional support, helping them with their emotions and it's got to be consistent. Because that's when you see young people, make the best attachments, new attachments with people when they've got that one person who is consistent (Focus Group 3: PEI4).

Participants linked the importance of building trust and providing consistent support to advocating for children. Participants outlined that without a child's trust, professionals would not be able to ensure their voice was heard:

> It's about speaking on their behalf, of being that really consistent person for them and fighting their corner whether that be with parents, social care or your own colleagues. Being that person on their side, all of the time, no matter what (Focus Group 1: PE4).

Participants across all three focus groups identified the importance of children living with PSM having trusted adults in their lives. This subtheme has identified the role of professionals in providing time, nurture, a safe place and of trusted relationships in schools.

20.2.4- Trusted adult relationships in school

Participants recognised the role schools can play in understanding children's behaviour and adapting their responses to better meet the emotional needs of children living with PSM. Participants reflected on the value of children having the opportunity to have time on a one-to-one basis with a trusted adult in school, even if this was not a structured session as such, but an opportunity for children to talk if they wanted to:

> It's more about giving them an outlet, building their strength and their confidence […] it's about doing what you can with that child, letting them know that they are cared for, letting them know that they are important, letting them know that they are good at something […] it might allow them to discuss their feelings, even if they can't disclose what's going on. But they have that trusted adult that they can lean on (Focus Group 1: PE7).

Understanding children as individuals with a need for tailor-made support plans was reiterated by participants who recognised the need for children to have an outlet. Participants identified the role schools can play in in building a trusted relationship with children to support them to become involved in positive activities. Participants identified that having an opportunity to engage in positive activities such as sports would enable children to have a break from their home life and can be an important factor which could strengthen their ability to cope:

> […] something outside of the home can be the salvation, because that's the place they find out they're a fantastic footballer, they find out that they've got a group of friends that will support them, they don't have to talk to adults about it because actually they've got their

> friends, they find out they're a fantastic dancer, it's that outlet that they can feel good about themselves because a lot of these children don't end up feeling very good about themselves (Focus Group 1:PE7).

Participants from education talked openly about the needs of the children they support, and spoke passionately about wanting to do all they could to support children living with PSM. Participants across all three focus groups stressed the importance of children having trusted adults in their lives. Support for children in school was viewed as a stepping-stone in helping to reduce the impact of PSM on children. However, professionals felt there was a need for children to have the opportunity to receive specialist support regarding their experience of living with PSM. The following subtheme explores the need for specialist support.

20.2.5- Specialist child focused support

Participants articulated the importance of having specialist support provisions available for children living with PSM. Participants also identified the need for professionals, from an early intervention level, to be trained to understand the impact of PSM and have the practice skills to be able to support children.

One participant reflected on their experience of having a specialist keyworker in school and how well this had worked in supporting children and their parents:

> We used to have trained pastoral workers in some schools…and that service throughout my time as a social worker was invaluable. Because the parents felt comfortable with those pastoral workers because they were linked to the school. They don't see them in the same way, as a threat, and the children were able to get the support and were able to talk about alcohol and drug use (Focus Group 2: PSC7).

Participants also identified the importance of specialist support provisions that can support the family as a whole. This support, which participants had

experience of in their local authority, was valued due to the practitioner's knowledge and expertise regarding PSM. Participants attributed to the professionals' specialist knowledge of PSM, the fact that a 'platform' had been created for children and families to talk openly and for children to have time with a specialist to 'understand' and, in essence, make sense of their world. Participants from statutory social care shared their frustrations that they were often unable to build trusting relationships with children due to the demands of their role and due to families fear of engaging with social workers. This meant, at a safeguarding level that required statutory interventions, there was a greater need for specialist support provisions for children living with PSM:

> I think it's more effective and, sadly, the person that's trying to explore things with the child isn't the social worker. Because I think it's more effective when it's not our role. Because of the consequences our role has and that's a shame really (Focus Group 2: PSC1).

The narrative echoed by many participants across all three focus groups regarding the provision of support for families was that children should have access to child-focused support. While interventions which were centred on the whole family were valued, participants felt that this approach would often mean the needs of children becoming lost:

> It's a child that needs support, separate from parents because, the young person gets lost (Focus Group 3: PEI4).

Participants' reflections of their experience in practice identified the importance of service provisions/ interventions for children, which were not time scaled. Linked to previous subthemes of gaining a child's trust and needing time to achieve this, professionals reflected on the need for children to have long-term support, if needed, due to the impact or prolonged exposure to PSM on a child's emotional health:

> [mum] has come through that cycle now and isn't using alcohol anymore […] the children have experienced it and even though they

> have come through it, the ripple effect and catalogue of chaos from substance misuse is still impacting on the children (Focus Group 1: PE5).

The importance of specialist support being available for children who are living with PSM has been identified in this subtheme. Participants have highlighted how having a professional in a child's life who understands PSM and is able to communicate with children and their families, has paved the way for a child's voice to be heard and, importantly, to be understood. Further, specialist support in primary schools and professionals being equipped to respond to the needs of children living with PSM as early as possible were also presented in this subtheme. The following theme will explore the needs of older children (teenagers) who live with PSM.

20.2.6- Responding to the needs of older children

The subthemes presented so far have highlighted the need for children living with PSM to have support from a trusted adult both within their family and to have the option to access specialist support. Participants also acknowledged the needs of older children and the importance of professionals responding to their needs, as participants felt older children often had a greater understanding of their circumstance:

> Many professionals don't give kids enough credit for what they know […] I've worked with teenagers who have a full awareness of what mum or dad are doing I can remember one teenage girl being so fed up with her mum because she just wasn't committed to making any kind of change and mum was selling herself for sex. And using a lot of amphetamines as well and the kid just had absolutely no trust in her mum […]it was so damaging to her (Focus Group 2: PSC7).

Participants reflected on their own practice and drew comparisons between supporting younger and older children. Participants identified the difficulty they had experienced in understanding the needs of older children, as for younger children the impact of PSM was very much focused in the impact of

physical harm. In comparison, participants felt the needs of older children were centred more so on their emotional needs:

> I think the risk initially when the child is younger can be quite physical risk in terms of not being supervised, you know being exposed to paraphernalia and being exposed to all those sorts of physical. But as they get older when children grow older it becomes more of an emotional risk, in the sense the more they understand what they're doing and what parents are choosing over them (Focus Group 2: PSC2).

The themes so far have identified that PSM can and does impact the emotional and physical health and wellbeing of both younger and older children, however, participants identified that the needs of teenage children are not prioritised in the same way as younger children:

> It's just by the time they get to teenagers I think it's our capacity to actually make changes at that time, sadly they are not our priority sometimes (Focus Group 2: PSC3).

Participants identified the challenges they face due to having to prioritise the needs of younger children who were at risk of immediate significant harm. There was a sense of powerlessness due to limited resources and processes aligned more so to the needs of younger children, as depicted below:

> The balance changes as the child grows older, the risk changes, because teenagers can look after themselves more in the sense […] We're limited because you wouldn't go into proceedings […] too much older and you wouldn't consider child protection at 16/17 [years of age] I think we're a bit more limited when they're a teenager. Sometimes there's a view that they can take care of themselves, the older they are the less flexibility we have (Focus Group 2: PSC2).

20.7- Overarching theme two: Summary

This theme has presented accounts from participants practice experience and their perspective of what children living with PSM need by way of protective factors. Participants' reflective accounts highlighted the importance of building trusting relationships with children and the need for this to be at a child's pace. Especially given the possibility children may have formed an inherent mistrust of adults and may carry a burden of having to keep their parents substance misuse a secret. The overarching theme identified the need for children to feel nurtured, to be valued and to be cared for and that this dedication of care and nurture can come from both within a child's family and from relationships with professionals.

The themes have highlighted that a significant protective factor, alongside relationships, was the need for children to have a safe space to retreat to and seek solace when life at home had become unsafe and unpredictable. The safe spaces presented were the homes of wider family members, children's schools, access to professional therapeutic support and children having opportunities seek comfort and solace in positive activities. Overwhelmingly, participants expressed the need for service provisions to be child focussed, as from their perspective, the needs of children can become overlooked within a whole family approach. The subthemes also identified the needs of older children and shared consensus that as children grow older and enter their teen years, risk factors do not diminish but simply change. The following overarching theme explores the challenges experienced by participants in practice in responding to the needs of children living with PSM.

Chapter 21

Overarching theme 3: Understanding challenges in practice: responding to the needs of children living with parental substance misuse

This overarching theme explores in greater detail the challenges in practice in responding to the needs of children living with PSM. The subthemes as shown below in Table 15 will each be presented in turn;

Table 15 Focus groups; subthemes 3.1-3.4

Subthemes
3.1 The impact of austerity measures on service provision
3.2 Changes in adult treatment services and the implications for children
3.3 Parental denial stigma and shame
3.4 Parental mental ill health and substance misuse
3.5 PSM: Knowledge and training

21.3.1- The impact of austerity measures on service provision

The impact of austerity measures over the past decade on the closing of community resources such as youth and children's centres and the disbanding of front-line services was raised in all three focus groups. The focus group interview schedule did not ask any direct or indirect questions relating to the current economic climate and the government's decision to implement austerity measures. However, this subtheme presents emotive reflections from participants on this topic.

The consensus among participants within all three focus groups outlined that austerity was a significant challenge which directly impacted on their practice in supporting children and families. Participants linked reduced services to being unable to respond to the needs of children in a timely manner or to prevent safeguarding concerns from escalating:

> When you cut services, that directly translates into children not meeting their milestones and not having a good life. It's that simple, you cut services, you cut money, children are not getting fed and are not getting services and that means children who are not resilient and able to go on to adulthood and to contribute to society (Focus Group 1:PE5).

The implementation of austerity measures and the direct impact this has had, especially on children and families affected by substance misuse, was highlighted by many participants. Participants reflected on their experience of supporting families where PSM was a safeguarding concern and how those families were often struggling to provide food for their children. The implementation of austerity, coupled with the new Universal Credit benefit system, meant children and their families were plunged deeper into poverty:

> The impact of Universal Credit and how poverty is becoming normalised because of the use of, and the need for, food banks […] I suppose overall cuts to services has a direct impact on these amazing young people (Focus Group 1: PE5).

A further concern raised by participants relating to the consequence of reduced services was the 'window of opportunity' being missed. Participants emphasised the need to be able to respond and to signpost children and families to specialist support. The frustration felt by many participants was that when the window of opportunity had gone, it was difficult to maintain the trust and relationships they had built with children and families.

Participants described needing to respond to the presenting needs of children and families when parents had acknowledged the impact their

substance misuse was having on their child or, had agreed to accessing support themselves:

> I'm at this point where I've built a relationship and 'right, let's go and get you some help' but because of all the pressures of other services […] I need it there and then (Focus Group 3: PEI8).

> […] because we've missed that opportunity it just reinforces it for the kid 'oh well, people can't help (Focus Group 3: PEI5).

Participants also raised the issue of early intervention; with continued cuts to frontline services, it was becoming increasingly difficult to protect children living with PSM from increased risk of harm and contextual safeguarding concerns:

> We've all talked today about dealing drugs, teenagers being groomed to deal drugs, it's happening all the time, it's just horrible, kids being brought into it from an early age, you can't blame the police, but there is an impact of reduced resources and police cuts (Focus Group 2: PSC7).

Participants reflected on their concerns about children living with PSM being at risk of, and in many cases victims of, sexual and criminal exploitation. Participants identified the loss of youth services in their local authority and the direct impact this had on those children vulnerable to exploitation:

> Youth clubs used to be able to get underneath all of that, they could get behind the information, be the early intervention and disrupt a lot of the grooming and exploitation (Focus Group 2: PSC4).

> You know the investment in the youth service, it pays off in so many different ways, you know, drug treatment, offending, mental health […]
>
> (Focus Group 3: PEI7).

Youth services/ clubs were highlighted by participants as a valued community resource that could often infiltrate, disperse gangs and prevent children from being groomed and exploited. Participants also identified the loss of early intervention services as a contributing factor on the increased pressures on statutory services:

> I think when we're picking up cases, teenagers need youth workers most of the time, not social workers (Focus Group 2: PSC3).

Participants' reflections highlighted the value of having informal support options, as children may not feel able, or ready, to seek and engage with formal support. This discussion regarding informal support such as youth centres and youth workers was linked to previous subthemes in relation to children's mistrust of adults, fear of social care intervention and the pressures of having to keep their family circumstance a secret.

A further lost opportunity to reach children living with parents who misuse substances was identified by participants in relation to children not attending school. This linked to participants' previous reflections on the impact PSM can have on children's school attendance. Participants identified that when children are regularly not in school, more needed to be done by professionals and services to reach those children:

> When you've got school refusers it's so frustrating that they can only access that service if they go into school, which is a huge gap (Focus Group 2: PSC2).

Participants identified further lost opportunities in reaching children living with PSM, especially when those children have developed unhealthy behaviours and coping strategies. 'Outreach' (Focus Group 3: PEI3) was identified by participants as an important aspect of day-to-day practice, outlining how children and families who may be fearful of interventions are less likely to attend centre-based services and so more needed to be done to offer support to those children and families most in need.

For children who have lived with PSM over a prolonged period of time, or who had suffered trauma, participants highlighted there was often a need for specialist mental health services. Unfortunately, due to reduced services as a consequence of implemented austerity measures, children were not able to access services in times of need. Participants shared their experiences of children requiring specialist mental health support and having to wait at least '12 weeks' (Focus Group1: PE3) for an initial appointment:

> Psychological support, emotional support, well-being support, it's not there, we haven't got the resources and there are massive waiting lists (Focus Group 3: PEI3).

> Cutting of services impacts on waiting times, for some children that might be that they need to wait a year for a service, that means a child is effectively not engaging with the whole year […] you know you're sat in the classroom but you're not doing the work, you're not progressing during that year, children don't get back that time in education, in some of the most precious years of their life, how many years of education are wasted (Focus Group 1: PE5).

This subtheme has presented the challenges professionals in front-line services face in trying to support children and their families who are plunged deeper into poverty and have limited access to mental health services because of the impact of austerity. The reduction of front-line services, most notably the disbanding of youth services in the community and long delays for children needing specialist mental health support, has highlighted the opportunities that have been lost in responding to the needs of children living with PSM. Participants' reflections of their experience in practice of lost opportunities highlighted the need for services to outreach, to reach children who were not in school and who would not attend formal appointments.

The next subtheme explores the challenges experienced by professionals in working alongside adult drug treatment services and the implications those challenges may have for children living with PSM.

21.3.2- Changes in adult treatment services and the implications for children

Participants shared their views regarding adult substance misuse services and how they too were lacking in 'outreach' support. There was agreement that outreach workers were especially valuable for parents who were ambivalent or fearful of being honest about their substance misuse and for parents who were not able to attend appointments. Participants also expressed a view that adult substance misuse services appeared to be too restrictive in terms of timescales and lacking in longer-term support:

> I think the same should be applied to mental health and drugs and alcohol. You know, it needs to be thought of as a lifetime solution and not a we'll give you 6 weeks CBT and then 'all the best' (Focus Group 1: PE5).

The experiences shared by participants regarding adult substance misuse treatment services led to reflections on the implications for children. Participants described a sense of distance between children and adult services, due to differing professional remits and priorities. The frustration aired by participants was that there was a gap between treatment services and social workers, and this gap is not conducive to supporting parents to engage in treatment, in facilitating change and in working with families to lessen the safeguarding concerns.

Participants identified that if there was improved communication and co-working between adult and children's services, then adult treatment workers could bridge that gap' and support the parents' engagement with their children's social worker:

> Adult services have a completely different remit to us. It's not necessarily a true picture of what is going on in that house […] the more joint work between adult and children, that would be helpful (Focus Group 2: PSC6).

Participants also described the frustrations they experience when supporting parents to access substance misuse services. Changes in the commissioning of services led to changes in service design and provision, as well as increased waiting times. Participants outlined their experiences of parents often not knowing how to access treatment services because of these frequent service changes:

> The other frustration is the way that adults' services are set up, if I'm honest […] it's this whole government idea that we need to commission you and then all of a sudden that commissioning changes and then it's all change […] If I as a practitioner am having to ask colleagues in that field what do I do, how the hell are substance misusers meant to do it? (Focus Group 3: PEI8).

The commissioning of adult treatment services and the implementing of payment by results was highlighted as a further challenge in practice, as participants shared their frustration at increased waiting time to access treatment services and the impact this has on parents' motivation.

> If we've got parents who have got to the point where they say yes, I want to make changes, the waiting lists to access services […] by the time you get to the top of the waiting list, you lose them […] their motivation has gone (Focus Group 2: PSC6).

Participants' reflections on their experiences in practice highlight the dedication shown to support parents when they are ready to access substance misuse treatment services. Yet, due to changes in commissioning and reduced services, parents were not always able to easily access this support; the consequence for children would be continued exposure to PSM. The following subtheme explores the challenges experienced by participants when parents are unable to be honest about their substance misuse or deny needing support.

21.3.3- Parental denial stigma and shame

Participants' reflections of their experience of supporting children and their families affected by PSM highlighted the complexity of attempting to build relationships and to support parents to make positive changes to their substance misuse. A significant challenge faced by professionals when responding to safeguarding concerns due to PSM was parents' denial or minimising of their substance misuse.

Reflections from participants in social care highlighted the emotional strain on parents to conceal their substance misuse, due to fear of the consequences of having their child removed from their care. Participants also shared their frustrations of rooting for parents to be honest so they could prevent safeguarding concerns from escalating and prevent the need for a child to be removed from their parents' care:

> […] when we're working with families who are still in that denial stage, it's really, really hard, especially when we have the child's timeframe in mind, particularly for under-fives when we think these concerns can't wait for help (Focus Group 2: PSC3).

Participants' narratives of the reasons why parents may feel reluctant to be honest about their substance misuse was also underpinned by a sensitive understanding that PSM is complex. Participants acknowledged that for many parents, their substance misuse may be the only coping strategy they feel they have, leading to an acknowledgment of the fear parents would have of facing the prospect of life without the one thing that has helped them to cope.

> It's not that they don't love their children or are not bothered about their children being taken from them […] They might tell you that they want to give up and they might really mean that; when they go back from that meeting into their life, it's so difficult for them to change (Focus Group 1:PE7).

One aspect identified by participants of the impact of parents concealing their substance misuse was that often the needs of children went ‘under the radar’ (Focus Group1: PE6) for too long. Participants explained that they were often unaware of the needs of so many children until a point of crisis, following a significant safeguarding incident. Participants also outlined that only at a point where families were in the legal arena were they able to accurately assess risk.

> Unless we get a referral from the police because there’s been a domestic, or a parent has presented at A&E, you don’t know how it’s impacting (Focus Group 2: PSC7).

Participants also identified the impact of parental denial and secrecy on children in relation to their emotional health and the impact on a child of wanting their parents to be honest and to accept support.

> Mum is telling social workers ‘I’m fine’, coming to TAC (Team Around the Child) meetings and saying ‘I’m fine, I’ve not drank anything for 18 months now, I’ve been dry for 18 months, the shakes are from my anxiety’ and the lad’s like ‘No she’s bringing home bottles of vodka’ (Focus Group 3: PEI7).

Underpinning parental denial or minimisation of substance misuse, as identified by participants, was parents’ overwhelming fear of losing their children. This was identified by participants as a significant barrier for parents accessing treatment and working openly with children’s services.

> I think it’s really easy for us to criticise their lack of honesty but when the consequences are so high, I can totally see why a parent wouldn’t say yes I use heroin three times week, for fear of the worst-case scenario, of their child being removed (Focus Group 2: PSC1).

Participants’ reflections of the challenges they face in practice when trying to build relationships and trust with parents who misuse substance has been presented. When parents were unable to be honest about their substance

misuse, participants shared emotive accounts of children not coming to the attention of services until there had been a significant safeguarding incident. This subtheme also highlighted the emotional toll on children of knowing their parents were not being honest. Participants' were sensitive to the reasons why parents may not be honest, such as experiencing shame, stigma and fear of the repercussions of being honest.

The following theme explores a further challenge identified by participants in being able to support children and their parents, when parental mental health co-exists with PSM.

21.3.4- Parental mental ill health and substance misuse

Participants within all three focus groups shared their experience of supporting parents who misused substances and the connection to poor mental health. Participants' appeared sensitive to the needs of parents and the complexity of parents struggles with past and present trauma and of ongoing mental health problems.

> I've never worked with a child where parents misused substances and parents didn't have mental health issues. Whatever the trauma that has led to that, it could be domestic abuse or problematic childhood experiences. I've never once worked with someone where it wasn't there (Focus Group 2: PSC1).

A significant concern raised by participants was the response from the adult substance misuse and mental health services. Participants aired their frustration that parents were not able to access specialist support. The descriptions by participants suggest that when necessary support and interventions are not available for parents, this had a knock-on negative impact on children:

> There is conflict between your need to address the substance issue first before we can address your mental health (Focus Group 3: PEI8).

> I don't think drug services in my experience, particularly look back that far as to why a person started. I mean, maybe they're not trained in that trauma-based stuff, it's very much the here and now (Focus Group 2: PSC2).

Whilst sensitive to the needs of parents, participants expressed their concern for children living with parents where mental health and substance misuse co-existed. Participants described how parents often 'neglected' themselves and were unable to meet their 'self-care' needs. The impact on children on witnessing their parent's mental health decline, being exposed to PSM and experiencing inconsistent parenting is linked to findings presented in overarching theme one:

> I don't like the word 'damaged' but they are so affected by their experiences that they can't be available for their children and that impacts on the next generation (Focus Group 3: PEI8).

Participants' reflections of their experience in practice has highlighted the multiple challenges they face when trying to engage, build trust and support parents who misuse substances. When parental mental health is intertwined with PSM, the challenges appear to be heightened both in terms of parent's access to services but of the impact on children due to having to endure added complexities. One of the challenges identified in this subtheme was in relation to knowledge and understanding of PSM and of the need for professionals to be trauma informed.

The following theme explores the challenges experienced by participants due to inadequate training and knowledge in responding to the needs of children living with PSM.

21.3.5- PSM: Knowledge and training

Participants' narratives regarding their knowledge of PSM was centred on a consensus that much of their practice was based on previous experience and a sense of learning on the job. Participants expressed frustration

regarding training on substance misuse, and PSM, across the children's workforce as a whole. Participants' detailed accounts suggested the training currently available was too basic, especially for statutory social workers:

> I think there's another level of training needed… drug and alcohol knowledge…I've been on the basic training we have but it's pretty limited information, you know, for the social worker to assess the impact on the child, it's too basic. I think there is another depth that's missing. You know I think a lot of us learn on the job, it should really be part of the basics of social work, because they don't cover it at uni. (Focus Group 2: PSC3).

Participants shared their concerns that due to a lack of knowledge and adequate training, particularly for professionals making decisions at the first point of contact, children and families were not receiving support early enough:

> Mum had been significantly using cocaine, she's absolutely broke, there are 5 children in the house, we went straight through to MASH [Multi Agency Safeguarding Hub] and I didn't hear anything back at all. There was zero curiosity about it […] there are 5 children in that house (Focus Group 1: PE4).

With limited knowledge and access to PSM training, participants identified that the consequence for families was inconsistent responses from professionals, especially regarding decision-making as to whether a family required statutory or early help services:

> I read a lot of social workers' assessments, sometimes it's hard to link the impact on the child. I often say to social workers 'Well, so what if mum is using drugs, so what if she drinks, what does it mean for that child? (Focus Group 2: PSC7).

Participants described discrepancies in practice because the assessment of the impact of PSM on children was often based on previous experience and a judgment that some drugs are worse than others:

> I know a couple of parents who use heroin and say that it actually helps them to function to be better parents. On the surface of it, you know you have a bit of preconceived idea of a heroin addict, don't you, you know that image. But actually, there are some people who completely don't have that image at all (Focus Group 3: PEI3).

In response to concerns raised by participants about the lack of appropriate training on substance misuse and the impact of PSM on children, participants identified what they felt they needed to better respond to the needs of children living with PSM:

> If it's possible, something like mapping parental substance misuse against child development. Like what a child needs at certain points and how parental capacity, parental substance misuse can be impacted and what children need in different age groups (Focus Group 2: PSC4).

> I think we do need specific training though, on parental misuse and substance misuse and I think we need to have that refreshed all the time (Focus Group 3: PEI3).

Participants identified the need for specific training on drug and alcohol misuse, to be able to understand the associated risk factors with each substance. Participants described how they would value training which would also provide them with an improved understanding of levels of substance use, linking this to the impact on children:

> I always think, well, what drugs are they using, what's problematic, how does it impact. Sometimes we just give it a term don't we and we don't actually know how problematic it is (Focus Group 2: PSC1).

One participant shared their experience of having been on a drug and

alcohol training course and the positive impact this had had on their practice, improving their assessment skills and confidence to talk openly with parents about their substance misuse:

> I felt far more equipped after that and I think it should be mandatory for all social workers […] just the basic level of what does crack actually do, what is that feeling that they're after, and how long does it last. I know it sounds a bit random, he even showed us how to cook up heroin […] it was about me then being able to see through the child's eyes what they're seeing and what they're exposed to […] he was explaining the safe way to do various things, and actually now I could have a conversation with a parent about their use and do they follow the safety advice from treatment workers (Focus Group 2: PSC2).

21.7- Overarching theme 3: Summary

This overarching theme has presented reflective accounts from participants of the challenges they have experienced in practice when responding to the needs of children living with PSM. Participants identified the challenge they face due to the implementation of austerity measures, resulting in reduced frontline services. Further challenges in practice were identified particularly in relation to the perceived fragmentation of adult treatment services, with continued restructuring and commissioning, leaving both professionals and parents unsure of new processes to access treatment.

The lack of outreach support for parents regarding their substance misuse was identified, especially when a parent was ambivalent or unable to access community resources. This was perceived to have a direct impact on children as they continued to be exposed to PSM. This theme has also highlighted practitioners' frustrations of their lack of knowledge of substance misuse and the impact this had on their ability to see the world through the eyes of children. This gap in knowledge and training highlighted the impact of

participants ability to accurately assess the needs of children and to have meaningful conversations with parents about their substance misuse.

21.8- Part 4 Summary: Focus groups with professionals

Professionals from across a children's workforce have shared their experience of supporting children and families where PSM is a safeguarding concern. The findings presented from the three focus groups has highlighted the complexity of PSM because of associated safeguarding concerns relating to children's exposure to domestic abuse, drug related crime and parental mental ill-health.

Participants shared their experience of the direct impact PSM can have on children not having their day to day emotional and physical health needs met. Participants reflected on their experience of children suffering physical neglect, as well as the emotional harm due to parents not being able to respond to their children's emotional needs. The impact of children experiencing neglect was linked to an increased risk of contextual safeguarding concerns, as children sought solace away from their home and were then at risk of exploitation. Participants acknowledged the needs of older children, however the impact of reduced resources meant they often had to prioritise the safeguarding needs of younger children.

The findings from the focus groups illustrated the complexity and unpredictability in the lives of children living with PSM, and the need for children to have trusted adults both within their family and from professionals. The shared consensus was that children living with PSM need to be nurtured, valued and cared for and services responding to the needs of these children should not be time limited.

Participants shared their frustrations of not receiving adequate training to appropriately assess and respond to the needs of children living with PSM. When training was available, participants described how this had a positive impact on their practice and ability to see the world through the child's eyes.

The impact of austerity measures highlighted the missed opportunities to support children and their families. In their endeavour to respond to the needs of children living with PSM, increased waiting times for services and services no longer existing, left participants with a sense they had missed opportunities to support families at an early stage.

The creative interviews with children illustrated the multiple layers of adversity and harm children can suffer when living with parents who misuse substances. The interviews also illustrated what children felt they needed in times of adversity and crisis to lessen the impact of PSM. The themes of risk and protection, of adversity and support, carried through to the professionals' focus groups findings.

The findings presented from the literature review, creative interviews with children and focus groups with professionals are complex and multi-layered. Part five of this thesis will present the discussion chapters and draw on all three data sets to provide an in-depth understanding of the needs of children living with PSM and how those needs span multiple systems. Before the discussion chapters are presented, it is important to acknowledge the limitations and challenges from this research project.

Chapter 22- Limitations and challenges

This research project was centred on privileging the voices of children living with parents who misuse substances. I chose not to collect information from the children's parents and keyworkers prior to the interview; this was done deliberately to ensure I understood the children's' narratives from their perspective and not through the lens of adults. Including the voice of the children's parents may have contributed to an understanding of the needs of the whole family. However, it was not possible to include another source of data due to the parameters of this research project. The inclusion of parents in the research may have also led to the research becoming focused on the needs of adults and not on the needs of children.

A further possible limitation relates to the focus group participants and whether professionals from different local authorities would have shared similar or different perspectives. It is possible that only participants who had an invested interest in this research project's topic volunteered to participate. This potential limitation was mitigated by the inclusion of participants from a number of different professional backgrounds, spanning multiple areas across the children's workforce.

The small number of child participants and small number of focus groups means the study is not generalisable, nor was it meant to be. The principles of hermeneutic phenomenology favour smaller numbers of participants, to reach a greater depth and level of understanding, which would not have been possible with a large number.

The integrity and trustworthiness of this phenomenological research project was protected by considered and detailed planning, as outlined in the methodology chapters. The number of data sets (literature review, creative interviews with children, and focus groups with professionals) 'increases the scope or depth of the study' and the presentation of detailed quotes from participants contribute to the credibility and trustworthiness of this study (Morse, 2015:1216). Whilst not generalisable the consistency of the findings

suggest they are relevant and transferable to other PSM settings identifying key issues and concerns to be addressed. The detailed and considered steps outlined in the research design (chapters 10 and 11) would enable this research to be replicated.

A significant limitation to this research was the absence of BAME (Black, Asian and Minority Ethic) representation. The lack of diversity means this study has not been able to contribute to the body of knowledge regarding particular issues that BAME children living with PSM may experience. BAME children were not identified by the special service to participate in the research. I am confident this was not a purposeful exclusion but a reflection of the local area's demographics. This is evident in a report of the local authority demographics, whereby the presented data outlines that the local authority is less 'ethnically diverse', as 92% of the population identify as white. This is in comparison with the national average of 86% ([Edited for anonymity] MBC:2016)

With additional time and resources, I would have ensured that children living in different local authorities, from BAME communities, and from different cultural and socio-economic backgrounds were included. Due to the limitations of time for a PhD, and of being a single researcher it was not possible to conduct a larger research project.

Part 5

Discussion and conclusion

Chapter 23 - Introducing the discussion

This research set out to understand the needs of children living with parental substance misuse (PSM). Specifically, the objectives of this research were to:

1. enable children and young people to talk about their experiences of PSM in a safe and supported way

2. investigate the experiences of professionals across a children's workforce in responding to PSM and how they can be better supported

3. build a model of practice grounded in the experiences of children and professionals.

The body of existing literature, as presented in part two of this thesis, demonstrates the adversities that children can experience when exposed to PSM. Despite the current knowledge, children living with parents who misuse substances are overlooked in UK legislation, and the responses in practice to the needs of those children remain fragmented.

The methodological design of this research was ground-breaking because this is the first time the experiences of children living with PSM was privileged along with practitioners from children's social care, education and early intervention services. The use of creative interviews with children provided new contributions to methodological knowledge. The two art-based creative methods; 'if alcohol or drugs was an animal' and 'the resilience tree', have not been used previously as a research method with children. These creative methods also contribute to methodological findings, as this research has shown that the use of less traditional methods does not compromise the

rigour and validity of qualitative research. I believe that the design of this research has enabled the children to share their actual and current lived experience at their pace and in their preferred way. This research has provided a depth of understanding of the needs of children living with PSM which otherwise may not have been achieved.

Drawing the findings together from across the three data sets (literature review, creative interviews and focus groups), this discussion will present new knowledge which will provide an in-depth understanding of the needs of children living with PSM, and bridge the gap between research and practice.

Framed by Bronfenbrenner's (1977) ecological systems theory, the complex interactions between a child's systems are discussed. Those systems include a child's Microsystem (immediate home environment, family relationships), Mesosystem (neighbourhood, friendships, social networks), Exosystem (community resources, service provision), Macrosystem (wider political systems) and Chronosystem (significant life events).

The significant themes from the three data sets will be discussed and the key messages for practice will be presented in three parts, in response to each of the three research questions:

- How do school aged children (aged 5-16) experience living with a parent who misuses substances?
- What do children need in order to promote and strengthen their emotional resilience and enable them, when appropriate, to live safely with parents who misuse substances?
- From the perspective of professionals, what changes are considered necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

Chapter 24

Understanding the complexity of children's experience: Living with parents who misuse substances

The findings from this research illustrate that the experiences of children living with PSM are complex and the impact on the lives of these children can be severe. The reflections from children and from professionals who endeavour to support children living with PSM, illustrated that PSM is associated with multi-layered and complex risk and protective factors. Existing research has not explored the complexity and severity of PSM from the perspectives of both children and professionals.

The key focus of this chapter is to discuss the interplay, severity and impact of accumulative risk factors, across multiple systems and answers one of this research project's three research questions:

- How do school-aged children (aged 5-16) experience living with a parent who misuses substances?

This chapter will critically integrate findings from the literature review with creative interviews with children and focus groups with frontline professionals. The following themes were chosen for discussion because they have not been discussed in previous literature and are integral to understanding the experience of children living with PSM. They illustrate the complexity of their lives and the factors associated with increased risk of significant harm:

- The complexity and severity of children's experience of PSM
- Children's lost childhood: Contextual safeguarding and the impact of PSM on older children
- The longevity of exposure to PSM: Towards a theoretical understanding.

As previously outlined within this thesis, not all children who live with parents who misuse substances are at risk of significant harm. For those children who are exposed to increased risk of harm, an understanding of associated risk factors is central to understanding the needs of children affected by PSM. The voices of children who participated are central to this research and it is their voice that will illuminate existing and new findings.

24.1- The complexity and severity of children's experience of PSM.

The findings from serious case reviews in England, which span 14 years of research (chapter 4.4), repeatedly outline domestic abuse, parental mental ill-health, and PSM as key factors which increase the severity of risk of harm to a child. The literature review also presented the findings from a report by the ADCS (2018:23) in which a combination of the three significant risk factors are referred to as the 'trigger trio'; these factors are the most prevalent reasons why children and their families come to the attention of children's social care.

It is important to understand that the combination of the trigger trio can cause significant harm to a child, but equally important to understand the complexity of other factors, beyond the 'trigger trio' that can negatively impact children living with PSM. Skinner et al., (2021:1) suggest that the 'idea of a toxic trio' has become 'deeply embedded' in both policy and practice, yet the idea of a toxic trio or trigger trio is theoretically underdeveloped. The findings from this research (part four), illustrate that the presence of the trigger trio is not always a precursor to the negative impact of PSM on children. As illustrated in part four (table 7, chapter 15) PSM was associated with multiple risk factors, but the severity of the negative impact on children was not always dependent on PSM co-existing with domestic abuse and parental mental ill-health.

The literature review also illustrated that research relating to PSM can be narrow. This was evident in research that focussed on either drugs or alcohol

and not both substances. The *Hidden Harm* report by the ACMD (2003), and research by Barnard and Barlow (2003), focused solely on parental drug misuse, excluding children whose parents misused alcohol. In contrast, the publications by Turning Point (2006), and POST (2018), focused solely on parental alcohol misuse. Chapter five of the literature review highlighted a focus on the impact and complexity of PSM on the lives of children in relation to domestic abuse (Velleman and Reuber, 2007; Templeton et al., 2009; Galvani, 2015). Further, chapter five also illustrated the narrow focus of research regarding PSM and the focus of literature on PSM and parental mental ill-health (Reuper et al., 2012: Arria et al., 2012). Therefore, it was important that this research avoided a singular focus, to ensure the complexity and severity of PSM could be understood, and how risk factors associated with PSM can increase and compound the negative impact for children.

A significant theme underpinning many of the children's reflections were feelings of their lives being fraught with uncertainty and exposure to multiple risk factors. The children shared detailed reflections of missing school, fleeing violence, being caught in the middle of family conflict, experiencing poverty, being separated from their parents when they were hospitalised, and witnessing significant parental injury. This complexity of PSM and the impact on the lives of children through exposure to multiple risk and adversity can be seen in table seven (chapter 15).

24.1.1- The impact of unpredictable behaviour

The practitioners across the three focus groups also shared their experiences of PSM, and the added complexity of parents' unpredictable behaviour as a result of substance misuse and poor parental mental health. As outlined by Kroll and Taylor (2009:114), PSM and parental mental ill health are linked and can lead to unpredictable behaviour which they refer to in terms of the 'before and after parent'. The findings from the focus groups emphasised the messy reality of PSM and the direct impact on children. Professional participants reflected on their experience of supporting families

where PSM was a safeguarding concern and how parents could often be described as ‘erratic’, ‘short tempered’ and their moods were ‘up and down’.

Changes in the behaviour of parents due to misusing substances is well documented in research literature, particularly in reference to how certain substances may impair parents’ behaviour and judgement (Arria et al., 2012). Parental misuse of substances such as heroin and alcohol, can result in states of extreme drowsiness and impaired concentration. Substances such as amphetamines and cocaine can be associated with states of agitation and restlessness (Dawe et al., 2008). Prolonged substance misuse has also been noted in the literature as resulting in heightened levels of suspiciousness, hostility and delusional beliefs (Dawe et al., 2008).

The connection between PSM and impaired parenting is documented in a mixed methods study by Arria et al. (2012). Their study analysed data from respondents aged 15-54 years from the National Comorbidity Survey in the USA. The focus of the study was to explore the relationships between PSM in childhood, parenting behaviours, and the risk of developing substance misuse in adulthood. The findings from the study by Arria et al. (2012:115) were based on quantitative data and retrospective accounts from participants who completed ‘supplemental interviews’. The study concluded that PSM leads to a decrease in positive parenting behaviours. Those behaviours included coercive control, harsh discipline, ineffective parenting and lower levels of parental involvement (Arria et al., 2012).

This research project evidenced that PSM was associated with unpredictable adult behaviour. A noticeable and important difference between this research and existing literature relating to PSM is that this research did not rely on retrospective accounts. This research included the voices of younger children who were living with their parents who misused substances. Another noticeable difference of this research project, compared with existing literature, was the emphasis the children placed on how the anticipation of the next episode of PSM (and the associated changes in parents’ behaviour) impacted on their own wellbeing. This research has brought to the forefront

the reality for children, their experience of unpredictable parental behaviour, and the confusion they must feel when their parent is cruel, evasive, and unable to offer warmth and comfort.

The impact on a child's emotional wellbeing needs to be understood and considered, not just in relation to visible changes in parents' behaviour, but also in relation to the non-visible and non-verbal parental behaviours, and of the continuous cycle of unpredictability experienced by children. Whilst a parent's ability to respond to their child's day-to-day physical care needs is important, so too is a parent's emotional availability for their child. This research has highlighted the significance for practitioners to understand the impact PSM can have on a parent's availability, and how it feels for a child to be living with a parent who is unable to offer comfort and warmth.

24.1.2- The role of domestic abuse

During the creative interviews, children were not asked any direct questions relating to domestic abuse but were asked to recall a memory of when their parent's substance misuse had been a worry for them. This question resulted in detailed and powerful reflections of witnessing violence, experiencing threats of violence, and seeing their parent's physical injuries. The reflections and shared experiences of many of the participating children illustrate the importance of understanding their reality from their perspective, given the complex and multiple risk factors they experienced.

A significant theme identified across all three focus groups was the interplay between PSM and domestic abuse. The children also shared detailed memories of seeing their parents injured. Though it was not always clear whether parental injuries had been sustained through a substance-related accident or as a victim of domestic abuse, there is little doubt that for a child it is both upsetting and frightening to see significant injuries, or a parent having a seizure. As we have seen from the children's reflections of their lived experience, risk of harm is not always overt and, arguably, as practitioners we can never truly know the extent and severity of the risk of harm to a child without being able to hear their voices.

The children's accounts illustrated the connection not only between PSM and domestic abuse, but also substance-related acts and threats of violence. The findings from the focus groups also identified that life for children living with PSM was often unpredictable and marred with violence and threats of violence. Children's exposure to violence was not only linked to domestic abuse, but a consequence of the acquisition of substances, threats because of drug debts, and the unpredictable and violent behaviour of adults when under the influence of substances.

The impact on children of the unpredictability of their home life and the feelings of uncertainty are documented in literature relating to domestic abuse. Within domestic abuse literature the term 'hypervigilance' is adopted to describe the symptoms experienced by children who have been exposed to domestic abuse, such as 'exaggerated startle, nightmares and flashbacks' (Margolin and Gordis, 2000:153). Children who have been exposed to repeated incidents of domestic abuse, where their home is no longer a 'safe haven', and 'marred by danger' have difficulty regulating their emotions due to their hypervigilance (Margolin and Gordis, 2000:152). The findings from a study by Mertin and Mohr (2002:560) also found children exposed to domestic abuse were 'easily startled'. The study concludes by stating that the most frequent symptoms experienced by children due to domestic abuse were 'thinking about violence, hypervigilance and difficulty falling or staying asleep' Mertin and Mohr (2002:560).

The negative impact on children's emotional health due to unpredictable cycles of adult behaviour can be found in domestic abuse literature. However, the negative impact on a child's emotional health due to living with uncertainty and unpredictable adult behaviour is absent in PSM literature. This research has illustrated the need to understand the negative effect PSM can have on children's emotional health, in relation to hypervigilance and children's experience of the perpetuating cycle of uncertainty.

24.1.3- Impact of PSM across multiple systems

This research is framed by ecological systems theory and it is this framework which has provided the lens in which to gain further insight into the impact of PSM on children. Ecological systems theory was initially centred on the theoretical paradigm that human development, through a lifespan, is influenced by changing immediate and wider environments (Bronfenbrenner, 1977). Bronfenbrenner (1986) identifies that it is the influence of all systems which create 'steadiness' or 'unsteadiness'. The greater number of stressful life events and instability within the family environment is associated with greater levels of poor mental health and criminality in adulthood.

In 1986 Bronfenbrenner added a further system, the chronosystem, to the existing micro-, meso-, exo- and macrosystems. Bronfenbrenner (1986) describes the chronosystems as the life changing events that can be influenced by multiple systems and life transitions such as puberty, marriage, retirement. But it is life-changing events that create instability, and would further influence a person's psychological development. Bronfenbrenner (1986:723) described the influence and interplay of systems and of 'intrafamilial processes affected by extrafamilial conditions'. The concept of chronosystems adds a greater depth of understanding to the complexities of the lives of children and their families and, in relation to this study, the impact of PSM.

This research differs from existing literature and illustrates that children's exposure to PSM needs to be understood not as a binary list of factors but in reference to the systems in which children live. This research has illustrated the severity and accumulation of risk factors children living with PSM experience; those risk factors cut across multiple systems, as shown in figure 18 below:

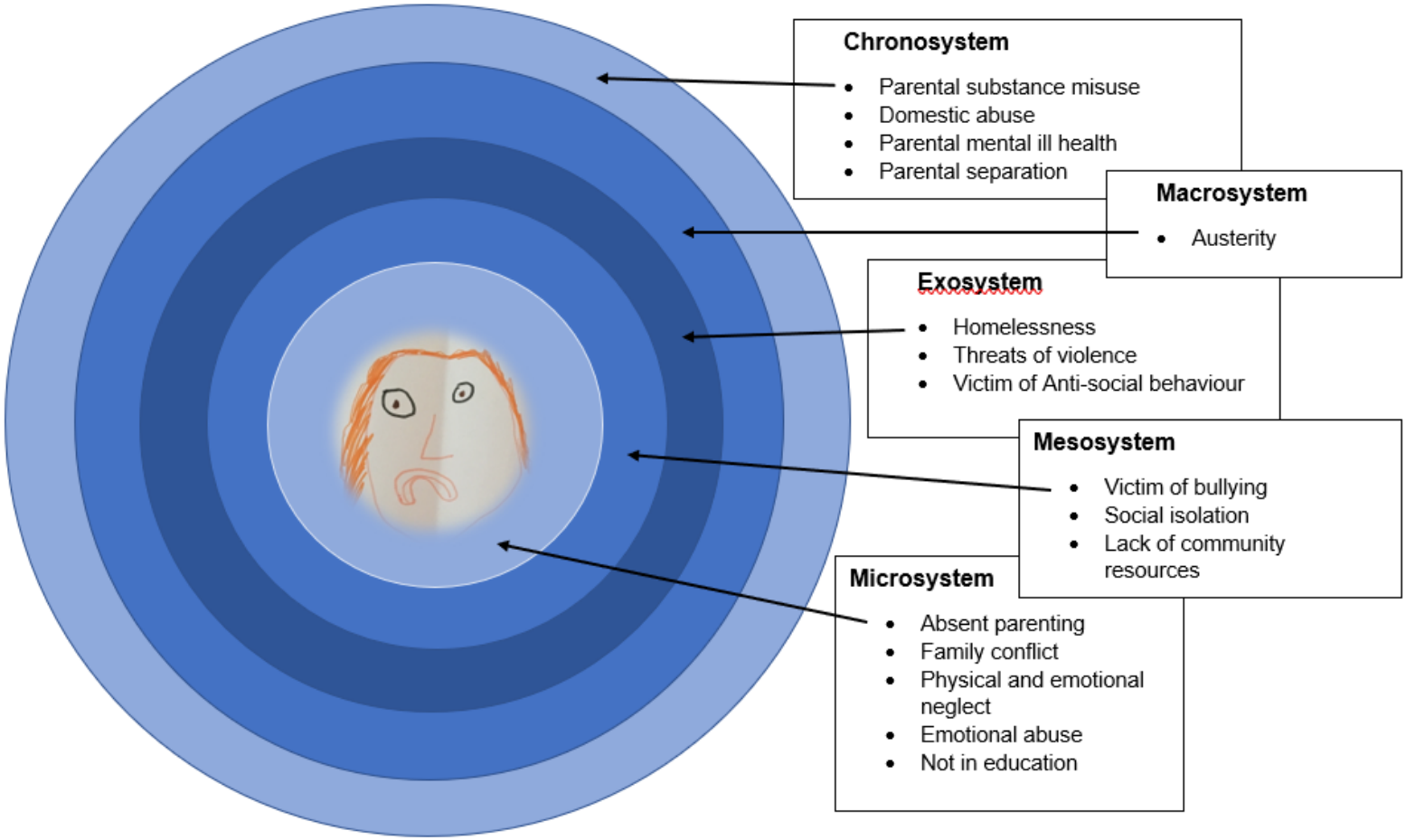


Figure 18 Complexity of PSM experienced by children across multiple systems

The impact of PSM on a child's safety, physical health, and the cumulative risks that can contribute to a child being inadvertently placed in danger, have been documented throughout the review of literature and the presentation of findings. The perpetuating cycle of uncertainty, carrying of the burden of secrecy, and the harsh and enduring reality for children was illustrated in part four of this thesis.

The implication for practice and for practitioners is the need to consider not just what children see and the physical aspect of safeguarding concerns, but also, what children feel and the emotional impact of PSM. As stressed by professionals across the three focus groups, often the priority regarding safeguarding concerns is the identification and assessment of risk of harm including neglect, physical abuse and child injury. The reflections from the children who participated illustrate the emotional impact of PSM on their lives and the need for practitioners to have improved knowledge, understanding and insight into the realities of the lives of children living with PSM.

This section has focused on the experience of children living with PSM, relating largely to their micro- and chronosystems. The following section will discuss the findings from this research relating to the needs of older children. The negative impact of PSM relating to contextual safeguarding and a child's meso- and exosystems will be discussed.

24.2- Children's lost childhood: Contextual safeguarding and the impact of PSM on older children

An unexpected finding within this research was the connection between contextual safeguarding, PSM, and the impact on older secondary school aged children (aged 11-16). Throughout this thesis, the terms 'children' and 'child' have been intentionally adopted, both in reference to children who participated in this research and when referring to existing literature. The rationale not to use terms such as 'adolescent', 'teenager', or 'young person', was to avoid a perception that just because a child is older, they are less at risk or more able to cope with adversity and trauma. Many of the focus group

participants shared their experience in frontline practice of the needs of older children being missed due to a perceived view that they were less likely to be at risk of significant harm, or due to practitioners having to prioritise the safeguarding of young children due to their immediate risk of harm.

Focus group participants shared their experience of older children being groomed by criminal gangs and being vulnerable to, and victims of, child sexual exploitation due to children escaping their home life and seeking relief in the community (meso- and exosystems). This research further extends the findings from existing literature in relation to the vulnerability of children's social networks to safeguarding concerns from outside of their family home.

The focus group findings (chapter 19 and 20) highlighted the needs of older children and the concept of contextual safeguarding. Contextual safeguarding (appendix 2), as detailed in the 2018 *Working Together to Safeguard Children* (H.M. Government, 2018), is defined as 'extra-familial threats'; the threats outlined include children being vulnerable to exploitation by criminal gangs and children being victims of sexual exploitation (HM Government, 2018:22). As illustrated in figure 18, the impact of PSM on the lives of children span multiple systems. The risk of contextual safeguarding for children living with PSM is evident from the risk factors they experience within their meso and exosystems.

As identified within the literature review, among the negative knock-on effects for children living with PSM is the risk of children developing early sexual relationships and becoming involved in risk-taking behaviour (Velleman and Templeton, 2016). Velleman and Templeton (2007:81) highlight the concept of 'precocious maturity', where children may engage in behaviour beyond their years, but in the absence of emotional stability and maturity, are unable to understand the significant impact on their mental and physical wellbeing.

The concept of precocious maturity arguably determines that children may have made choices to engage in early sexual and/or risk-taking behaviour

such as substance misuse, as opposed to identifying children as victims of abuse and exploitation. The concept of precocious maturity embeds a view in practice that older children have choices, which creates a misconstrued narrative in practice that older children who are seen to be risk-taking have chosen to do so. This is worthy of further research.

This research has illustrated the need for an empathic understanding that children living with PSM may not have had a choice, and may be victims of exploitation, or, they may be seeking to fulfil an un-met emotional and physical need. This was identified from professional participants in this research who recalled working with children who became involved in gangs because life at home was unbearable and they sought a pathway of escape.

The children who participated in this research also illustrated the stark reality of living with PSM, the impact on their health, mental health, lack of positive activities and lack of availability of parents for support and comfort. The experiences shared by the children in this research highlight their vulnerability, especially during times of increased severity of PSM. When parents are unable to offer guidance, warmth and support (microsystem), older children will seek comfort and escapism outside of their family home, leaving them potentially exposed to adults who seek to exploit their vulnerability. This has implications for frontline practitioners including understanding the needs of older children, increased practitioner awareness of extra-familial risk factors, and an increased understanding that older children living with PSM are at risk of exploitation, as opposed to actively partaking in risky behaviours.

Practitioners need to have increased awareness not only of the presenting safeguarding concerns, but also of the potential pathways and destinations for children affected by PSM. As one focus group participant outlined, safeguarding concerns do not reduce as children grow older, they simply change.

24.3- Section summary

This section has discussed the complexity and severity of the impact of PSM on children and how this negative impact on children spans multiple 'systems' as defined by Bronfenbrenner (1986). This research has brought to the fore the multi-layered risk factors associated with PSM, and the negative impact this has on children's physical and emotional health and safety. The findings from this research evidence the direct connection between children living with PSM and contextual safeguarding concerns, as children become vulnerable to exploitation and being groomed into gangs as a consequence of trying to escape their homelife. The following section will discuss and explore the findings from this research relating to the long-term negative impact of PSM on a child's pathway through adolescence and into adulthood.

24.4- The longevity of exposure to PSM: Towards a theoretical understanding

This research project has shown PSM has a significant impact on the emotional and physical safety, and wellbeing, of children. The complex lives of children living with PSM requires knowledge and understanding, not just of the immediate risk of significant harm, but of the duration and severity of exposure to PSM and the long-term impact PSM can have on a child's emotional wellbeing and development.

This is not to say that all children who experience PSM will suffer from negative outcomes in later life. To understand why some children will experience negative outcomes, and to understand the concept of longevity, in addition to the complexity and severity of PSM, an exploration of theoretical models is necessary. An improved theoretical understanding of the needs of children living with PSM will serve as the foundation of knowledge for the next chapter of this discussion, where a model of practice for children living with PSM will be presented.

24.4.1- Adverse childhood experiences

The literature review (chapter 6) presented the findings from the study of adverse childhood experiences (ACE's). The study of ACE's dates over 30 years, however, the number of studies has steadily increased with 201 ACE-related studies conducted up to 2018. The largest increase was between 2016-2017 with 66 publications (Kelly-Irving and Delpierre, 2019). The increase in studies in recent years evidences the popularity of ACE's and the use of it as a 'buzzword' in practice (Kelly-Irving and Delpierre, 2019:450).

The consistency of findings across the study of ACE's, which evidence the connection between childhood adversity/ trauma and 'chronic disease trajectories' (Kelly-Irving and Delpierre, 2019:450), is important to acknowledge but it provides a narrow lens. As outlined in chapter 6.1, the ACE narrative does not engage with an understanding of a person's environment, and the impact of social inequalities (Asmussen et al., 2020). Kelly-Irving and Delpierre (2019:451) outline the importance of practitioners remembering that ACE studies evidence 'probability' and are not deterministic. ACE's do not provide an understanding of a person's individual circumstance, their environment, or the impact of experienced adversity across a lifespan (Bellis et al., 2017; Ford et al., 2019; Kelly-Irving and Delpierre, 2019).

This research study identifies the need for an understanding of ACEs but also the need for an understanding of the systems in which a child lives, as it is their wider socio and environmental factors such as poverty, lack of community resources, social isolation, and experiencing anti-social behaviour that can further compound the negative impact of PSM (Bellis et al., 2017; Ford et al., 2019; Kelly-Irving and Delpierre, 2019). Of the risk factors experienced by the children who participated in this research (figure 18, chapter 24.1.3), few are identified as ACE's. Nonetheless, they were severe, enduring, and undoubtedly had a negative impact on the lives of these children.

24.4.2- Lifespan theory

This research is framed by Bronfenbrenner's (1977) ecological systems theory, and as this chapter has discussed, children living with PSM experience multiple risk factors, across multiple systems. The findings presented in part four illustrate that children's experience of PSM was cyclical and often enduring. As chapter 24.2 concluded, the risk factors for children living with PSM do not reduce as children grow older, they simply change. Therefore, to understand the experiences of children living with PSM, and the possible negative outcomes as they enter adulthood, this discussion engages with the findings from this research in relation to the theory of lifespan development.

Lifespan development theory suggests that human development can only be fully understood if consideration is given to each stage of life. Erikson's theory of development is founded on the principle that human psychological development is a series of stages. Dunkel and Sefcek (2009:14) present the work of Erikson, who theorised there were eight stages of psychological development;

- Infancy
- Toddlerhood
- Preschool
- Childhood
- Adolescence
- Young adulthood
- Middle adulthood
- Late adulthood

Erikson's theory postulates that the early stages influence the outcomes in the later stages and, in relation to experienced crises, it is important to understand psychosocial development throughout a life span (Dunkel and Sefcek, 2009:13). Lifespan development theory also underlines the

importance of the timing of events in life; this is especially important during a child's teenage years when considering the stresses, a teenager faces in terms of high school, exams, puberty, peer groups, and potentially changing relationships at home (children becoming more independent and less reliant on parents) (Coleman, 2019).

Coleman (2019) outlines the importance of understanding the needs of adolescents who experience multiple and simultaneous life stresses in addition to the perceived normal adolescent experiences. Amnie (2018:2) also stressed the importance of understanding that the negative impact of exposure to abuse and trauma is not 'limited to childhood years'. The negative impact of exposure to trauma in adolescence, and the longevity of experienced abuse, can have a profound impact on a child's emotional development through adolescence, as Amnie (2018:2) outlines:

> Adolescents who experience any adversity that threatens their sense of safety and security may continue to live with emotional trauma. Exposure to trauma in adolescent development could negatively affect identity formation, producing a foreshortened sense of the future, poor self-cohesion, and peer relationships, as well as causing a regression in adult executive functioning.

It is therefore essential for practitioners supporting older children to have a theoretical understanding of both ACE's and lifespan development in considering children's vulnerability and prioritising their needs. However, ACE's are not an exhaustive list and as this research has shown, children who live with PSM experience multiple and severe risk factors, of which not all were identified ACE's.

As the lifespan development theory suggests, it is the timing, accumulative, and simultaneous experience that can lead to further vulnerability (Coleman, 2019). This is of significance when considering children being at risk of child sexual and criminal exploitation, especially for those children who are more

independent, ‘self-governing’, and perceived to have agency and choice in risk-taking behaviour (Coleman, 2019).

The children who participated in this research experienced multiple adversity and traumas that spanned multiple systems. The negative impact of PSM was not restricted to identified ACE’s, nor did the children experience adversity and trauma simultaneously. Their lives were a complex web of risk factors which were intertwined, severe, accumulative and enduring.

24.5- Chapter summary

This chapter has discussed the findings from this research in reference to the first of three research questions:

1) How do school-aged children (aged 5-16) experience living with a parent who misuses substances?

This research has evidenced the harsh reality of the lives of children living with parents who misuse substances. The children who participated in this research experienced multiple, accumulative, severe, and enduring adversity. The complexity of their lives and the identified risk factors were not substance-specific; all children experienced multiple adverse childhood experiences regardless of whether their parents misused alcohol or misused drugs. The experienced adversity was also not age-specific, as both younger and older children experienced multiple adversities and risk factors, across multiple systems.

The findings from the focus groups demonstrated that younger children were often viewed by practitioners as more vulnerable than older children. This research project has illustrated the vulnerabilities for older children living with PSM and the need for frontline practitioners not to lose sight of the safeguarding needs of older children. The findings also illustrated the stark reality for children who live with PSM and their survival strategies to meet their unmet needs. This discussion chapter has drawn attention to the

connection between the risk of contextual safeguarding and the vulnerabilities of children living with PSM.

This chapter has also explored PSM in relation to existing theory and concluded that the experiences of children living with PSM are complex. It is therefore important that PSM is not considered just as an ACE, but that the experiences of children are understood from the perspective of ecological systems and lifespan development theory; as it is not just the severity of a risk factor, but the timing and accumulation of risk across a life span which need to be understood.

This is not to claim that the destination for children living with PSM is predetermined, or that all children affected by PSM will experience negative outcomes in later life. In order to understand what a child needs to mitigate the negative outcomes of PSM, and to support children not simply to survive but to thrive, the following chapter will seek to answer the second research question regarding the support needs of children and protective factors.

Chapter 25

Understanding the support needs of, and protective factors for, children living with parents who misuse substances

The key focus of this chapter is the proposal of a new model of practice. This model proposes the minimum requirements for an intervention, which meaningfully responds to the needs of children living with PSM. The model of practice illustrates the need for change in practice, and provides a clear approach for a new way of working that appropriately reflects the needs of children living with PSM.

The model takes into consideration the identified risk factors presented within this research project's three data sets (literature review, creative interviews and focus groups) illustrating the harsh, and, sometimes enduring reality for children living with PSM. While the harsh reality and the associated risks of PSM should not be shied away from, it is also important to acknowledge that for some children, different outcomes may be possible and not all children are adversely affected by PSM (Velleman and Templeton, 2016).

This chapter will critically engage with existing literature and the findings from this research to provide a new depth of understanding of the needs of children living with PSM. By understanding what children need to feel safe and supported, from their perspectives, this chapter explores the quality and availability of protective factors and will answer the second research question:

- What do children need in order to promote and strengthen their emotional resilience and enable them, when appropriate, to live safely with parents who misuse substances?

The chosen themes for discussion are guided by ecological systems theory and will explore the everyday interactions, relationships, trusted adults, and wider support networks which contribute to keeping children emotionally and physically safe. The findings from this research have drawn attention to the notion of resilience in children. This chapter will conclude by critically engaging with the existing literature on resilience and discuss the appropriateness of this concept when considering the needs of children living with PSM.

The themes presented for discussion are:

- Child's meso- and exosystem: Community level protective factors
- Child's microsystem: Individual level protective factors
- Understanding the concept of resilience for children living with PSM

25.1- A child's meso- and exosystem: Community level protective factors

The existing models of practice outlined in the literature review (chapter 7.4) do not meet the needs of children living with PSM. In relation to an understanding of the life span and ecological systems theory, models of practice which are time-limited contradict the findings presented in this research project. Nor do they give consideration to an understanding of risk, and protective factors, and the need for practitioners to have the time to build trust due to familial secrecy and children's loyalty to their parents.

By paying attention to the voices of children, this thesis bridges the gap between research and practice, by proposing a model informed by children, for children. In support of the children's voice and their need to have trusted adults outside of their family, focus group participants also shared their view that children need time to learn to trust adults. Focus group participants also expressed their view that children living with PSM needed support in their own right, as all too often from their practice experience, a whole family approach meant the voices of children were lost.

In chapter 7.4 of the literature review, examples of practice within the UK in response to children living with PSM were presented. The literature review summarised key limitations to existing models; these included provisions for children being time-limited, aligned to adult substance treatment services, and dependent on their parent's engagement. The exploration of existing models of practice also found that services for children living with PSM were predominantly aligned to statutory intervention, crisis intervention and care proceedings.

This research has illustrated that children living with PSM experience multiple risk factors and are therefore in need of multiple protective factors to mitigate the negative impact of PSM. The voices of children who participated

in this research illustrated their need to feel connected within their communities and to have adults who they can trust.

In considering what a model of practice means, Stanley (2019: accessed online) suggests it is:

> […] a particular way of, or approach to, working with children and families. It is values-based and, when successful, transformative […] When it's done carefully and well, innovation moves social work forward and that leads to better decision-making and more impactful direct work with children and families.

Stanley (2019) also outlines that new models must reflect and respond to the presenting challenges for children and their families, and that any model of practice maintains a continuous focus on children, to enable them to thrive. In response to the findings from this research, and the existing challenges due to interventions which do not meaningfully respond to the needs of children living with PSM, this research proposes a new model of practice. The model presented in figure 19 below, is informed by the firm narrative from children and professionals that children living with PSM need trusted adults to talk with and that specialist support should not be time-limited.

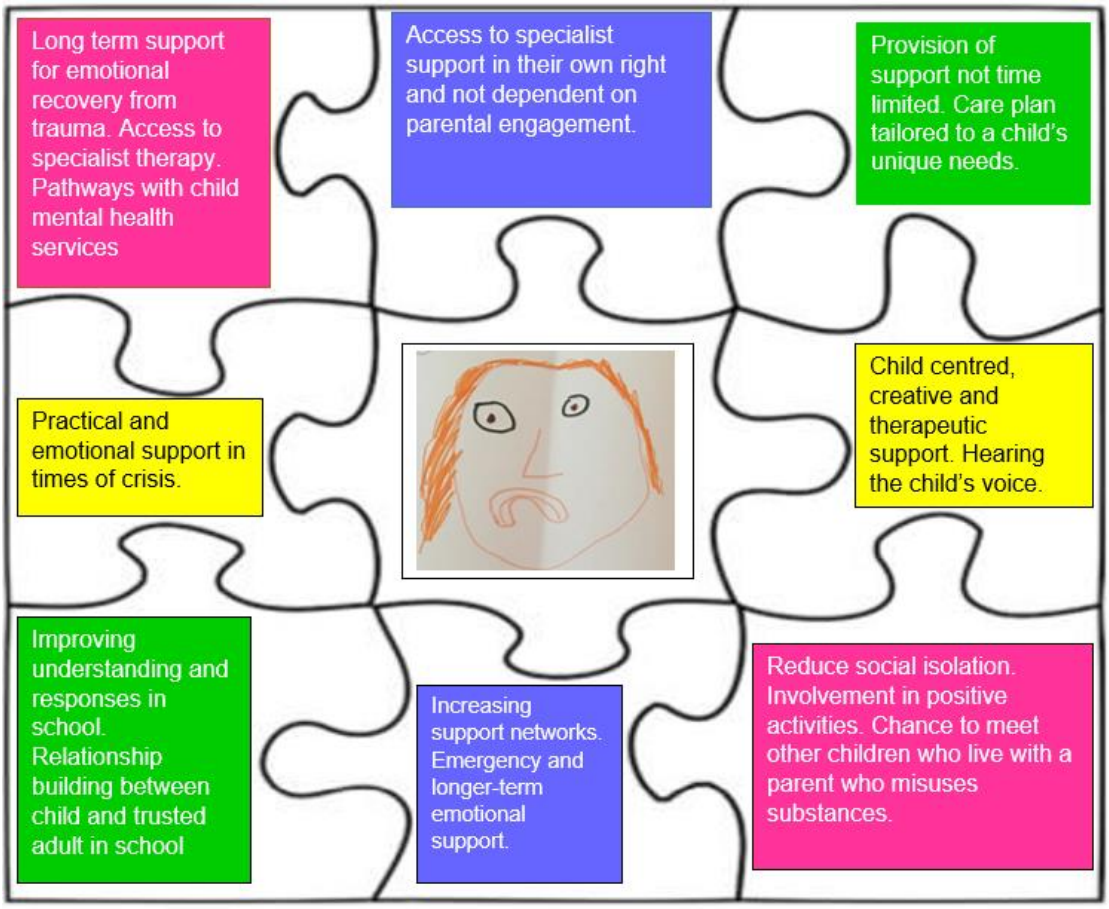


Figure 19 Proposed model of practice in response to the needs of children living with PSM

This model of practice needs to align within the structure of early intervention services within the community and not with statutory social care or schools. As the findings from this research illustrated, school was not always a safe place for children, and a community-based intervention would ensure that children who were not in education could be reached.

The model is underpinned by key principles of child-centred practice. O'Reilly and Dolan (2016) identify those key principles as being:

- a child's right to participate
- children need to be listened to
- practitioners spending time with children and utilising age-appropriate communication, through using playful and creative practice skills

- providing a child-friendly environment
- ensuring the voice of children is central to decision-making

The model proposes the key minimum requirements of specialist services for children living with PSM (figure 19). These include children having the opportunity to meet other children with similar experiences, and to reduce stigma, shame, and social isolation. As both children and focus group participants raised the issue of delayed responses from specialist mental health services, the model also sets out the need for improved pathways for access to these.

The principles and delivery of this model would be determined by local authorities, in terms of whether they were provided internally or externally-commissioned. The challenge for local authorities to implement this model of practice and respond to the needs of children living with PSM, given the current economic climate, is unprecedented. This is discussed further in chapter 26 in response to this research study's third and final research question.

This model of practice is underpinned by a clear ethos that children living with PSM need to be connected to trusted adults. The following section explores the value of connectedness and trusted adults in more detail.

25.1.1- The need for connectedness and trusted adults

This research has shown the significant role of positive adult relationships in a child's life when they are growing up and living with PSM, highlighting the need for children to have nurturing relationships in preventing the harmful effects of PSM.

The children who participated in this research had a shared consensus that positive relationships with adults were needed. They all shared that they needed to have somebody to talk to, have somebody to help them in a crisis, and have support until they felt safe. The need to have trusted adults, to be

nurtured, to have somebody rooting for their success and for children to have opportunities to talk outside of their family home, was shared by focus group participants. Chapters five and seven of the literature review outlined the findings from research specific to PSM, and of the social isolation and heavy burden of secrecy that children living with PSM can experience. The findings from this research illustrate the need for children to have trusted adults they can confide in, and the importance of trusted adults both within and outside of the family.

Existing literature identifies the power of relationships in mitigating the harmful effects of childhood adversity, as (Merrick 2017: 17) outlines:

> Developing safe, stable, nurturing relationships and fostering positive environments can play a key role in preventing early adverse experiences and overcoming the harmful effects of early adversity.

Being able to trust and confide in adults may not always be easy for children. As this research project has highlighted, children are often burdened with the pressure and responsibility to keep their parent's substance misuse a secret. Often, this secret is maintained through fear of the consequences; as focus group participants described, children were often repeatedly told by their parents not to trust professionals, especially social workers.

Meltzer et al. (2018:576) defines trusted adults as 'someone other than the young person's parents'. Relationships with trusted adults can occur across a child's ecological systems, extending their network of relationships from their microsystem to their meso- and exosystems (Meltzer et al., 2018). For a child to trust, the trusted adult needs to be somebody whom the child is 'willing to be vulnerable with', 'willing to rely on', and there needs to be a belief by the child that their trusted adult will protect them (Meltzer et al.,2018).

Meltzer et al. (2018:577) also suggested that trusted adults are adults whom children have 'independently chosen to trust' rather than adults who are in formal roles, such as teachers. The connectedness between a child and

trusted adults can occur in a child's natural networks (e.g. family friends). However, trusted adults can also be professionals who are not in a formal role, such as a teacher or statutory social worker and with whom the child has developed a 'chosen trusted rapport' (Meltzer et al., 2018:577).

Given the depth of understanding this research has presented in relation to the importance of relationships, it is important to note here the concept of connectedness. Although this concept is widely researched in child and adolescent psychology (Barber and Schluterman, 2008), it is not a concept that has been adopted within literature relating to PSM. Barber and Schluterman (2008:213) refer to their previous studies and outline their definition of connectedness as:

> […] a tie between the child and significant other persons (groups or institutions) that provides a sense of belonging, an absence of aloneness, a perceived bond. Depending on the intimacy of the context, this connection is produced by different levels, degrees or combinations of consistent, positive, predictable, loving, supportive, devoted, and/or affectionate interaction.

The definition of connectedness within the literature illustrates the importance of children being connected to adults. It is this connectedness that is perceived as serving as a significant protective factor for children experiencing adversity (Resnick et al., 1993; Resnick, 2000; Foster et al., 2017). Resnick (2000:158) stresses the need for children to be connected and that this connectedness is absolutely 'salient as a protective factor' to mitigate the negative impact of adversity, especially in adolescents who are at risk of internalising and externalising problem behaviours. The concept of connectedness provides a construct for the importance of relationships not just within a child's family (microsystem) but within their wider networks (meso- and exosystem).

The need for connectedness within multiple ecological systems is especially important as children enter their teenage years, as this is a time when

children's social focus moves away from their family and they 'begin to immerse in ever-widening circles of interaction' (Thompson et al., 2018:109; Meltzer et al., 2018). The role of connectedness for older children links to the findings in this research relating to the risk of contextual safeguarding issues (focus group findings, chapters 19-21).

Foster et al., (2017:329) outline the 'structural' inequalities that children exposed to risk and adversity face outside of their families, due to poorly resourced neighbourhoods, schools, and community outsources, and exposure to 'community violence'. As well as understanding the needs of children living with PSM across multiple systems, it is paramount that the needs of children living with PSM are understood from a life span theoretical perspective. As the findings from the focus groups illustrated, the needs of children living with PSM do not reduce as they get older, they simply change.

The importance of children's connectedness to trusted adults is recognised in a report by the Early Intervention Foundation (EIF) which was commissioned by the Home Office (EIF, 2018). The report sought to review the role of trusted relationships for children who are vulnerable to child sexual exploitation or child sexual abuse, and how those relationships could be enabled in public sector services (EIF, 2018). The report presents key findings highlighting the role that trusted adults play in supporting children to 'avoid risky situations', 'stress-buffering: helping them to overcome adverse circumstances', and preventing negative life outcomes for children (EIF,2018).

As well as outlining the importance of trusted relationships, the report outlined the need for children to have time to build trust, and for professionals to allow time to truly listen to children (EIF, 2018). Similarly, Asmussen et al. (2020:4) suggest there needs to be a strong workforce to respond to the needs of children and their families experiencing adversity, with time to build trusting relationships, as there is no 'quick fix'. Although the report does not extend to the needs of children living with PSM, there is a key message for practice in response to the needs of vulnerable children,

and I argue that this should extend to children who live with PSM, because as EIF (2018:15) outlines:

> Without learning how to form a positive relationship there is a danger that a child may reach adulthood unable to trust anybody, which could have a lasting impact on their lives […] it is as important for a child to feel able to discuss a concern at school (at the universal end of the spectrum) as it is for them to be able to talk through more complex needs and problems with a specialist service provider.

The findings from this research illustrate the importance of trusted adults to support and respond to the needs of children living with PSM. Children identified the importance of having somebody they trusted to talk to, and having a specialist keyworker who could be there for them until they felt safe. Focus group participants echoed the need for children living with PSM to have trusted adults in their lives emphasising the need for practitioners to have the time to invest and gain a child's trust. Sometimes simply taking a child for a game of pool, or for something to eat, was something focus group participants felt was imperative to relationship building and gave children who had experienced emotional and physical neglect, a feeling of care, warmth and nurture.

Focus group participants also recognised the structural difficulties especially for statutory social workers, as time to invest in relationship building was not something they had the luxury of. A report commissioned by the Department for Education identified this difficulty and outlined that one of the key reasons social workers left the profession was due to the lack of time to spend with children (Johnson et al., 2019). This finding supports the message for practice from the EIF (2018) report, that vulnerable children require specialist service provision.

25.2- Section summary

The research has drawn attention to the limitations of existing models of practice which do not meaningfully engage with or appropriately respond to the needs of children living with PSM. Through attention to the voices of the children who participated in this research and their firm narrative of the importance of trusted adults, this section has presented a new model of practice. The model proposes the minimum requirements for an intervention to meaningfully support children living with PSM. The model which is informed by children, for children, is not time-limited and not reliant on parental engagement.

This section has highlighted that existing literature relating to the importance of connectedness and trusted adults does not include the needs of children living with PSM. This research has extended the findings from existing literature illustrating the need for children living with PSM to have connected trusted adults within their family and from their wider community networks. The children and focus group participants shared a firm narrative that children living with PSM need professionals they can trust, and that their microsystem support network alone, is not enough to act as a buffer against the negative impact of PSM. The following section critically explores, the needs of children living with PSM relating to their microsystem.

25.3- A child's microsystem: Individual level protective factors

The findings from this research identified that despite their prolonged exposure to, and the negative impact of PSM, many children continued to strive to achieve in school and maintained an ambition and hope for a successful future. This ongoing success has been partially explained by the presence of individual level protective factors in their lives, including personal characteristics and traits, including personality traits (Afifi and MacMillan, 2011). Individual protective factors such as personality traits may include having an easy temperament and being able to 'elicit positive attention from family and others' (Sattler and Font, 2018:105).

The findings from this research also illustrate that the needs of children living with PSM are multiple, and personal characteristics are not enough to buffer children from the negative impact of severe and enduring risk factors. As Bronfenbrenner's (1977,1986) ecological systems theory suggests, it is the influence of multiple systems which can determine a child's psychological development, but it is the presence of a robust support network, not just individual character traits, which is the most important attribute for stability and a child's positive psychological health and wellbeing.

The voices of children were central to this research project, in seeking to understand their support needs and the role of relationships which may act as a buffer to mitigate the negative impact of PSM. Their support networks varied greatly both in terms of the availability of support from trusted adults, but also in the quality of their support network. Kit, Rowan, Charlie and Taylor all shared their experience of having a parent who did not misuse substances. For Kit, Rowan and Charlie, this meant they were able to call upon that parent for practical and emotional support in times of crisis. Having a parent who didn't misuse substances appeared to be a much-needed lifeline for many of the child participants. Similarly, focus group participants identified strong child-parent relationship and parental warmth as important protective factors for children, to aid their self-worth and ability to cope with

adversity. Focus group participants also highlighted how a child needs to receive nurture from within their family, but also from their wider support networks.

25.3.1- Parental warmth and nurture

The findings from this research illustrated that children did not consistently experience parental warmth; this was due to unpredictable cycles of PSM and absent parenting. When children were not able to rely on their parents for their emotional needs to be met, they needed a wider support network and trusted adults who could respond to their presenting needs. Understanding the needs of children living with PSM in relation to parental warmth is also significant when considering the risk of contextual safeguarding. This research has illustrated that children living with PSM are at increased risk of exploitation when their emotional needs are unmet at home.

Literature relating to resilience and protective factors identifies nurturing parenting, and warm and supportive relationships within a child's immediate family, as imperative for 'normative development (Afifi and MacMillan, 2011; Sattler and Font, 2017:105). In reference to parental warmth, Rothenberg et al. (2020:837) explain the concept in relation to the 'acceptance-rejection theory', and posit that 'humans have developed the need for warmth from their caregivers' and experiencing parental warmth may serve as a 'universal protective factor' for children. Their international study, across 12 countries including the USA, Kenya, China and European countries (not the UK), explored the connections between parental warmth and children externalising and internalising behaviours. The study included 1,298 children aged 8 to 14, recruited through schools, who completed a youth self-report behaviour checklist, and their parents who completed a parental acceptance-rejection/control questionnaire. The findings from the study concluded that parental warmth protects against the 'emergence' of children internalising and externalising behaviour (Rothenberg et al., 2020:848). The study presents connections between parental warmth and children experiencing

positive emotional and behavioural development. However, the study is limited in that it does not provide insight into the needs of children who experience significant trauma, or suggest whether, in the absence of parental warmth, other family members can step in to fill this void.

A smaller scale study in the USA by Suchman et al. (2007) adopted similar methods (questionnaires) to Rothenberg's et al., (2020), and was specific to PSM. The study explored parental control and parental warmth among 98 mothers and their children (Suchman et al., 2007). The authors defined parental control in relation to parental supervision and parents exercising decisions and rules for their children. Parental warmth was characterised as an 'expression of interest in children's activities', and an 'expression of enthusiasm and praise for children's accomplishments and demonstration of affection and love' (Suchman et al., 2007: 2). The findings concluded that parental control was associated with children having fewer behavioural problems, and being able to form positive relationships with peers and their teachers. Parental warmth was found to be 'critical to children's psychological and emotional wellbeing' (Suchman et al., 2007:8).

The notion of warmth within a child-parent relationship is of significant importance, especially for children during adolescence. As Benson and Elder (2011) suggest, adolescence is a time that can be associated with added distress due to puberty, and so having a parental relationship consisting of high warmth can be a valued source of protection.

Bronfenbrenner (1977) argues that the needs of a child should be considered in relation to life span theory, as a child's needs change over time. Darling (2007:209) outlines the importance not only of a child-parent relationship but of 'parental monitoring' and a parent's knowledge of their child's behaviour. It is 'parental monitoring' that is viewed as a significant protective factor and predicator of positive child development (Darling, 2007). This is especially important in considering Bronfenbrenner's view of the need to understand children's needs across a lifespan, and the connections between PSM and the risk of contextual safeguarding which this study has brought to the fore.

Existing research, regarding familial relationships in relation to protective factors and resilience (Afifi and MacMillan, 2011; Sattler and Font, 2017), or research specific to parent-child relationships and a child's need for emotional warmth (Rothernberg et al., 2020; Suchman et al., 2007), has failed to explore the specific needs of children who experience the perpetuating cycle of PSM. The existing literature does not engage with the fact that children's experience of PSM is not static. As such, this research is unique in its exploration of, and endeavour to understand, the needs of children who live with PSM from their perspective.

25.3.2- Quality and availability of familial relationships

This research has illustrated the complex nature of PSM and the continuing cycle of 'ups and downs' experienced by children, dependent on the severity of their parent's substance misuse. The children who participated in this research shared emotive reflections of worrying about changes in their parent's behaviour and their need for other trusted adults to step up and provide emotional and practical support.

This research also illustrated that although on the surface children may appear to have robust family support networks, this was not always the case. Due to family conflict, parental separation and family members no longer being emotionally or physically available, children's support networks were not always a source of comfort and protection. For frontline practitioners it is therefore imperative that protective factors are understood from a child's perspective and explored both in terms of availability and quality. In support of this message for practice, Misca and Smith (2014:162) conclude:

> …it is the quality of a child's home environment and their relationships with parents (whether parents live together or not) which provide a key factor for the healthy adjustment, development and wellbeing of children.

For children living with PSM, life is complex and as such, their risk and protective factors need to be understood by professionals not as a binary list.

Risk factors need to be appreciated by practitioners in greater depth by understanding the severity of a child's exposure to PSM and the accumulation of risk factors over time. Protective factors also need to be understood in greater depth and practitioners need to know, from a child's perspective, what their protective factors are, as well as the quality, and availability of those protective factors, as illustrated in figure 20 below. Further, this chapter has shown the importance of understanding a child's experience of PSM from a life span and ecological systems theoretical perspective.

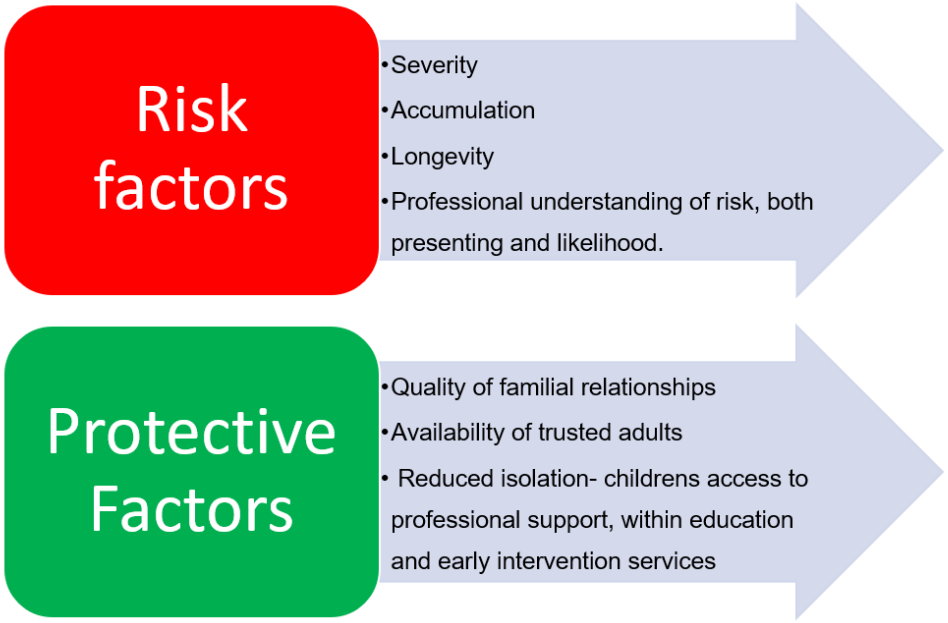


Figure 20 Understanding the complexity of risk and protective factors for children living with PSM

Many of the children who participated in this research shared their reflections of the importance of their grandparents in providing much-needed comfort, warmth, and practical support in times of need. Focus group participants also shared their experience in frontline practice of the value of grandparents in supporting children and their families where PSM was a safeguarding concern. This research illustrated that relationships with immediate family,

including parents and grandparents, were key in providing protection for children, but these relationships were also complicated.

PSM is identified as being a significant factor in grandparents becoming involved in caring for their grandchildren, either part- or full-time (Templeton, 2012). The complex nature of PSM often results in grandparents facing significant challenges in navigating how involved they should be, in terms of whether taking on additional care of their grandchildren either helps or hinders the ability of their own child (the parent) to address their substance misuse. The experienced emotional turmoil for grandparents is evident in the study by Templeton (2012:13) who concluded that grandparents have 'dual identities, as a parent and a grandparent', which often resulted in children being at the centre of family conflict.

The importance of family relationships and especially the role of grandparents in providing comfort, warmth, and care to children living with PSM in times of need, is invaluable. Focus group participants raised the issue of children needing a safe place to be when their circumstance at home became too unpredictable and dangerous. As outlined by Templeton (2012), PSM is often a significant factor in grandparents needing to care for their grandchildren either full- or part-time.

The need for children to have a safe place in times of increased risk is a valued protective factor, yet if a children's grandparents live in rented accommodation and are not formal kinship carers this raises the possible issue of financial hardship. In April 2013, the UK government's choice to implement austerity measures continued in the form of the 'removal of the spare room subsidy', also known as the 'bedroom tax' (Moffat et al., 2016:197). This controversial reform on social housing meant that those in receipt of housing benefit suddenly found themselves with a significant reduction in their income if they were living in a property that was deemed too large for their needs (Moffat et al., 2016:197).

This is a clear example of how a child's macrosystem impacts on their microsystem; in this case, a family who are not home owners may be unable to provide practical support by way of children staying overnight, for a sustained period of time, due to the impact of austerity measures. Grandparents who are not providing full-time care for their grandchildren under a formal care arrangement would fall victim to the bedroom tax if they had a spare bedroom. Whereas, a child whose family members are home-owners would not need to worry about the bedroom tax or have to downsize for having a spare bedroom. This evidences the widening gap in inequality in the UK and how children living with PSM are negatively impacted by multiple factors across multiple systems.

This research has demonstrated that children who are living with PSM need multiple protective factors within their micro, meso and exosystem. Multiple protective factors are needed to act as buffers for children, especially in times of crisis and to account for their unpredictable homelife. A child's microsystem alone is not enough to act as a buffer to mitigate the negative impact of PSM and, as figure 21 below illustrates, a child needs multiple protective factors across multiple systems. Not all of the children who participated in this research experienced multiple protective factors and all of the children were failed by their macrosystem.

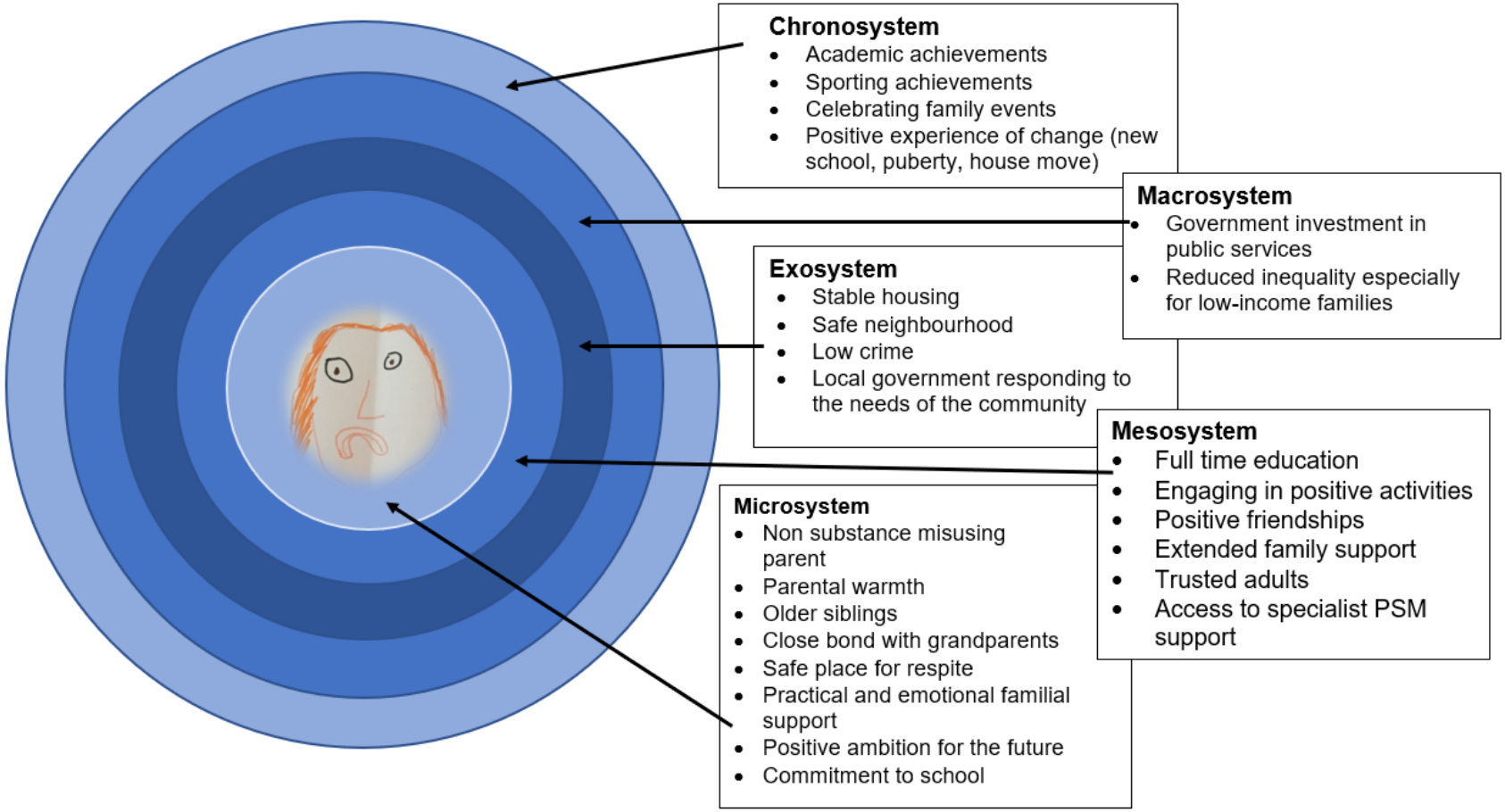


Figure 21 Understanding children's protective factors across multiple system

25.4- Section summary

This section has critically discussed the protective factors for children living with PSM in relation to their microsystems. This research has shown that the lives of children living with parents who misuse substances can be unpredictable and PSM is experienced within a perpetuating cycle of ups and downs. Though the quality and availability of protective factors within a child's microsystem are important, this research has highlighted that a child's microsystem alone is not enough to buffer against the negative impact of PSM.

The existing literature evidences the need for children to experience parental warmth and nurturing familial relationships, to support healthy development and wellbeing. Despite the knowledge of the positive impact of warmth and nurturing relationships for children, the existing literature does not include the experiences of children living with PSM.

Children who experience PSM need multiple protective factors within their micro-, meso-, and exosystems. If the focus in practice was solely on a child's microsystem, there is a real risk that the responsibility to cope would fall onto the shoulders of children, when instead the focus needs to be on building protective factors for children across all their systems. When discussing the importance of protective factors, the notion of resilience is inextricably linked. The following section critically engages with the notion of resilience and explores whether this is an appropriate concept when considering the needs of children living with PSM.

25.5- Understanding the concept of resilience for children living with PSM

Despite the existence of Bronfenbrenner's ecological systems theory, and knowledge of how an individual is located within a 'nested arrangement of structures' and how those structures or systems influence human development across a life span (Bronfenbrenner, 1977:514), literature does not always engage with the 'full utility of resilience' (Shaw et al.,2016:36). The body of literature relating to resilience is predominantly from the USA and Australia (Sattler and Font, 2018).

The absence of literature regarding resilience from the UK that encompasses the ecological systems theory, has resulted in a gap in knowledge relating to the current socio-economic and political environment. This research, though a small-scale study, has contributed to reducing this gap in knowledge by providing original findings which illustrate the complex needs of children living with PSM. As the previous section illustrated, the needs of children living with PSM go beyond their microsystems. Using ecological systems theory, this research has shown how a child's systems interact to both exacerbate risk factors and mitigate the impact of PSM.

The children who participated in this research had endured multiple cycles of PSM. They had adopted roles above and beyond the expectations of children their age. Charlie described their caring role and having to be 'a bit adult' when their mum repeatedly did not return home due to alcohol misuse; their perceived maturity could be viewed as resilience. Roux and Cody had experienced significant trauma due to witnessing threats of violence. Despite their adversity, they were keen to be back in school and receive help with their homework; though it is possible they craved routine and the safety of the school routine, they could also be perceived as resilient children. Quinn's ability to adapt and develop strategies at home, such as storing food in their bedroom when it was too dangerous to venture downstairs, could be viewed as resilience. For Taylor, who had endured multiple cycles of PSM, their

isolation at home before receiving specialist support meant they had felt there was no other way to cope than self-harming. Given the definitions of resilience (chapter 7), by self-harming Taylor did not demonstrate resilient behaviour. Yet this appears unfair, as for Taylor self-harming was their survival strategy at that time. Arguably, a more accurate assessment of all the children's responses to adversity was that of a strategy of survival.

Rutter (2007) outlines that there is a vast diversity in relation to outcomes for people who have experienced adversity. It is this diversity which has led to the notion of resilience, and the phenomenon of why some individuals have good outcomes, despite experiencing adversity (Rutter, 2007). To understand the needs of children living with PSM, and the role of protective factors in mitigating the impact of PSM, the concept of resilience is an important point of discussion.

To date, the resilience narrative has largely focused on individual characteristics, with certain traits such as 'intelligence, hardiness, sociability, grit, and optimism' identified as protective factors that can contribute to a person's ability to overcome 'challenging circumstances' (Shaw et al., 2016:34). The focus on individual traits turns attention away from the systems in which an individual lives, and fails to acknowledge the 'structures that can either exacerbate adversity or support success' (Shaw et al., 2016:35). The study of resilience has also predominantly focussed on the importance of an individual's microsystem and family cohesion as a significant protective factor (Afifi and MacMillan, 2011).

The tendency for resilience to be focussed towards an individual's behaviour engages with a narrative that children choose to engage in negative behaviours (chapter 23), as opposed to victims of adversity and trauma. This individualised focus also places the responsibility on children to navigate their difficult circumstance to avoid negative outcomes. This can be found in a study by Howell et al., (2010:150) which examined why some pre-school-aged children who were exposed to 'intimate partner violence' were more resilient than others. The study included 56 mothers of children aged

between four and six years old, investigated over a two-year period; the research did not include the voices of children. The study concluded by outlining that a child's resilience was largely dependent on being exposed to less severe violence and that this correlated with a child's ability to regulate their emotions and have fewer 'maladaptive behaviours' (Howell et al.,2010:150). The language used in this report such as 'better cope' and 'emotional regulation' (Howell et al., 2010:161) suggest it is a child's responsibility to emotionally self-regulate and to be resilient. Howell et al. (2010) also fail to engage with the specific needs of children from their perspective.

Reducing resilience to an individual trait fails to engage with structural inequalities and portrays a message that it is a child's responsibility to be (and become) resilient, instead of the narrative being based upon building resilience systems for children. The impact of this narrative for children is outlined by Shaw et al. (2016:36):

> […] when an individual is not successful in beating the odds, his or her failure can reinforce the structural and intrapsychic message that he or she truly is just "not good enough"

Understanding the concept of resilience across multiple systems is important as children can be found to be resilient within a 'single domain', but when 'assessing resilience over multiple domains' they are found to be less resilient (Sattler and Font, 2018:105). Existing literature regarding resilience has also failed to engage with the specific needs of children living with PSM, as literature has predominantly focused on protective factors, and resilience relating to children's exposure to domestic abuse (Howell et al., 2010: Kitzmann et al., 2003).

The current literature relating to resilience demonstrates a failure to acknowledge the environmental and social factors interacting in a child's life, and places the responsibility for their situation on children themselves, inferring they are either resilient or not. Children who have experienced

extreme and enduring adversity may not be resilient, but this is by no means their fault. Perhaps the focus needs to be on preventing the cumulative risk and promoting protective systems when considering the outcomes in later life for children. As Ungar et al. (2013) outlines;

> […] changing the odds stacked against the individual contributes far more to changes in outcomes than the capacity of individuals themselves to change (Ungar et al., 2013:357).

The concept of resilience requires caution, especially in practice, when practitioners are assessing the risk of harm and a child's protective factors. Though a helpful term when considering the emotional wellbeing of a child who has experienced everyday difficulties, such as a tough day in school, or a fall out with a friend, resilience is not an appropriate attribute to ascribe to a child who has suffered multiple, prolonged abuse and trauma.

25.6- Section summary

This section has outlined that the concept of resilience within the existing body of literature has predominantly centred on research relating to children who have been exposed to domestic abuse. Further, research regarding resilience has tended to focus on individual traits, resulting in a gap in research and a failure to acknowledge the significance of multiple protective factors that extend beyond a child's microsystem. This research has bridged this gap by presenting empirical findings that evidence the need for children to have multiple protective factors both within their microsystems, and across their meso and exosystems.

This section has presented a challenge to the existing literature on resilience and suggested that resilience is not an appropriate concept to ascribe to a child who has suffered significant trauma. This research has illustrated that adopting the term 'resilience' in practice requires caution. Children living with PSM not only need multiple protective factors but resilient systems to safeguard and protect them from the negative impact of PSM.

25.7- Chapter summary

Through a discussion of the findings from this research, and with special attention to the children's narrative, this chapter has presented a proposed model of practice in response to the needs of children living with PSM. The findings from this research have shown that children's experiences of living with PSM are all unique. Responses in practice to the needs of these children therefore need to be tailored. Practitioners need to consider and understand risk factors in terms of severity and longevity, and protective factors need to be considered in terms of their quality, availability and appropriateness.

The impact of PSM and whether it is safe for a child to remain in the care of their parents, is potentially a life-changing decision for both child and parent, and requires thorough and in-depth understanding by practitioners of the reality of children's lives. Above all, children's voices need to be heard. The message for practice is clear; just because a child is not showing signs of distress, or of being involved in risk-taking behaviour, does not mean that they are not experiencing the negative consequences of living with a parent who misuses substances.

This chapter has highlighted the needs of children living with PSM and outlined the importance of having multiple protective factors. Within a child's microsystem, the importance of parental warmth and parental involvement to nurture, guide, and support positive mental health in children was outlined. Though microsystem-level protective factors are important, this research has shown that they are not enough to act as a buffer for children, against the negative impact of PSM. In addition to parental warmth and familial support, this chapter has discussed the need for children to be connected to trusted adults. It is this connectedness to trusted adults for children living with PSM that serves as a significant protective factor.

Though absent in PSM literature, this chapter has drawn attention to the need for connectedness and trust to be applied in practice. This chapter has

illustrated the need for children to have trusted adults who can demonstrate consistent warmth and care, both within their family and from wider networks, to mitigate the negative impact of PSM. The importance of positive relationships to empower children to feel they have choices, dreams for their future, achieve academic success, and to feel understood and cared for, is crucial in lessening the burden of PSM on children.

This research has evidenced the need for the quality and availability of identified protective factors and relationships to be understood. Children living with PSM need trusted adults outside of their family. This is especially true when considering the needs of older children, and the very real possibility of children being at risk of sexual and criminal exploitation.

In light of the findings from this research regarding the complexity and severity of risk factors experienced by children living with PSM, the use of the term ‘resilience’ in practice was challenged. Though an important concept to understand, this chapter has argued that resilience is not an appropriate term to ascribe to a child who has experienced prolonged abuse and trauma. In response, the narrative in practice needs to change and move towards an improved understanding of preventing risk factors and promoting positive protective systems for children.

Despite the accumulating body of knowledge regarding the negative impact of PSM on a child’s emotional and physical health, as outlined throughout this thesis, children living with PSM do not receive the necessary responses from policy and practice. The following chapter will discuss the systemic failings in response to the needs of children living with PSM, and discuss the need for system-level problems to be resolved with system-level solutions.

Chapter 26

Understanding the systemic changes required to respond to the needs of children living with PSM

The findings drawn from the literature review, and the focus groups with frontline professionals, illustrate that children living with PSM are ill-served in many ways, particularly through inadequate service provision, and inadequate practitioner training and knowledge.

The key focus of this chapter is a proposed new training model which will improve practitioners' skills in assessing and responding to the needs of children living with PSM. It draws on this study's research findings, and is designed to support practitioners to identify children living with PSM and appropriately assess risk and protective factors, to inform an analysis of need and intervention. This training model will equip practitioners with the necessary knowledge to enable families to stay together where appropriate, or enable informed and timely decisions for permanence when this is not possible. In addition to practitioner knowledge and training, further exosystem-level failings will be discussed in relation to changes in adult substance misuse treatment provisions, and the negative impact this has on parents with complex needs and their children.

Set against a backdrop of over a decade of austerity measures, this discussion chapter will also draw attention to the macrosystem-level failures which further compound the negative impact of PSM on the lives of children

This final chapter will therefore answer the third research question posed at the start of this research:

- From the perspective of professionals, what changes are considered to be necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

Framed by Bronfenbrenner's (1977) ecological systems theory, this chapter will discuss the findings from this research in relation to the exosystem and the macrosystem, and show how these systems interconnect. As illustrated in figure 22 below, the deep-rooted systemic failures in response to PSM have to be addressed across every system if sustained change is to be seen.

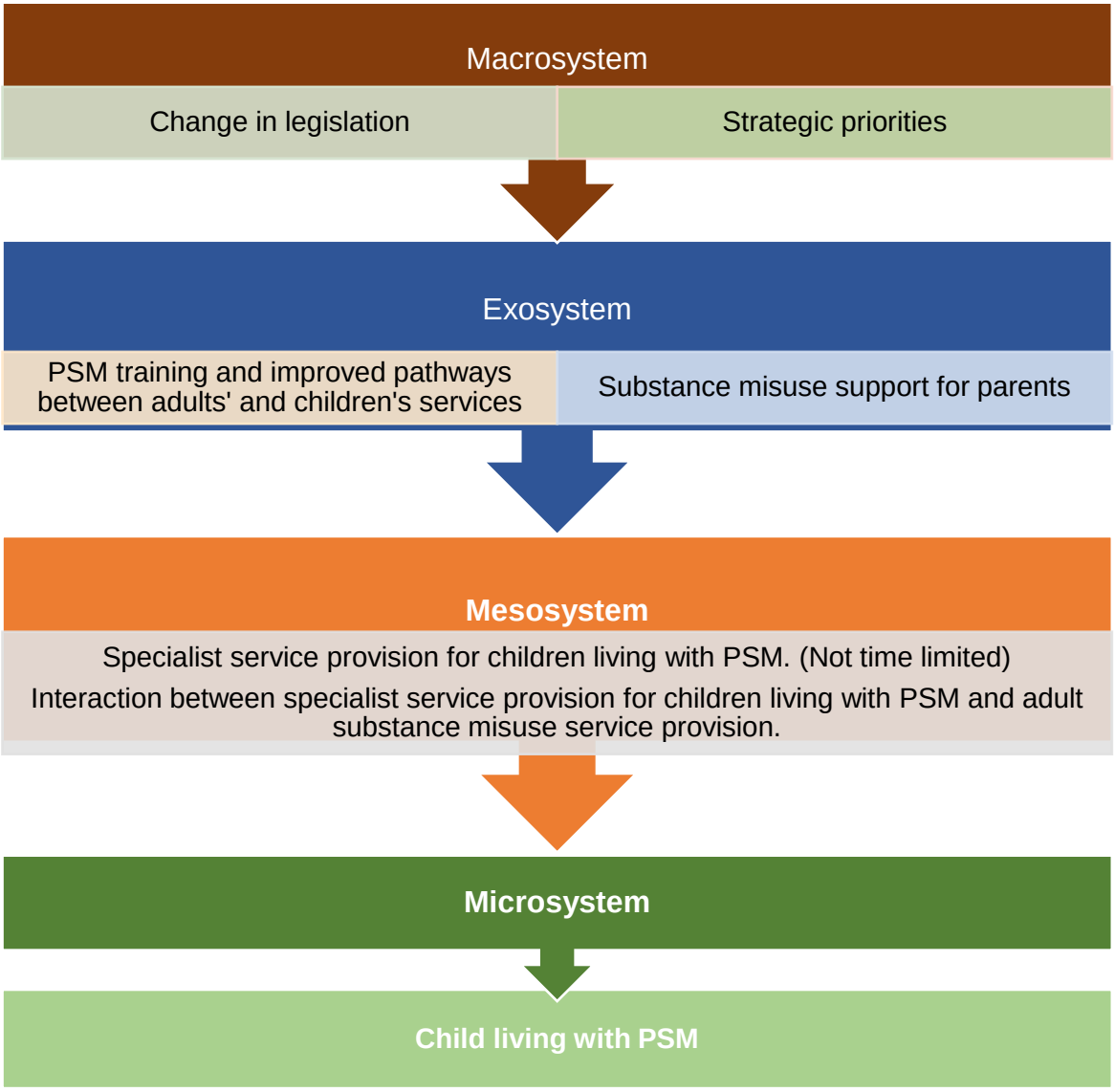


Figure 22 - Systemic failure in response to the needs of children living with PSM

The following sections will further discuss these system levels and the importance of considering each system level's impact on children living with PSM.

26.1- Training needs of frontline professionals in responding to the needs of children living with PSM (exosystem level)

The findings presented in this research project from professionals working in education, early intervention services, and children's social care, identified a firm narrative that professionals are ill-equipped to respond to the needs of children living with PSM. If children living with PSM are to be reached and supported at an earlier level, all frontline practitioners across the children's workforce need to have access to appropriate quality training. This new model of training should be delivered as part of every local authority's workforce development service, to equip frontline practitioners with the knowledge for earlier identification of children living with PSM and improved assessment of risk.

This research has identified the exosystem failure of inadequate PSM training for frontline professionals. Informed by the findings from this research, the model below (figure 23) proposes the minimum requirements for a model of training in response to this failure.

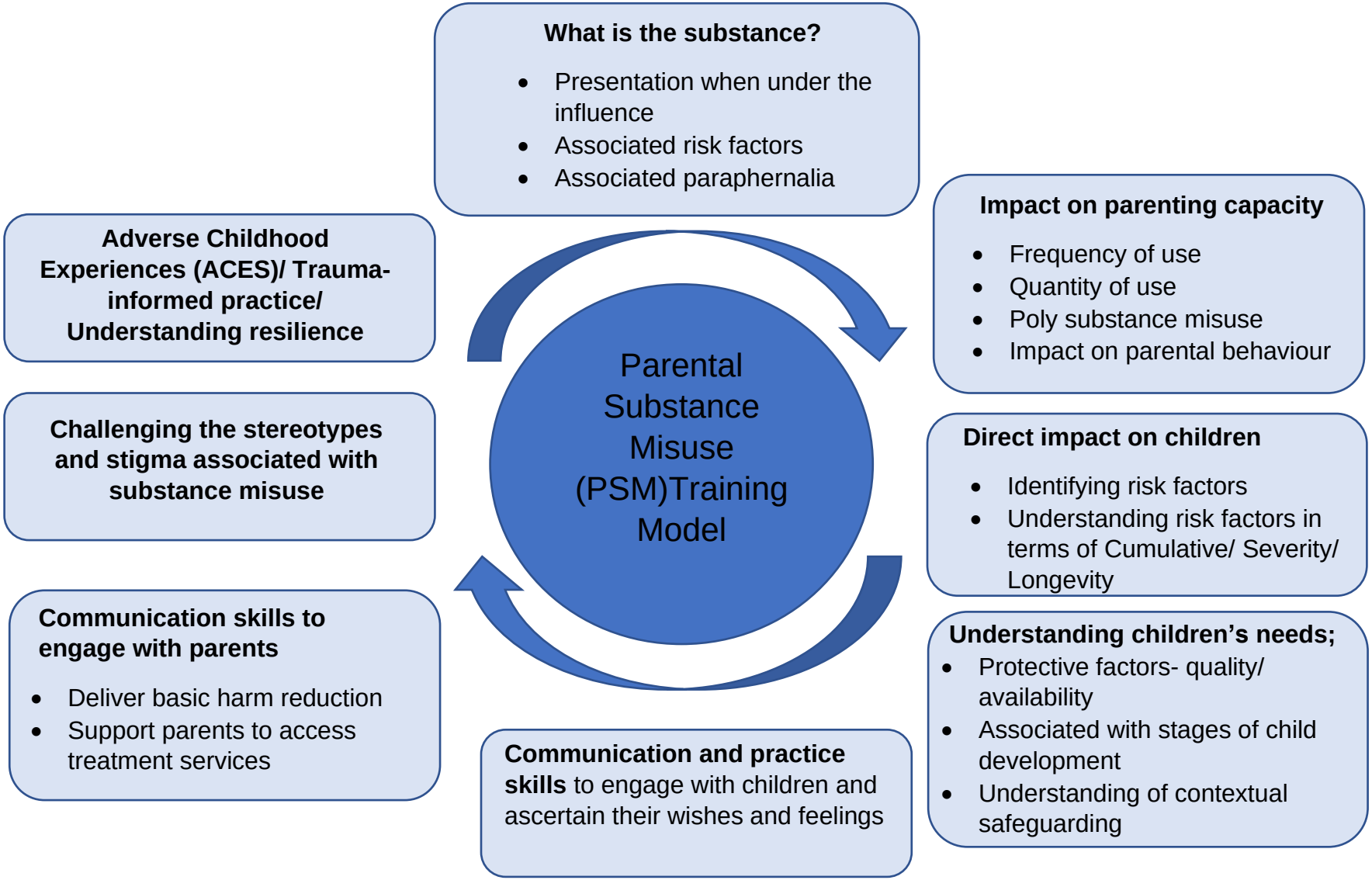


Figure 23 - Proposed training model for frontline practitioners

As evidenced from the findings with focus groups, participants within all three sectors of a children's workforce had differing levels of knowledge which meant children and their families were not receiving consistent responses from practitioners. Without adequate training, participants felt unable to appropriately assess safeguarding concerns, unable to talk to parents about their concerns and, worryingly, participants felt unable to talk to children about their experiences of PSM. As we heard from children who participated in this research, they all valued having a trusted professional they could talk to an confide in.

What this model illustrates is that without knowledge of substances, understanding risk and protective factors, being trauma informed, and without the knowledge and practice skills to communicate with parents and children, practitioners will not be able to respond effectively and confidently to the needs to children living with PSM. Improving practitioner confidence in the assessment of risk, will enable the needs and protective factors of children living with PSM to be understood. This improved understanding will enable practitioners to identify children living with PSM who are in need of support before the point of severity.

The failure to equip practitioners with the knowledge and practice skills to support adults misusing substances, and to respond to the needs of children living with PSM, is both systemic and longstanding (Galvani, 2017). The need for training to equip practitioners with the knowledge to assess and respond to the needs of children living with PSM at the earliest opportunity is also evident in the findings from serious case reviews (chapter 4.5).

The eighth consecutive report-examining SCR's in England was published in 2020; as with the seven preceding reports, PSM features heavily in the complexity and cumulative harm children had suffered (Brandon et al., 2020). The 2020 report illustrated recurring themes, notably the combination of risk factors such as parental mental ill-health, domestic abuse, and PSM. A significant difference outlined in the most recent report was the cumulative

and multiple factors children had endured and the complexity between PSM, domestic abuse and poverty.

A further significant finding from the examination of SCR's was that where the focus was on the needs of parents, 'the voice and lived experience of the child can easily be overlooked' (Brandon et al., 2020:16). This research has attempted to rectify this to a small degree by prioritising the voices of children. The frontline professionals in this research also illustrated the need for children to have the opportunity to access support in their own right, as all too often the needs of adults become the focus of practitioners.

Without the provision of services or practitioners having knowledge and training to identify and assess the needs of children living with PSM, it is likely those needs will continue to be overlooked. A key message for practice is the need for both adult and children's services to improve joint working, share information, and develop realistic plans for the safeguarding of children (Brandon et al., 2020). The need for knowledge of PSM across adult and children's services is vital. Although improved practitioner training in itself will not completely prevent child deaths, it will contribute to improved identification and assessment of risk.

Ultimately, practitioner training of PSM has the potential to prevent escalating and accumulating risk, thereby safeguarding and protecting more children. All frontline practitioners across adult and children's services who are in contact with parents who misuse substances need to know how to assess and respond to the needs of children living with PSM.

The failure of social work programmes to equip social workers with knowledge of substance misuse and the impact of PSM on children, is only one part of the systemic failure. Once qualified, social workers may or may not have access to training provided by their local authority; as with children's access to specialist support, social workers' access to ongoing training is a postcode lottery (Galvani, 2017).

This research project found similar findings; social workers, including newly-qualified and more senior practitioners, raised the issue of education and training. Social workers reported not receiving any education pre-qualification on substance misuse and/or the impact of PSM on children. Some participants, from the local authority where the research took place, spoke highly of their access to training. One newly-qualified social worker described how substance misuse training had allowed them to understand the intricacies of preparing a drug (such as heroin or crack cocaine) for use, as well as information about treatment and basic harm reduction. This had equipped them with the knowledge of how to challenge parents who were either denying or minimising their use, as well as being confident to support parents to access treatment service. Most of all, substance misuse training had allowed social workers to see the world through the eyes of the child, to see and understand what they see.

Other social workers, who had worked in different local authorities, spoke of their frustration of not receiving specialist training, hence being unable to ask explorative questions with parents about their substance misuse and, most worryingly, being ill-prepared and ill-equipped to talk to children about PSM. In the absence of training, once in practice, social workers are likely to focus on visible risk factors such as 'impaired functioning' (Dance et al., 2014:568), and have little understanding of the risk and protective factors associated with PSM, as presented in this research project.

Social workers practice in a variety of roles, and it is their knowledge and practice skills to engage with vulnerable families which means they are best placed to respond to the needs of substance users and their children. Yet a lack of education and training means social workers are reliant on their own knowledge, perhaps gained through personal experience or individual study or both. A lack of training has been found to be a factor in the inappropriate use of language relating to substance misuse, and of the lens through which social workers perceive substance misuse (Livingston, 2017).

Despite being best placed to support, assess, and respond to the needs of those misusing substances, social workers who have received little, or no, substance-use training or practice experience, will have less of a desire to work with this population (Senreich and Straussner, 2013). The lack of training and understanding by frontline practitioners regarding the needs of adults who misuse substances is only likely to further compound the risk of children living with PSM being overlooked and remaining hidden or provided with inappropriate services.

Across higher education establishments and local authority workforce development services, the failure to incorporate PSM education into the very core of safeguarding education and training results in failures to protect some of the most vulnerable children in our society. The failures do not lie simply with social work, but across the board of professions from education (nursery, primary and secondary school), health (e.g. midwifery, health visitors, school nurses) and children's early intervention services. The need for frontline professionals to be equipped with knowledge and training of PSM is not just the responsibility of services for children, but also that of adult services providing support to adults with children, to ensure practitioners never lose sight of the needs of children living with PSM.

The findings presented in chapter 21.3 highlighted the frustrations from frontline professionals of having to learn on the job. Without adequate training this has resulted in misconstrued and inaccurate judgements about substances and substance users. The findings illustrated that the absence of PSM training has led to inconsistencies in decision-making, as to whether, for example, a family required statutory safeguarding intervention or an early intervention service. The impact for children and their families included inconsistent responses by professionals, the likelihood of children at risk of significant harm remaining hidden, and decisions to remove a child from their parent's care being made too hastily.

The new model presented and discussed in this section enables a consistent response to children living with PSM and a workforce that would feel more

confident and competent to engage with both children living with PSM and their parents.

26.2- Responding to the needs of parents who misuse substances

The findings from this research have outlined a systemic failure in practice (figure 22) to respond to the needs of children living with PSM. This research has found that the negative impact of PSM experienced by children, is connected to austerity, the falling provision of substance treatment services, and the failure of adult substance misuse services to meet the needs of parents who misuse substances.

The impact of reduced funding and restructures of substance misuse services was identified by focus group participants. Participants expressed their concern and frustration that even when a parent had made the decision to access treatment services, they were faced with multiple barriers. Focus group participants shared their frustration of the process to access treatment services due to parents first needing to attend a triage assessment before being referred to a treatment service. The implication of the time lapse between the initial triage, referral to a substance misuse treatment service, and receiving an intervention, meant the window of opportunity to support parents to address their substance misuse was often lost. As evidenced in the research findings, when the window of opportunity for parents to access treatment was lost, the negative impact on children was continued exposure to their parent's substance misuse and associated risk factors.

The Advisory Council on the Misuse of Drugs (ACMD) and the Recovery Partnership have also outlined a number of current problems in the delivery of substance misuse services; namely continued funding cuts, 'rapid re-tendering cycles', and the 'loss of qualified staff' (Alcohol Concern, 2018:1). The impact of austerity is evident in the cuts to adult substance treatment services. Where services have been maintained, the reduction in funding for specialist practitioners has meant an over-reliance on volunteers 'with limited

training' (Drummond, 2017:1). Drummond (2017:1) suggests that the implementation of payment by results (commissioning based on outcomes), has added further strain to treatment services, and is likely to lead to services being reluctant to 'take on' those with complex needs and where their engagement in treatment is likely to be long term.

Focus group participants highlighted their frustration at the lack of outreach support for those parents with complex needs who disengaged from treatment. The lack of outreach support is especially pertinent for the needs of mothers who misuse substances. Women who misuse substances and who are mothers are likely to experience a range of complex adversities including poverty, mental ill-health, domestic abuse and limited support networks (Bohrman, 2017).

Women who misuse substances are not only likely to experience significant adversity, but they are also faced with the very real fear that accessing treatment services may lead to children's social care intervention (Bohrman, 2017). The fear of losing a child can prevent women from accessing the support they need (Elms, 2018). Child-care issues and safety fears, due to a male-dominated environment in treatment services and group support, have been identified as common barriers for women seeking treatment for their substance misuse (Elms, 2018).

In the absence of tailored substance misuse support for parents, especially mothers who experience complex adversity, it is likely that windows of opportunity to support children and their parents will continue to be missed. Further, it is possible that an over- reliance on group work rather than one-to-one sessions, will contribute to missed opportunities for practitioners to explore the impact of PSM and openly discuss strategies with parents to reduce risk. Cuts to adult treatment services and an over-reliance on 'peer mentors' also raises the important issue of training' (Alcohol Concern, 2018:21) and highlights the paramount need for improved training of PSM for practitioners within adult treatment services as well as children's services.

The lack of services which are specifically tailored to meet the needs of women, form another layer of failure for children living with PSM. This results in the likelihood of them only coming to the attention of services at a level of severe safeguarding concern. The negative impact for children is prolonged exposure to safeguarding risks associated with PSM, and missed opportunities to support children, and their parents, before the point of severity and crisis.

A 2017 report from the ACMD explored the impact of commissioning structures on treatment for drug misuse. The report make's reference to the 2017 Drug Strategy and the commitment to 'effectively funded and commissioned services, targeted at helping people fully recover from dependence'. Despite the commitment of the 2017 Drug Strategy, the ACMD (2017:2) states, 'it difficult to see how that aspiration can be delivered', and recommend that drug services should be mandated within local authority budgets with protected investment.

The report provides clear recommendations to protect funding and reduce the negative impact of 'frequent re-procurement that drains vital resources and creates a 'churn', resulting in poorer service user recovery outcomes, at least in the short term' (ACMD, 2017). The report does not make reference to the impact on children of reduced funding to treatment services. However, as this research has illustrated, reduced treatment services for parents will result in missed opportunities for parents to address their substance misuse and to reduce the negative impact on their children.

Though the report by the ACMD (2017) made clear recommendations to secure and ring fence funding for adult substance treatment, those recommendations appear an unlikely outcome. The report by Alcohol Concern (2018:6) outlines the continued wave of cuts to substance treatment services, due to a change from services being funded through public health teams to services being 'funded through local business rate retention'. It is anticipated that this change will further widen the inequality gap, leaving those in 'high need' in regions where there will be the least funding available

(Alcohol Concern, 2018:6) and a ‘skeleton service’ for parents with complex needs (Alcohol Concern, 2018:7).

26.3- Section summary

While this is a small-scale research study it is significant. The research has connected the findings from the wider literature, relating to a lack of adequate PSM training for frontline practitioners, the impact of austerity, and reduced adult substance treatment provisions. The findings from this research and the wider literature illustrates the systemic failures across the exosystem and macrosystems. The implication is a continued failure in practice to respond to the needs of children living with PSM.

This research also presented findings from the literature review (chapter 4) which outlined the over-representation of children living with PSM open to statutory children’s social care, subject to child protection plans and care proceedings. Alongside the continued cuts to substance misuse treatment services, and without systemic change it is unlikely that the over-representation of children within these categories will change. The following section will discuss the impact of the government’s chosen austerity measures in relation to the provision of community resources for children and the impact this has on children living with PSM.

26.4- The impact on children living with PSM during austerity

This research has illustrated the need for children living with PSM to have multiple protective factors, across multiple systems. This includes their meso- and exosystems and the need for community resources to act as a buffer against the negative impact of PSM. The focus groups with practitioners, highlighted the importance of community resources to prevent escalating and enduring harm, as evidenced by the connection between PSM and contextual safeguarding concerns.

This research has also found that the current macrosystem has negatively impacted on children living with PSM and compounded their suffering

because of austerity measures. The governments choice to implement austerity measures (Jones et., 2019) has resulted in reduced services which once served as a valuable community resource for children and families in need of support. This research has brought to the fore the connection between austerity and the direct impact the current macrosystem is having on children who live with PSM. The implication for children living with PSM during the current time of austerity is at best isolating and marginalising, at worst it is severe and enduing.

Since 2010 there has been a 40% reduction in funding to local authorities from central government (Jones et al., 2019). The funding that remains available has not been distributed to areas with high deprivation and instead, has been funnelled to more affluent area's which are understood to be predominantly conservative strongholds (Jones et al., 2019).

Since 2010, the implementation of austerity policies has been 'rapid and radical' and 'reinforced year after year' (Jones et al., 2019:8). The impact of austerity has resulted in families who live in areas of 'high social need' being made poorer. The year-on-year reinforcement of austerity means that for children and families in need, they have not just been made poorer, but have been driven from 'deprivation to destitution' (Jones et al., 2019:8). As the focus group participants illustrated in this research, poverty has become a new normal, as have the need for food and clothes banks; vital services for families that have sadly become the trademark of austerity since 2010 (Jones et al., 2019:8).

The UK Government's endeavour to implement austerity measures was based on the promise of fairness, and a 'more efficient' economic and welfare system (Morris, 2016:100). The sweeping economic reform is far from fair despite the government's pledge that cuts to welfare would be made fairly. The hardest hit were people who were most in need and less 'able to bear' the cuts; the greatest 'skew' was against 'the disabled and social care users' (Morris, 2016:105).

Reduced resources are coupled with continued welfare reforms, including a cap on benefits for larger families, freezing of working tax credits, and further punishment on families for having a spare room (bedroom tax), with few social housing options available to enable families to downsize their property (Morris, 2016:105). All of which will undoubtedly plunge children from poorer households living with PSM deeper into poverty. This macrosystem-level failure forms an additional layer of harm for children living with PSM. The moral economic failures on children and families who are most in need, is illustrated by Morris (2016:111) in this quote taken from a parliamentary discussion:

> The final verdict on any government is how they treat the poorest in society during the hardest of times. The rise in need for foodbanks is a horrifying indictment.

Reduced community resources can also be seen with cuts in funding for breakfast clubs, closure of libraries which offered a 'free and warm' space for children, children's centres and Sure-Start centres closures, and funding for free leisure activities such as swimming being pulled (Ridge, 2013:410). The UK Government's welfare reform, and continued implementation of austerity measures, means that those children who are the most in need of community resources are hit the hardest.

The findings from this research have identified a direct association between PSM and the risk of children being at risk of and exploited (contextual safeguarding). The findings also illustrated the invaluable role youth services play in supporting the most vulnerable children in our communities. Focus group participants stated that youth workers and youth services were especially important in the prevention of children becoming victims of child sexual and criminal exploitation.

Yet, the decline of youth services for children is another example of a moral economic failure which directly impacts on the most vulnerable children in our society. The YMCA (2019) report that funding for youth services has

been cut by 60% since 2010; in the North West of England the figure was 74%, and in some regions the funding cuts reached 90%. The chief executive of the YMCA in England and Wales outlines the importance of youth services:

> Youth services exist to provide a sense of belonging, a safe space, and the opportunity for young people to enjoy being young. However, for almost a decade now local authorities have struggled under the weight of funding pressures, meaning youth services are being forced to endure continued and damaging cuts. (YMCA, 2019:online)

While these pressures are at the macro systems level, the impact is felt on a micro systems level with the responsibility being placed on individual children and families. The UK Government's narrow focus on 'troubled families' was intended to 'break the cycle' of poverty and 'troubled' behaviours by ensuring that children are not the 'poor parents' of the future (Ridge, 2013:412). As Ridge points out, the government does not provide the resources for this to be achieved while simultaneously placing the responsibility 'squarely on the shoulders of impoverished children' (Ridge, 2013:412).

26.5- Macro level failure to adequately respond to needs of children living with PSM

The empirical data collected in this research, combined with the existing evidence review (chapter 3.3) outlines how policy and government commissioned reviews, such as *Hidden Harm* (ACMD 2003) have failed to lead to improvements for children living with PSM. In response, this research presents a new model of practice and training model drawn from the voices of participants and existing evidence.

Hidden Harm, which was published in 2003, is an opportunity lost (ACMD, 2003). It should have been the catalyst for systemic change for children living with parents who misuse substances. It contained 48 recommendations for practice (ACMD, 2003). In 2006, the ACMD published *Hidden Harm: Three*

Years On: Realities, Challenges, and Opportunities, which outlined that one of the key challenges of implementing the 48 recommendations from *Hidden Harm* in 2003, was that it 'cut across a wide range of services, most notably children's services and adult drug treatment services' (ACMD, 2006:24). The report concludes that without a coherent and joined up approach, across government departments, there will continue to be a 'diluted' response to the needs of these children (ACMD, 2006:24).

The report by the ACMD (2006) presented evidence that there had been some progress, in that PSM had been included in the Common Assessment Framework (non-statutory assessment for early identification of the needs of children and their family). Though PSM is included in this standardised assessment, this research and the wider literature has evidenced that practitioners do not have access to standardised PSM training. In response, this research has presented a proposed model of practice (figure 19 in chapter 25) for children living with PSM, and a training model (figure 23 in chapter 26), to equip and support frontline practitioners to assess, respond, and support children and their families where PSM is a safeguarding concern.

Practitioners in this research reported a lack of guidance and frameworks for responding to children living with PSM. This is not surprising given the dominant publication informing safeguarding children practice, *Working Together to Safeguard Children* (H.M. Government, 2018), requires practitioners only to be 'alert' to the needs of children living with PSM. *Working Together* (H.M. Government, 2018) omits any detailed guidance for practitioners regarding risk and protective factors and why some children are at 'greater risk of harm'. The needs of children living with PSM are also mentioned in the *2017 Drugs Strategy* (Home Office, 2017). Although no clear details are provided of how children's needs are to be assessed, there is a call for evidence-based interventions to meet the needs of children and their families affected by substance misuse.

As with *Hidden Harm* (2003;2006)*, Working Together* (H.M. Government, 2018) and the *2017 Drugs Strategy* (Home Office, 2017), there is an absence of clear guidance for frontline practitioners on how to meet the needs of children and families affected by PSM, and no statutory obligation for either adult or children's services to provide training for frontline practitioners. The words presented in these documents provide an acknowledgement, at best, of the issues facing children living with PSM, but are void of statutory obligation and provide scant guidance for practitioners. This research begins to fill in this gap by offering a proposed model of training and practice (chapter 25 and 26).

Children affected by PSM fall between the cracks, as neither adult, nor child-care legislation provides adequate protection. The fragmented approach in the response to the needs of children living with PSM is indicative of the 'fracture lines' between adult and children's services and the different government departments they are responsible to i.e., the Department of Health and the Department of Education, respectively (McLaughlin 2013). PSM is a safeguarding concern which cuts across both adult and children's sectors. Practitioners within services for children need to know how to support and signpost parents to substance misuse services, and practitioners within services for adults need to understand the needs of children, with knowledge to assess risk and signpost to services for children.

During a time of continued austerity and cuts to vital public services, the lack of legislative protection adds a further layer of failure. There is a risk that as local authority budgets are squeezed tighter, local authorities will have no option but to only deliver statutory requirements. The figures from National Audit Office show local authority budgets have been cut by 50% since 2010 (ADCS, 2018). Not surprisingly, as local authority budgets have been halved, the decimation of services has been felt across the non-statutory sector. The ADCS (2018) report stressed there is some evidence of local authorities who have managed to protect some early help services. However, with local authorities continuing to face reduced budgets, the sustainability of early help services remains under threat.

The prevailing reasons why children are coming to the attention of early help and/or children's social care continue to be domestic abuse, parental mental ill-health, and PSM (trigger trio). Despite the knowledge of PSM being a significant safeguarding concern, the responses in practice are not consistent. The ADCS (2018:6) identified there is a 'sharper focus' in practice on interventions for vulnerable children who have experienced neglect, domestic abuse, and who are at risk of child sexual exploitation.

Perhaps the prevalence of PSM is missed on a practice level due to how data is collated and recorded. If PSM is recorded under more dominant categories such as neglect and domestic abuse, it is possible that the prevalence of PSM is under- recorded and misunderstood. The profile of children living with PSM will continue to receive less attention, both in terms of practitioner training and service provision.

In response, this research proposes the need for improved localised data. Localised data where PSM is identified as the primary safeguarding concern should be collated from early help assessments (common assessment framework), social work assessments, child protection plans and care proceedings. This would ensure that PSM is not hidden under safeguarding categories such as neglect or emotional abuse. It would also provide an improved and accurate reflection of the prevalence of PSM. Accurate data can then be presented and discussed with local authority safeguarding partners (adult and children's services) to coordinate and commission reservices in response to the needs of children living with PSM.

26.6- Chapter summary

This research has illustrated the multi-layered and systemic failings in policy and practice in response to the needs of children living with PSM. This chapter has discussed important findings from this research and presented a model of training (figure 23) for frontline practitioners. The training model will support practitioners by improving their knowledge of PSM and increase their confidence in the assessment of risk. The model will also enable

practitioners to understand the needs of children living with PSM, and enable them to meaningfully respond to those needs of, and provide the required support for, children living with PSM. The need for adequate training, improved joint working between adult and children's services and, above all, the need for children's voices to be heard, are reaffirmed no more so than in the findings from serious case reviews.

Further layers of failure were discussed in relation to the macro level influence and the decimation of early help services for children and families due to severe and sustained cuts to local authority budgets. The decimation of services due to the Government's choice to implement austerity measures has also been felt across services for adults. With significant cuts to substance misuse treatment services and the loss of much-needed outreach and tailored support for the needs of parents, namely women experiencing complex adversity.

Austerity measures have had a direct impact on children and families where PSM is a safeguarding concern. With local authorities having to focus their attention on statutory obligations, the opportunity to reach families at an early level and reduce the risk of children being exposed to prolonged adversity is being missed.

Without appropriate recognition in legislation, adequate funding for local authorities to commission services the systemic failure to protect and respond to the needs of children living with PSM will likely continue. In the absence of coherent legislation, accurate prevalence data, and a continued post code lottery of service provision in response to the needs of children living with PSM, this research has proposed the need for improved localised data and localised knowledge of children living with PSM.

As presented throughout the discussion chapters, the findings from this research have extended existing knowledge. The discussion chapters have illustrated a depth of understanding, and outlined that only by addressing the complexity of PSM across multiple systems, can real and sustained change

be achieved for children. Commissioners, policy makers, educators and service providers need to listen and respond to the actual needs of children living with PSM. The recommendations for change to bridge the gap between research and practice are presented in the following chapter.

Chapter 27

Bridging the gap between research and practice: Recommendations for change

To raise the profile of the needs of children living with PSM, this chapter presents recommendations for change. This is especially important for those children who live in local authorities with no access to specialist support, who are hidden and whose voice is not heard.

27.1- Recommendations for change: Legislation

1. Children living with PSM need to be recognised in current legislation (The Children Act 1989) as children in need, with PSM recognised as a primary factor. This would ensure children living with PSM receive an appropriate assessment under section 17 of The Children Act 1989. Furthermore, this group of children should also be recognised in the associated regulations and guidance, *Working Together to Safeguard Children* (HM Government, 2018).

   The current legislation and supporting legislative guidance states practitioners need to be 'alert' to the needs of children living with PSM. To mirror the language adopted for other identified vulnerable groups of children, legislation should reflect need and clearly state; local authorities **must** assess the needs of children living with PSM and commission appropriate services.

27.2- Recommendations for Change: Policy

1. Localised data from early help assessments, social work assessments, child protection plans and care proceedings, where PSM is identified as the primary safeguarding concern, should be collated.
2. Localised data concerning the prevalence of PSM and local and national data regarding the findings from serious case reviews need to be communicated with safeguarding partners (formally known as local safeguarding children's board). Responses to localised data need to be monitored and routinely evaluated.
3. Improved pathways and collaboration between adult treatment services and services for children need to be achieved. Both parties should recognise their responsibility regarding PSM; adult treatment services have a duty to identify the needs of children, and children's services have a duty to signpost parents to appropriate support. Parental substance misuse training for adult treatment and children's services is the first step to achieve improved pathways.
4. The needs of children living with PSM must be on the radar of those who specialise in developing, commissioning, and delivering services for children; as such PSM should be a topic of discussion for The Association of Directors for Children's Services and Association of Directors of Adult Services.
5. Mirroring the responses for complex safeguarding concerns where high-risk domestic abuse cases are discussed (MARAC- Multi Agency Risk Assessment Conference) local authorities should adopt a multi-agency response where PSM is the primary safeguarding concern. This should include representatives from adult treatment, children's services, health and education. The needs of children living with PSM should be discussed and responses coordinated at the earliest opportunity, and not at the point of severe harm or during care proceedings.

27.3- Recommendations for change: Training

1. Social work education needs to include substance use and parental substance misuse within its core curriculum. The needs of these children are too great for this topic to be overlooked.
2. The proposed model of training presented in chapter 26 needs to be accessible for all frontline child focussed practitioners who support children and families where PSM is prevalent. This includes those practitioners in adult facing roles.
3. Practitioners within adult treatment services need training to enable them to confidently explore with parents the needs of their children.

27.4- Recommendations for change: Practice

1. Children who are living with parents who misuse substances should have access to specialist support. Informed by the voices of children who participated, this research has proposed the minimum requirements for a model of practice (chapter 25).
2. Support for children living with PSM should not be time-limited or dependent on their parent's engagement. Access to support should be available for children in their own right.
3. Responses in practice for children and families should not be defined by the substance, services for children should not be alcohol or drug specific.
4. Adult treatment services need to respond to the complex needs of parents who misuse substances and tailor care plans for the unique needs of parents, especially parents who present with complex needs.

27.5- Recommendations for further research

1. Quantitative studies are needed which examine the prevalence of PSM, and are not reliant on data collated from adult treatment services and children's social care. Using localised data of PSM measured against levels of deprivation is one option.
2. Further research is required to understand the needs of children living with PSM who are young carers and whether young carers' services meet their specialist needs regarding PSM.
3. Further research is required to understand the needs of children living with PSM from Black, Asian and Minority Ethnic (BAME) groups given the absence from this, and the majority, of research in this area.
4. Research is required to evaluate existing specialist services for children living with PSM in order to identify and disseminate good practice.
5. Research evaluating the introduction, and impact, of PSM training for frontline practitioners, to understand practitioner confidence and ascertain whether frontline practitioners are adequately equipped to respond to the needs of children living with PSM.

The overarching aim of this research was to bridge the gap between research and practice, to enable families to stay together safely and enable practitioners to make informed and timely decisions when this is not possible. The models of practice presented in the discussion chapter and the recommendations above, illustrate how bridging the gap between research and practice can be achieved. The implementation of the above recommendations is by no means an easy feat, especially given the current climate of continued austerity and in the midst of a global pandemic. That said, this research has illustrated, through the voices of children and frontline practitioners, that change is urgently needed. The proceeding and final chapter will present the overall conclusion for this research study.

Chapter 28

Conclusion

This research should not have been necessary and yet it was needed, because children who live with parents who misuse substances continue to be failed due to inadequate responses in legislation, policy and practice. This research set out to understand how children experience living with PSM and to inform policy and practice.

The review of the existing evidence and wider literature sought to explore what is known about the prevalence of PSM, what is known about the impact of PSM on children's emotional wellbeing and safety, and how this knowledge is reflected in policy and practice. The review drew attention to the unreliable data of the prevalence of PSM, as data was dependent on two sources; adult treatment services and children's social care. Thus, those parents who were not accessing treatment, or whose needs have not come to the attention of statutory children's social care remain hidden.

The review explored the representation of children living with PSM in legislation, policy and practice. The ground-breaking publication of *Hidden Harm* (ACMD, 2003) with its 48 recommendations for policy and practice, some 18 years ago, should have been a catalyst for sustained change. As the review illustrated, children living with PSM continue to be over-represented in statutory children's social care, child protection plans, and in the number of care proceedings. Without the legislative backing to embed the recommendations from *Hidden Harm* (ACMD, 2003), children living with PSM continue to be failed on every level.

The vague language adopted in UK child legislation, outlines how children living with PSM may be at risk of harm and states professionals need to remain alert. But the legislative guidance falls short of providing any statutory obligation for local authorities to respond to the needs of children living with PSM. This has resulted in a postcode lottery of service provision to

adequately meet the needs of this vulnerable group of children and a fragmented response in the provision of training for practitioners.

The critical discussion of the body of literature identified the gaps in legislation, policy, the direct impact on inadequate training for frontline practitioners, and the lack of appropriate services for children living with PSM. The review demonstrated that where specialist services were available for children living with PSM, these were short term interventions, designed and adapted from adult models of practice, and seemingly not informed by theoretical understandings of trauma and resilience. The review also identified the absence of the voices of younger children. Research presented illustrated a reliance on the voices of older children and young adults' retrospective reflections of their experience.

In response to siloed and fragmented responses in legislation, policy, practice, and lack of appropriate services for children living with PSM, this research identified three research questions;

- How do school aged children (aged 5-16) experience living with a parent who misuses substances?
- What do children need in order to promote and strengthen their emotional resilience and enable them, when appropriate, to live safely with parents who misuse substances?
- From the perspective of professionals, what changes are considered to be necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

The research questions informed the research design which sought to privilege the voices of children; in doing so, creative research methods were adopted. Guided by the principles of hermeneutic phenomenology, seven children aged 7-16 years participated. The children were all living with their parents who misused substances and as such the findings from the children's emotive reflections provide a real-time understanding of their lived experience. Interpretive phenomenological analysis provided a

methodological framework which enabled me to engage reflexively with the data and seek to understand a further depth of meaning.

Three focus groups with 22 professionals were also included in this phenomenological research design, specifically to understand the needs of practitioners across a children's workforce; as such, inclusion of practitioners from multiple professional backgrounds, from education, early intervention services and from within children's social care was purposeful. This is the first-time children's voices and the voice of professionals from multiple professional backgrounds were heard together. This unique research design has resulted in a new, and in-depth, understanding of the needs of children living with PSM.

Part four of this thesis presented the findings from both the creative interviews with children and the focus groups with professionals. Children who participated in this study experienced multiple adversity and harm because of their parent's substance misuse. The emotive reflections bravely shared by children demonstrated the harsh and enduring reality of their lives, compounded by multiple layers of adversity such as financial hardship, homelessness, violence, domestic abuse, and parental mental ill-health.

The impact of PSM on the lives of these children resulted in their loss of childhood, the chance to be a child free from worry, to play, and to have fun. The findings demonstrated that the substance misused by parents and the child's age was not indicative of increased or reduced risk. As both the youngest and oldest child participants experienced multiple risk and adversity. The severity of experienced risk factors was not persistent and as the findings illustrated, the children not only faced multiple risk factors, they also experienced heightened levels of anxiety due to the unpredictability of their parent's behaviour.

The creative interviews were also designed to understand from the children's perspective the protective factors they valued. The children's reflections illustrated the value they placed, not just on support from family, but of their

need to have professional support for as long as they needed and until they felt safe. The findings from this research demonstrate the wide and varying complexity of PSM, and shows that children living with PSM are not a homogenous group, as no two children experienced the same risk and protective factors.

The findings from focus groups with professionals identified the challenges, stresses, and strains experienced by individual professionals and organisations. They shared their experience of inadequate training pre- and post- qualification which impacted their ability to effectively identify, assess, and respond to the needs of children living with PSM, with an over-reliance on past professional experience. The challenges experienced were compounded by the direct impact of almost a decade of austerity measures which have reduced early intervention services and as a result, professionals had to prioritise the needs of younger children to the detriment of older children. The powerful reflections by professionals demonstrated the direct impact of PSM on older children, resulting in the increased risk of significant harm because of contextual safeguarding; child criminal exploitation and child sexual exploitation.

The ecological systems theoretical framework of the discussion chapter which connected the review of literature, creative interviews with children, and the focus groups with professionals, helped to frame an in-depth understanding of the experience and the needs of children living with PSM. These included the need for children's experiences to be understood in terms of severity, accumulation, longevity of risk, and the need for children to have multiple protective factors across multiple systems.

This research has demonstrated the systemic failure across multiple levels, in legislation, policy and practice, to adequately respond to the needs of this vulnerable group of children. Without adequate training, frontline practitioners will lack the ability and knowledge to effectively assess risk and make informed decisions, and will ultimately fail to protect the most vulnerable children living with PSM. In response, this research has informed a training

model and, as outlined in the recommendations chapter (chapter 27), training regarding PSM needs to be for all frontline practitioners, across education, health, early intervention services, social care (adult and children), and adult treatment services.

This research is original in design, and the findings have informed recommendations for practice as well as the necessary changes required to bridge the gap between research and practice. Children living with PSM have fallen through the widening fracture lines of legislation, policy and practice; their needs are too great to continue to be overlooked. This research has shown the vital need for systemic change. No longer should children living with PSM be hidden behind generalised safeguarding categories, such as neglect, physical, and/or emotional abuse. The profile of children living with PSM needs to be raised, they need be seen, heard, and listened to in their own right, with specific services for them.

To truly understand the needs of children living with PSM, children need to be listened to; if we as adults cannot listen, we cannot understand. This research valued the children's 'truth', it is their truth and their experiences which were privileged, and remained at the very heart of this research. It is their voices which have informed the minimum requirements for a model of practice, informed by children, for children.

References

Adamson, J. and Templeton, L. (2012) *Silent Voices: Supporting children and young people affected by parental alcohol misuse.* Children's Commissioner of England. [Online] [Accessed on 7th October 2020] https://dera.ioe.ac.uk/15497/1/FINAL_OCC_Report_Silent_Voices_Parental_Alcohol_Misuse_FULL_REPORT_11_Sept_2012%5B1%5D.pdf

Advisory Council on the Misuse of Drugs. (1971) *Misuse of Drugs Act 1971.* [Online] [Accessed on 7th October 2020] https://www.legislation.gov.uk/ukpga/1971/38/crossheading/controlled-drugs-and-their-classification

Advisory Council on the Misuse of Drugs. (2003) *Hidden Harm Full Report*. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

Advisory Council on the Misuse of Drugs. (2006) *Hidden Harm Three Years On: Realities, Challenges and Opportunities.* [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/119104/HiddenHarm1.pdf

Advisory Council on the Misuse Drugs. (2017) *Commissioning impact on drug treatment: The extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery*. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.

Afifi, T. O. and MacMillan, H. L. (2011) *Resilience following Child Maltreatment: A Review of Protective Factors*. Los Angeles: SAGE Publications.

Akin, B. A., Brook, J., Lloyd, M. H. and McDonald, T. P. (2017) 'Effect of a Parenting Intervention on Foster Care Reentry After Reunification Among Substance-Affected Families: A Quasi-Experimental Study.' *Child maltreatment,* 22(3) pp. 194-204.

Akin, B. A., Johnson-Motoyama, M., Davis, S., Paceley, M. and Brook, J. (2018) 'Parent perspectives of engagement in the strengthening families program: An evidence-based intervention for families in child welfare and affected by parental substance use.' *Child & family social work,* 23(4) pp. 735-742.

Alase, A. (2017) 'The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach.' *International Journal of Education & Literacy Studies*, 5(2) pp. 9-19.

Alcohol Concern. (2018) *The hardest hit: Addressing the crisis in alcohol treatment services.* Alcohol Research UK. [Online] [Accessed on 7th October 2020] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-hardest-hit.pdf?mtime=20181116174247&focal=none

Alderson, P. (2000) 'Research by children'. *International Journal of Social Research Methodology,* 4(2) pp. 139-153.

Aldridge, J. (2017) 'Introduction to the Issue: "Promoting Children's Participation in Research, Policy and Practice".' *Social Inclusion*, 5(3) pp. 89-92.

Amnie, A. G. (2018) 'Emerging themes in coping with lifetime stress and implication for stress management education'. *SAGE Open Medicine,* 6 pp.1-9.

Arria, A. Mericle, A. Meyers, K. and Winters, K. (2012) 'Parental substance use impairment, parenting and substance use disorder risk'. *Journal of Substance Abuse Treatment,* 43(1) pp. 114-122.

Asmussen, K. Fischer, F. Drayton, E. McBride, T. (2020) *Adverse childhood experiences What we know, what we don't know, and what should happen next*. Early Intervention Foundation. [Online] [Accessed on 7th October 2020] https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Association of Directors of Children's Services (ADCS). (2018) *Research Report Safeguarding Pressures Phase 6*. [Online] [Accessed on 7th October 2020] https://adcs.org.uk/assets/documentation/ADCS_SAFEGUARDING_PRESSURES_PHASE_6_FINAL.pdf

Backett-Milburn, K., Wilson, S., Bancroft, A. and Cunningham-Burley, S. (2008) 'Challenging Childhoods: Young people's accounts of `getting by' in families with substance use problems.' *Childhood,* 15(4) pp. 461-479.

Bambrough, S., Shaw, M. and Kershaw, S. (2014) 'The Family Drug and Alcohol Court Service in London: A New Way of Doing Care Proceedings'. *Journal of Social Work Practice,* 28(3) pp. 357-370.

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K. and Masters, H. (2004) *Parental drug and alcohol misuse: Resilience and transition among young people.* Joseph Rowntree Foundation. [Online] [Accessed on 7th October 2020] https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/1859352499.pdf

Barber, D. and Schluterman, D. (2008) 'Connectedness in the Lives of Children and Adolescents: A Call for Greater Conceptual Clarity'. *Journal of Adolescent Health,* 43(3) pp. 209-216.

Barnard, M. and Barlow, J. (2003) 'Discovering parental drug dependence: silence and disclosure.' *Children & Society,* 17(1) pp. 45-56.

Barone, T., Jr., Eisner, E. W. and Eisner, P. (2012) *Arts Based Research.* Thousand Oaks: SAGE Publications.

Bate, A. and Bellis, A. (2018) *The Troubled Families programme (England) Briefing Paper.* House of Commons Library. [Online] [Accessed on 7th October 2020] https://dera.ioe.ac.uk/32005/1/CBP-7585%20.pdf

Becci, A. A., Brook, J. and Lloyd, M. H. (2015) 'Co-Occurrence of Parental Substance Abuse and Child Serious Emotional Disturbance: Understanding Multiple Pathways to Improve Child and Family Outcomes.' *Child Welfare,* 94(4), pp. 71-96.

Bellis, M. A., Hardcastle, K., Ford, K., Hughes, K., Ashton, K., Quigg, Z. and Butler, N. (2017) 'Does continuous trusted adult support in childhood impart life-course resilience against adverse childhood experiences - a retrospective study on adult health-harming behaviours and mental well-being.' *BMC Psychiatry,* 17(1) pp. 110-110.

Benson, J. E. and Elder, G. H. (2011) 'Young adult identities and their pathways: A developmental and life course model.' *Developmental Psychology,* 47(6) pp. 1646-1657.

Bérubé, A., Lafantaisie, V., Clément, M.-È., Coutu, S., Dubeau, D., Caron, J. and Lacharité, C. (2017) 'Caseworkers' perspective on risk factors in the family environment influencing mothers' difficulties in meeting children's needs.' *Children and Youth Services Review,* 82 pp. 365-372.

Bradbury-Jones, C. Sambrook, S. Irvine, F. (2009) 'The phenomenological focus group: an oxymoron?.' *Journal of Advanced Nursing*, 65(3) pp. 663-671.

Brandon, M., Belderason, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005*. Department for Children, Schools and Families. [Online] [Accessed on 7th October 2020] https://dera.ioe.ac.uk/7190/1/dcsf-rr023.pdf

Brandon, M. Sidebotham, P. Bailey, S. Belderson, P. Hawley, C. Ellis, C. Megson, M. (2012) *New learning from serious case reviews: a two-year report for 2009-2011*. Department for Education. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf

Brandon, M. Sidebotham, P. Belderson, P. Cleaver, H. Dickens, J. Garstang, J. Harris, J. Sorensen, P and Wate, R. (2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report March 2020*. Department for Education. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative Research in Psychology*, 3(2) pp. 77-101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research: a practical guide for beginners.* London: SAGE.

Braun, V. and Clarke, V. (2014) 'What can "thematic analysis" offer health and wellbeing researchers?.' *International Journal of Qualitative Studies on Health and Well-being*, 9(1) pp. 26152-26152.

Bronfenbrenner, U. (1977) 'Toward an experimental ecology of human development.' *The American Psychologist,* 32(7) pp. 513-531.

Bronfenbrenner, U. (1979) *The Ecology of Human Development: Experiments by nature and design.* London: Harvard university Press.

Bronfenbrenner, U. (1986) 'Ecology of the Family as a Context for Human Development: Research Perspectives.' *Developmental psychology,* 22(6) pp. 723-742.

Bröning, S., Wiedow, A., Wartberg, L., Ruths, S., Haevelmann, A., Kindermann, S.-S., Moesgen, D., Schaunig-Busch, I., Klein, M. and Thomasius, R. (2012) 'Targeting children of substance-using parents with the community-based group intervention TRAMPOLINE: a randomised controlled trial--design, evaluation, recruitment issues'. *BMC Public Health,* 12(1) pp. 223-223.

Bröning, S., Sack, P.-M., Haevelmann, A., Wartberg, L., Moesgen, D., Klein, M. and Thomasius, R. (2019) A new preventive intervention for children of substance-abusing parents: Results of a randomized controlled trial. *Child & Family Social Work,* 24(4) pp. 537-546.

Bohrman, C., Tennille, J., Levin, K., Rodgers, M. and Rhodes, K. (2017) 'Being Superwoman: Low Income Mothers Surviving Problem Drinking and Intimate Partner Violence'. *Journal of family violence,* 32(7) pp. 699-709.

Burke, N. J. Hellman, J. L. Scott, B. G. Weems, C. F. Carrion, V. G. (2011) 'The impact of adverse childhood experiences on an urban paediatric population.' *Child Abuse and Neglect*, 35 pp. 408-413.

Cattapan, O. and Grimwade, J. (2008) 'Parental Illicit Drug Use and Family Life: Reports From Those Who Sought Help.' *Australian and New Zealand Journal of Family Therapy,* 29(2) pp. 77-87.

Children's Commissioner (2018*) "Are they shouting because of me?" Voices of children living in households with domestic abuse, parental substance misuse and mental health issues.* Children's Commissioner for England. [Online] [Accessed on 7th October 2020 https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/08/Are-they-shouting-because-of-me.pdf

Christensen, P. and Prout, A. (2002) 'Working with Ethical Symmetry in Social Research with Children.' *Childhood*, 9(4) pp. 477-497.

Christensen, P. M. and James, A. (2008) *Research with children: perspectives and practices.* 2nd ed., London: New York: Routledge.

Chuang, E., Moore, K., Barrett, B. and Young, M. S. (2012) 'Effect of an integrated family dependency treatment court on child welfare reunification, time to permanency and re-entry rates'. *Children and Youth Services Review,* 34(9) pp. 1896-1902.

Cleaver, H. Nicholson, D. Tarr, S and Cleaver, D. (2008) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice.* Department for Children, Schools and Families. [Online] [Accessed on 7th October 2020] https://dera.ioe.ac.uk/8820/7/child-protection-domesticviolence-parentalsubstance-misuse-2_Redacted.pdf

Coleman, J. (2019) *Understanding adolescent development in the context of child sexual exploitation*. IN: Pearce, J. (ed) *Child exploitation Why theory matters*. Bristol. Policy Press.

Copello, A., Templeton, L., Orford, J. and Velleman, R. (2010) 'The 5-Step Method: Principles and practice.' *Drugs: Education, Prevention and Policy,* 17(1) pp. 86-99.

Costley, C., Elliott, G. D. and Gibbs, P. (2010) *Doing work based research: approaches to enquiry for insider-researchers.* London: SAGE Publications.

Creswell, J. W. (2003) *Research Design Qualitative, Quantitative and Mixed Methods Approaches Second Edition*. London: SAGE Publications.

Creswell, J. W. (2013) *Qualitative inquiry and research design: choosing among five approaches.* 3rd ed., Los Angeles: SAGE Publications.

Crotty, M. (1998) *The foundations of social research: meaning and perspective in the research process.* London: SAGE Publications.

Dalziel, K., Dawe, S., Harnett, P. H. and Segal, L. (2015) 'Cost-Effectiveness Analysis of the Parents under Pressure Programme for Methadone-Maintained Parents.' *Child Abuse Review,* 24(5) pp. 317-331.

Danaher, T. and Briod, M. (2005) Phenomenological approaches to research with children. IN: Greene, S. and Hogan, D. (ED) *Researching children's experiences: methods and approaches.* London: SAGE.

Dance, C., Galvani, S. and Hutchinson, A. (2014) 'The Extent and Nature of Practitioners, Encounters with Alcohol and Other Drug Use in Social Work and Social Care Practice.' *Social Work Education: Substance Use in Social Work Education and Training,* 33(5) pp. 557-572.

Darling, N. (2007) 'Ecological Systems Theory: The Person in the Center of the Circles.' *Research in Human Development,* 4(3-4) pp. 203-217.

Davis, L. (2014) *Social worker's guide to children and families law.* 2nd ed. London: Jessica Kingsley Publishers.

Dawe, S. Harnett, P and Frye, S. (2008) 'Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do. Child Abuse prevention issues.' *Australian Institute of Family Studies,* 29 pp. 1-16.

De Bortoli, L., Coles, J. and Dolan, M. (2013) 'Parental substance misuse and compliance as factors determining child removal: A sample from the Victorian Children's Court in Australia.' *Children and Youth Services Review,* 35(9), pp. 1319-1326.

Department for Education. (2017) *Child sexual exploitation definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation.* [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

Drummond, C. (2017) 'Cuts to addiction services are a false economy', *BMJ,* 357 pp.1-2.

Dunkel, C.S. and Sefcek, J.A. (2009) 'Eriksonian Lifespan Theory and Life History Theory: An Integration Using the Example of Identity Formation'. *Review of General Psychology*, 13(1) pp. 13-23.

Early Intervention Foundation. (2018) *Building trusted relationships for vulnerable children and young people with public services.* [Online] [Accessed on 7th October 2020] https://www.eif.org.uk/report/building-trusted-relationships-for-vulnerable-children-and-young-people-with-public-services

Eiden, R. D., Lessard, J., Colder, C. R., Livingston, J., Casey, M. and Leonard, K. E. (2016) 'Developmental Cascade Model for Adolescent Substance Use From Infancy to Late Adolescence.' *Developmental Psychology,* 52(10) pp. 1619-1633.

Elms, N., Link, K., Newman, A., Brogly, S. B. (2018) 'Need for women-centered treatment for substance use disorders: results from focus group discussions.' *Harm Reduction Journal,* 15(1) pp. 40-40.

European Monitoring Centre for Drugs and Drug Addiction (2018) *European Drug Report Trends and Developments. Luxembourg. Publications office of the European Union*. [Online] [Accessed on 7th October 2020] http://www.emcdda.europa.eu/system/files/publications/8585/20181816_TDAT18001ENN_PDF.pdf

Evans-Agnew, R.A., Rosenberg, M.A. (2016) 'Questioning Photovoice Research: Whose Voice?.' *Qualitative Health Research*, 26(8) pp. 1019–1030.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. and Marks, J. S. (1998) 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study.' *American Journal of Preventive Medicine,* 14(4) pp. 245-258.

Finlay, L. (1998) 'Reflexivity: An Essential Component for All Research?'. *British Journal of Occupational Therapy*, 10 pp. 453-456.

Finlay, L. (2008) 'A dance between the reduction and reflexivity: explicating the "phenomenological psychological attitude"'. *Journal of Phenomenological Psychology*, 39(1) pp. 1-32.

Ford, K., Hughes, K., Hardcastle, K., Di Lemma, L. C. G., Davies, A. R., Edwards, S. and Bellis, M. A. (2019) 'The evidence base for routine enquiry into adverse childhood experiences: A scoping review.' *Child Abuse & Neglect,* 91 pp. 131-146.

Forrester, D. (2012) *Parental substance misuse*. London: BAAF.

Forrester, D. and Harwin, J. (2006) 'Parental substance misuse and child care social work: findings from the first stage of a study of 100 families.' *Child & Family Social Work,* 11(4) pp. 325-335.

Forrester, D. and Harwin, J. (2009) 'Parental Substance Misuse and Child Welfare: Outcomes for Children Two Years after Referral'. *The British Journal of Social Work,* 38(8) pp. 1518-1535.

Forrester, D. and Harwin, J. (2011) *Parents who misuse drugs and alcohol: effective interventions in social work and child protection.* West Sussex: Wiley-Blackwell.

Forester, D., Copello, A., Waissbein, C. and Pokhrel, S. (2008) 'Evaluation of an intensive family preservation service for families affected by parental substance misuse.' *Child Abuse Review,* 17(6) pp. 410-426.

Foster, C. E., Horwitz, A., Thomas, A., Opperman, K., Gipson, P., Burnside, A., Stone, D. M. and King, C. A. (2017) 'Connectedness to family, school, peers, and community in socially vulnerable adolescents.' *Children and Youth Services Review,* 81 pp. 321-331.

Foster, D. (2020) *An overview of child protection legislation in England*. House of Commons Library. [Online] [Accessed on 7th October 2020] https://commonslibrary.parliament.uk/research-briefings/sn06787/

Fraser, C., McIntyre, A. and Manby, M. (2009) 'Exploring the Impact of Parental Drug/Alcohol Problems on Children and Parents in a Midlands County in 2005/06.' *British Journal of Social Work*, 39(5) pp. 846-866.

Galvani, S. (2015) Drugs and Relationships Don't Work: Children's and Young People's Views of Substance Use and Intimate Relationships. Wiley Subscription Services.

Galvani, S. (2017) 'Social work and substance use: Ecological perspectives on workforce development.' *Drugs: Education, Prevention and Policy*, 24(6) pp.469-476.

Galvani, S., Dance, C. and Hutchinson, A. (2013) 'Substance Use Training Experiences and Needs: Findings From a National Survey of Social Care Professionals in England.' *Social Work Education,* 32(7) pp. 888-905.

Galvani, S. and Forrester, D. (2011) *How Well Prepared are Newly Qualified Social Workers for Working with Substance Use Issues? Findings from a National Survey in England.* Taylor & Francis Group.

Gance-Cleaveland, B., Mays, M. and Steffen, A. (2007) 'Association of Adolescent Physical and Emotional Health with Perceived Severity of Parential Substance Abuse.' *Journal for Specialists in Paediatric Nursing, 13(1) pp.15-25.*

Ghertner, R., Waters, A., Radel, L. and Crouse, G. (2018) 'The role of substance use in child welfare caseloads'. *Children and Youth Services Review,* 90 pp. 83-93.

Gifford, E. J., Eldred, L. M., Vernerey, A. and Sloan, F. A. (2014) 'How does family drug treatment court participation affect child welfare outcomes?' *Child Abuse & Neglect,* 38(10) pp. 1659-1670.

Giorgi, A. (2010) 'Phenomenological Psychology: A brief History and Its Challenges.' *Journal of Phenomenological Psychology*, 41 pp. 145-179.

Gorin, S. (2004) *Understanding what children say: children's experiences of domestic violence, parental substance misuse and parental health problems.* London: National Children's Bureau.

Gorski, P. S. (2013) 'What is Critical Realism? And Why Should You Care?.' *Contemporary Sociology (Washington),* 42(5) pp. 658-670.

Greene, M. (2014) 'On the Inside Looking In: Methodological Insights and Challenges in Conducting Qualitative Insider Research.' *The Qualitative Report*, 19 pp. 1-13.

Greene, S. and Hogan, D. (2005) *Researching children's experiences: methods and approaches.* London: SAGE.

Guba, E. G. and Lincoln, Y. S. (1989) *Fourth generation evaluation.* London: Sage Publications.

Hart, C. (2014) *Doing a literature review: releasing the research imagination.* 2nd ed. Los Angeles: SAGE.

Harwin, J., Alrouh, B., Ryan, M. and Tunnard, J. (2013) 'Strengthening prospects for safe and lasting family reunification: can a Family Drug and Alcohol Court make a contribution?.' *The Journal of Social Welfare & Family Law,* 35(4) pp. 459-474.

Harwin, J. Ryan, M. Broadhurst, K. (2018) 'How does FDAC Succeed with Parents with Substance Misuse Problems? Exploring Relational Practices within the English Family Drug and Alcohol Court.' *Child Abuse Review*, 27 pp. 266–279.

Hedges, K. E. (2012) 'A family affair: contextual accounts from addicted youth growing up in substance using families.' *Journal of Youth Studies,* 15(3) pp. 257-272.

HM Government. (1989) *Children Act 1989*. [Online] [Accessed on 7th October 2020] https://www.legislation.gov.uk/ukpga/1989/41/contents

HM Government. (2000) *Children (Leaving Care) Act 2000* [Online] [Accessed on 7th October 2020] https://www.legislation.gov.uk/ukpga/2000/35/contents

HM Government. (2014) *Care Act 2014*. [Online] [Accessed on 7th October 2020] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

HM Government. (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

HM Government. (2017) *Children and Social Work Act 2017*. [Online] [Accessed on 7th October 2020] https://www.legislation.gov.uk/ukpga/2017/16/contents/enacted

HM Government. (2018) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

Holland, S., Forrester, D., Williams, A. and Copello, A. (2014) 'Parenting and Substance Misuse: Understanding Accounts and Realities in Child Protection Contexts'. *British Journal of Social Work,* 44(6) pp. 1491-1507.

Home Office. (2017) *2017 Drugs Strategy*. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

Howell, K. H., Graham-Bermann, S. A., Czyz, E. and Lilly, M. (2010) 'Assessing Resilience in Preschool Children Exposed to Intimate Partner Violence.' *Violence and Victims,* 25(2) pp. 150-164.

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L. and Dunne, M. P. (2017) 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis'. *The Lancet. Public health,* 2(8) pp. e356-e366.

Husserl, E. (1931) *Ideas: a general introduction to pure phenomenology.* London: Allen and Unwin.

Huxley, A. and Foulger, S. (2008) 'Parents who misuse substances: implications for parenting practices and treatment seeking behaviour.' *Drugs and Alcohol Today,* 8(3) pp. 9-16.

Jääskeläinen, M., Holmila, M., Notkola, I.-L. and Raitasalo, K. (2016) 'Mental disorders and harmful substance use in children of substance abusing parents: A longitudinal register-based study on a complete birth cohort born in 1991.' *Drug and Alcohol Review,* 35(6) pp. 728-740.

Johnson, C., Coburn, S., SandersEarley, A., Felton, J., Winterbotham, M., McLaughlin, H., Pollock, S., Scholar, H. and McCaughan, S. (2019) Longitudinal study of local authority child and family social workers (Wave 1) Research report. Department for Education. [Online] [Accessed on 7th October 2020] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/906780/Longitudinal_study_of_local_authority_child_and_family_social_workers_Wave_1.pdf

Jones, D., Lowe, P., West, K. (2019) ‘Austerity in a disadvantaged West Midlands neighbourhood: Everyday experiences of families and family support professionals.’ *Critical Social Policy*, pp. 1-16.

Kamenopoulou, L. (2016) ‘Ecological systems theory: A valuable framework for research on inclusion and special educational needs/ disabilities.’ *Inclusion of Children with Special Educational Needs*, 88 pp. 515-527.

Kanuha, V. K. (2000) ‘"Being" Native versus "Going Native": Conducting Social Work Research as an Insider.’ *Social work (New York),* 45(5) pp. 439-447.

Kelly-Irving, M. and Delpierre, C. (2019) ‘A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses.’ *Social Policy and Society: A journal of the Social Policy Association,* 18(3) pp. 445-456.

Kepple, N. J. (2018) ‘Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns’. *Child Abuse & Neglect,* 76 pp. 44-55.

Kirisci, L., Dunn, M. G., Mezzich, A. C. and Tarter, R. E. (2001) ‘Impact of Parental Substance Use Disorder and Child Neglect Severity on Substance Use Involvement in Male Offspring.’ *Prevention Science,* 2(4) pp. 241-255.

Kitzmann, K. M ., Gaylord , N. K ., Holt , A. R ., & Kenny , E. D .(2003) ‘Child witnesses to domestic violence: A meta-analytic review.’ *Journal of Consulting and Clinical Psychology,* 71(2) pp. 339 – 352.

Kroll, B. (2004) ‘Living with an elephant: Growing up with parental substance misuse.’ *Child and Family Social Work,* 9(2) pp. 129-140.

Kroll, B. and Taylor, A. (2009) *Parental substance misuse and child welfare.* London: Jessica Kingsley Publishers.

Laverty, S. M. (2003) ‘Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations.’ *International Journal of Qualitative Methods*, 2(3) pp. 21-35.

Liamputtong, P. (2016) *Focus group methodology: principles and practice.* London: SAGE.

Livingston, W. (2017) ‘Learning about Alcohol: Personal Experiences Taken into Social Work Practice.’ *Practice,* 29(1) pp. 3-18.

Manning, V., Best, D. W., Faulkner, N. and Titherington, E. (2009) ‘New estimates of the number of children living with substance misusing parents: results from UK national household surveys.’ *BMC Public Health,* 9(1) pp. 377-377.

Margolin, G. and Gordis, E. B. (2000) 'The effects of family and community violence on children.' *Annual Review of Psychology,* 51(1) pp. 445-479.

McCarthy, T. and Galvani, S. (2004) *SCARS: A New Model for Social Work with Substance Users.* Taylor & Francis Group.

McGovern, R., Gilvarry, E., Addison, M., Alderson, H., Geijer-Simpson, E., Lingam, R., Smart, D. and Kaner, E. (2018) 'The Association Between Adverse Child Health, Psychological, Educational and Social Outcomes, and Nondependent Parental Substance: A Rapid Evidence Assessment.' *Trauma, Violence & Abuse,* 21(3) pp. 470-483.

McLaughlin, H. (2013) *Keeping interprofessional practice honest: fads and critical reflections*. IN: Littlechild, B. Smith, R. (ed) *A Handbook for interprofessional practice in the human services Learning to work together*. Oxon: Routlege.

McWhirter, J. (2014) 'The draw and write technique as a versatile tool for researching children's understanding of health and well-being.' *International Journal of Health Promotion and Education*, 52(5) pp. 250-259.

Melhuish, J. (2011) 'Crack Cocaine Use and Parenting: An Analysis of Three Parents' Accounts of the Impact Their Crack Cocaine Use Had on Family Life.' *Practice (Birmingham, England),* 23(4) pp. 201-213.

Meltzer, A., Muir, K. and Craig, L. (2018) 'The Role of Trusted Adults in Young People's Social and Economic Lives.' *Youth & Society,* 50(5) pp. 575-592.

Merrick, M. T., Ports, K. A., Ford, D. C., Afifi, T. O., Gershoff, E. T. and Grogan-Kaylor, A. (2017) 'Unpacking the impact of adverse childhood experiences on adult mental health.' *Child Abuse & Neglect,* 69 pp. 10-19.

Mertin, P. and Mohr, P. B. (2002) 'Incidence and Correlates of Posttrauma Symptoms in Children From Backgrounds of Domestic Violence.' *Violence and Victims,* 17(5), pp. 555-567.

Ministry of Justice. (2014) *Action research to explore the implementation and early impacts of the revised Public Law Outline (PLO).*
[Online] [Accessed on 7th October 2020]
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/304477/action-research-to-explore-plo-implementation-and-early-impacts.pdf

Misca, G. and Smith, J. (2014) *Mothers, Fathers, Families and Child Development. IN: Abela, A. and Walker, J. (ed) Contemporary issues in family studies global perspectives on partnerships, parenting and support in a changing world*. West Sussex: John Wiley& Sons.

Moffatt, S., Lawson, S., Patterson, R., Holding, E., Dennison, A., Sowden, S. and Brown, J. (2016) 'A qualitative study of the impact of the UK 'bedroom tax'.' *Journal of Public Health,* 38(2), pp. 197-205.

Moore, T., Noble-Carr, D. and McArthur, M. (2010) 'Who cares? Young people with parents who use alcohol or other drugs talk about their experiences with services.' *Family matters (Melbourne, Vic.),* 85 pp. 18-27.

Morris, L. (2016) 'The moral economy of austerity: analysing UK welfare reform.' *The British Journal of Sociology,* 67(1) pp. 97-117.

Morrow, V. and Richards, M. (1996) 'The Ethics of Social Research with Children: An Overview.' *Children and Society*, 10(2) pp. 90-105.

Moustakas, C. (1994) *Phenomenological research methods*. SAGE Publications.

Neger, E. N. and Prinz, R. J. (2015) 'Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations.' *Clinical Psychology Review,* 39 pp. 71-82.

Newman, T. and Blackburn, S. (2002) *Transitions in the Lives of Children and Young People: Resilience Factors.* Interchange 78
[Online] [Accessed on 7th October 2020]
https://eric.ed.gov/?id=ED472541

NICE (2012) *Drug use disorders in adults*. London: NICE.
[Online] [Accessed on 7th October 2020]
https://www.nice.org.uk/guidance/qs23

O'Connor, L., Forrester, D., Holland, S. and Williams, A. (2014) 'Perspectives on children's experiences in families with parental substance misuse and child protection interventions.' *Children and Youth Services Review,* 38 pp. 66-74.

O'Reilly, L. and Dolan, P. (2016) 'The Voice of the Child in Social Work Assessments: Age-Appropriate Communication with Children.' *The British Journal of Social Work,* 46(5) pp. 1191-1207.

O'Reilly, M., Ronzoni, P., Dogra, N. and Seaman, J. (2013) *Research with children: theory and practice.* Los Angeles: SAGE.

Orford, J., Copello, A., Velleman, R. and Templeton, L. (2010) 'Family members affected by a close relative's addiction: The stress-strain-coping-support model.' *Drugs : Education, Prevention & Policy,* 17(1) pp. 36-43.

Osborne, C. and Berger, L. M. (2009) 'Parental Substance Abuse and Child Well-Being: A Consideration of Parents' Gender and Coresidence.' *Journal of Family Issues,* 30(3), pp. 341-370.

Oulton, K., Gibson, F., Sell, D., Williams, A., Pratt, L. and Wray, J. (2016) 'Assent for children's participation in research: why it matters and making it meaningful: Assent for children's participation in research.' *Child: Care, Health & Development,* 42(4) pp. 588-597.

Parolin, M., Simonelli, A., Mapelli, D., Sacco, M. and Cristofalo, P. (2016) 'Parental Substance Abuse As an Early Traumatic Event. Preliminary Findings on Neuropsychological and Personality Functioning in Young Drug Addicts Exposed to Drugs Early.' *Frontiers in Psychology,* 7 pp. 887-887.

Percy, A., Thornton, M., and McCrystal, P. (2008) 'The extent and nature of family alcohol and drug use: findings from the Belfast youth development study.' *Child Abuse Review*, 17(6) pp. 371-387.

Pietkiewicz, I. and Smith, J.A. (2012) 'A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology.' P*sychological Journal,* 18(2) pp. 361-369.

Ponterotto, J. G. (2005) 'Qualitative Research in Counseling Psychology: A Primer on Research Paradigms and Philosophy of Science.' *Journal of Counseling Psychology,* 52(2) pp. 126-136.

Parliamentary Office of Science and Technology. (2018) *Parental Alcohol Misuse and Children*. Houses of Parliament.
[Online] [Accessed on 7th October 2020]
http://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf

Public Health England. (2018) *Problem parental drug and alcohol use: a toolkit for local authorities.*
[Online] [Accessed on 7th October 2020]
https://www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem

Public Health England. (2019) *National Statistics Adult substance misuse treatment statistics 2018-2019: report.*
[Online] [Accessed on 7th October 2020]
https://www.gov.uk/government/publications/substance-misuse-treatment-for-adults-statistics-2018-to-2019/adult-substance-misuse-treatment-statistics-2018-to-2019-report

Punch, S. (2002) 'Research with Children: The Same or Different from Research with Adults?.' *Childhood*, 9(3) pp. 321-341.

Reiners, G. (2012) 'Understanding the differences between Husserl's (descriptive) and Heidegger's (Interpretive) phenomenological research.' *Journal of Nursing and Care,* 1(5) pp.1-3.

Resnick, M. D., Harris, L. J. and Blum, R. W. (1993) 'The impact of caring and connectedness on adolescent health and well-being.' *Journal of Paediatrics and Child Health,* 29 (1) pp. S3-9.

Resnick, M. (2000) 'Protective Factors, Resiliency, and Healthy Youth Development.' *Adolescent Medicine: State of the Art Reviews,* 11(1) pp.157-164

Reupert, A., Goodyear, M. and Maybery, D. (2012) 'Engaging with, and understanding children whose parents have a dual diagnosis.' *Child and Adolescent Mental Health,* 17(3) pp. 153-160.

Ridge, T. (2013) 'We are All in This Together'? The Hidden Costs of Poverty, Recession and Austerity Policies on Britain's Poorest Children.' *Children & Society,* 27(5) pp. 406-417.

Robertson, A. S. and Haight, W. (2012) 'Engaging child welfare-involved families impacted by substance misuse: Scottish policies and practices.' *Children and Youth Services Review,* 34(10) pp.1992-2001.

Rothenberg, W. A., Lansford, J. E., Bornstein, M. H., Chang, L., Deater-Deckard, K., Di Giunta, L., Dodge, K. A., Malone, P. S., Oburu, P., Pastorelli, C., Skinner, A. T., Sorbring, E., Steinberg, L., Tapanya, S., Uribe Tirado, L. M., Yotanyamaneewong, S., Alampay, L. P., Al-Hassan, S. M. and Bacchini, D. (2020) 'Effects of Parental Warmth and Behavioral Control on Adolescent Externalizing and Internalizing Trajectories Across Cultures.' *Journal of research on adolescence,* 30(4) pp. 835-855.

Russo, M. F., Verman, J. and Wolbert, A. (2006) 'Sandplay and storytelling: Social constructivism and cognitive development in child counselling.' *The Arts in Psychotherapy, 33*(3) pp. 229-237.

Rutter, M. (2007) 'Resilience, competence, and coping.' *Child Abuse & Neglect,* 31(3) pp. 205-209.

Sattler, K. M. P. and Font, S. A. (2018) 'Resilience in young children involved with child protective services.' *Child Abuse & Neglect,* 75 pp. 104-114.

Schlosser, R. W., Wendt, O., Bhavnani, S. and Nail-Chiwetalu, B. (2006) 'Use of information-seeking strategies for developing systematic reviews and engaging in evidence-based practice: the application of traditional and comprehensive Pearl Growing. A review.' *International Journal of Language & Communication Disorders,* 41(5), pp. 567-582.

Scottish Executive. (2000) *Drugs Action Plan Protecting Our Future. Tackling Drugs in Scotland.* Crown Copyright.
[Online] [Accessed on 7th October 2020]
https://lx.iriss.org.uk/sites/default/files/resources/051.%20Protecting%20Our%20Future%20%20Scottish%20Executive%20Drug%20Action%20Plan%202000

Scottish Executive. (2003) *Getting our priorities right: good practice guidance for working with children and families affected by substance misuse.* Edinburgh: Stationery Office.
[Online] [Accessed on 7th October 2020]
https://www.drugsandalcohol.ie/5948/

Senreich, E. and Straussner, S. L. A. (2013) 'The Effect of MSW Education on Students' Knowledge and Attitudes Regarding Substance Abusing Clients.' *Journal of Social Work Education,* 49(2) pp. 321-336.

Sewell, K. (2011) 'Researching sensitive issues: a critical appraisal of 'draw-and-write' as a data collection technique in eliciting children's perceptions.' *International Journal of Research & Method in Education*, 34(2) pp. 175-191.

Shaw, R. (2010) Embedding Reflexivity Within Experiential Qualitative Psychology. *Qualitative Research in Psychology,* 7(3), pp. 233-243.

Shaw, J., McLean, K. C., Taylor, B., Swartout, K. and Querna, K. (2016) 'Beyond Resilience: Why We Need to Look at Systems Too.' *Psychology of violence,* 6(1), pp. 34-41.

Sidebotham, P., Bailey, S., Belderson, P. and Brandon, M. (2011) 'Fatal child maltreatment in England, 2005–2009.' *Child Abuse & Neglect*, 35(4) pp. 299-306.

Sidebotham, P., Brandon, M., Sue Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A., Sorensen, P. (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report. Department for Education.*
[Online] [Accessed on 7th October 2020]
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014-Pathways_to_harm_and_protection.pdf

Skinner, G.C.M. Bywaters, P.W.B. Bilson, A. Duschinsky, R. Clements, K. Dustin Hutchinson, D. (2021) 'The 'toxic trio' (domestic violence, substance misuse and mental ill-health): How good is the evidence base?.' *Children and Youth Services Review*, 120 pp. 1-11.

Slesnick, N., Feng, X., Brakenhoff, B. and Brigham, G. S. (2014) 'Parenting under the influence: The effects of opioids, alcohol and cocaine on mother–child interaction.' *Addictive Behaviors,* 39(5) pp. 897-900.

Smith, J. A. (2008) *Qualitative psychology: a practical guide to research methods.* 2nd ed. London: SAGE Publications.

Smith, J. A., Larkin, M. H. and Flowers, P. (2012) *Interpretative phenomenological analysis: theory, method and research.* London: SAGE Publications.

Suchman, N. E., Rounsaville, B., DeCoste, C. and Luthar, S. (2007) 'Parental control, parental warmth, and psychosocial adjustment in a sample of substance-abusing mothers and their school-aged and adolescent children.' *Journal of Substance Abuse Treatment,* 32(1) pp. 1-10.

Social Work England. (2020) Professional Standards. [Online] [Accessed on 7th October 2020] https://www.socialworkengland.org.uk/standards/professional-standards/

Stanley, Y. (2019) *Social care commentary: using models of practice successfully.* Ofsted. [Online] [Accessed on 7th October 2020] https://www.gov.uk/government/speeches/social-care-commentary-using-models-of-practice-successfully

Tait, A. Wosu, H. (2012) *Direct work with vulnerable children Playful activities and strategies for communication.* London. Jessica Kingsley Publishers.

Taplin, S. and Mattick, R. P. (2013) 'Mothers in methadone treatment and their involvement with the child protection system: A replication and extension study.' *Child Abuse & Neglect,* 37(8) pp. 500-510.

Taylor, J. (2011) 'The intimate insider: negotiating the ethics of friendship when doing insider research.' *Qualitative Research: QR,* 11(1) pp. 3-22.

Taylor, M. F., Marquis, R., Coall, D. and Wilkinson, C. (2017) 'Substance Misuse–Related Parental Child Maltreatment: Intergenerational Implications for Grandparents, Parents, and Grandchildren Relationships.' *Journal of Drug Issues,* 47(2) pp. 241-260.

Teater, B. Roy, J. Carpenter, J. Forrester, D. Devaney, J. Scourfield, J. (2017) 'Making Social Work Count: A Curriculum Innovation to Teach Quantitative Research Methods and Statistical Analysis to Undergraduate Social Work Students in the United Kingdom.' *Journal of teaching in social work*, 37(5) pp. 422–437.

Templeton, L. (2012) 'Dilemmas facing grandparents with grandchildren affected by parental substance misuse.' *Drugs: Education, Prevention and Policy,* 19(1), pp. 11-18.

Templeton, L., Velleman, R., Hardy, E., and Boon, S. (2009) 'Young people living with parental alcohol misuse and parental violence: 'No-one has ever asked me how I feel in any of this'.' *Journal of Substance Use*, 14(3-4) pp. 139-150.

Templeton, L., Novak, C. and Wall, S. (2011) 'Young people's views on services to help them deal with parental substance misuse.' *Drugs: Education, Prevention and Policy,* 18(3) pp. 172-178.

Templeton, L. (2014) 'Supporting families living with parental substance misuse: the M-PACT (Moving Parents and Children Together) programme.' *Child & Family Social Work,* 19(1) pp. 76-88.

Templeton, L. and Sipler, E. (2014) 'Helping children with the Steps to Cope intervention.' *Drugs and Alcohol Today,* 14(3) pp. 126-136.

Testa, M. F. and Smith, B. (2009) 'Prevention and Drug Treatment.' *The Future of Children,* 19(2) pp. 147-168.

The Children's Society (2017) *Good Childhood Report 2017.* [Online] [Accessed on 7th October 2020] https://www.childrenssociety.org.uk/good-childhood

Thomson, K. C., Oberle, E., Gadermann, A. M., Guhn, M., Rowcliffe, P. and Schonert-Reichl, K. A. (2018) 'Measuring social-emotional development in middle childhood: The Middle Years Development Instrument.' *Journal of Applied Developmental Psychology,* 55 pp. 107-118.

Tsantefski, M., Parkes, A., Tidyman, A. and Campion, M. (2013) 'An extended family for life for children affected by parental substance dependence.' *Family Matters (Melbourne, Vic.),* (93) pp. 74-83.

Turning Point. (2006) *Bottling it up: The effects of alcohol misuse on children, parents and families.* [Online] [Accessed on 7th October 2020] https://www.drugsandalcohol.ie/6276/1/3499-3720.pdf

UNCRC. (1989) *The United Nations Convention on the Rights of the Child.* [Online] [Accessed on 7th October 2020] www.unicef.org.uk/wpcontent/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf

Ungar, M. (2013) 'Resilience, Trauma, Context, and Culture.' *Trauma, Violence & Abuse,* 14(3) pp. 255-266.

Van Manen, M. (1990) *Researching lived experience: human science for an action sensitive pedagogy.* New York: State University of New York Press.

Van Manen, M. (2016) *Researching Lived Experience: Human science for an Action Sensitive Pedagogy. 2nd ed.,* New York: Routledge

Van Manen, M. (2017) 'Phenomenology in Its Original Sense.' *Qualitative Health Research*, 27(6) pp. 810-825.

Velleman, R. and Orford, J. (1999) *Risk and Resilience Adults who were the children of problem drinkers*. Oxon: Routledge.

Velleman, R. Reuber, D. (2007) Domestic Violence and Abuse experienced by Children and Young People living in Families with Alcohol Problems: Results from a Cross-European Study. ENCARE.
[Online] [Accessed on 7th October 2020]
www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2007/Encare_ParentalAlcoholProblems.pdf

Velleman, R. and Templeton, L. (2007) 'Alcohol, drugs and the family: Results from a long-running research programme within the UK.' *European Addiction Research,* 9(3) pp. 103.

Velleman, R. and Templeton, L. J. (2016) 'Impact of parents' substance misuse on children: An update.' *BJ Psych Advances,* 22(2) pp. 108-117.

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., Senu, H. and Holland, F. (2014) 'The accordion and the deep bowl of spaghetti: eight researchers' experiences of using IPA as a methodology.' *The Qualitative Report*, 19(24) pp. 1.

Wilkinson, D. and Birmingham, P. (2003) *Using research instruments: a guide for researchers.* London: RoutledgeFalmer.

Wilkinson, S. (2008) IN Smith, J. A. (2008) *Qualitative psychology: a practical guide to research methods.* 2nd ed. London: SAGE Publications.

Woodgate, R. L., Zurba, M. and Tennent, P. (2017) 'Worth a thousand words?: Advantages, challenges and opportunities in working with photovoice as a qualitative research method with youth and their families.' *Forum Qualitative Social Research*, 18(1) pp. 1-22.

Woolfall, K. and Sumnall, H. (2010) 'Evaluating interventions for children of substance using parents: A review of outcome measures.' *Addiction Research & Theory,* 18(3) pp. 326-343.

YMCA. (2019) *Almost a billion-pound decline in funding for youth services by local authorities across England and Wales*.
[Online] [Accessed on 7th October 2020]
https://www.ymca.org.uk/outofservice

[annonyised author to protect participant annonimity MBC]. (2016): Accessed online from local authoroity website. [Online] [Accessed on 7th October 2020]

Appendices

Appendix 1- Ethical Approval

31/01/2019
Project Title: Understanding the needs of children living with parental substance misuse: perspectives of children and professionals

EthOS Reference Number: 5226

Ethical Opinion

Dear Hannah Todman,

The above application was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 31/01/2019, was given a favourable ethical opinion. The approval is in place until 08/01/2021 .

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Project Proposal	Project proposal ethics application htodman FV	19/12/2018	1
Consent Form	consent form for focus group participants ethics app htodman FV	19/12/2018	1
Consent Form	parental consent form ethics app htodman FV	19/12/2018	1
Consent Form	Child participation informaiton and assent form htodman FV	19/12/2018	1
Consent Form	teenage child information and assent form htodma FV	19/12/2018	1
Information Sheet	Participation information sheet Focus group htodman FV	19/12/2018	1
Information Sheet	Participation information sheet PARENTS htodman amended version	24/01/2019	2

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make a change to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

HPSC Research Ethics and Governance Committee

Appendix 2- Glossary of terms

Term	Definition
Child Criminal Exploitation	'As set out in the Serious Violence Strategy, published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology' (H.M. Government, 2018:110)
Child Protection	'Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm' (H.M. Government, 2018:106)
Child Sexual Exploitation	'Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator.

	The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology' (H.M. Government, 2018: 107)
Contextual safeguarding	'As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; teenage relationship abuse; sexual exploitation and the influences of extremism leading to radicalisation […] Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare' (H.M. Government, 2018:25)
Early intervention sometimes referred to as **Early help**	Early intervention means identifying and providing effective early support to children and young people who are at risk of poor outcomes […] the best evidence shows that effective interventions can improve children's life chances at any point during childhood and adolescence (Early Intervention Foundation, 2021: accessed online)
Neglect	'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious

	impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: a. provide adequate food, clothing and shelter (including exclusion from home or abandonment) b. protect a child from physical and emotional harm or danger c. ensure adequate supervision (including the use of inadequate caregivers) d. ensure access to appropriate medical care or treatment It may also include neglect of, or unresponsiveness to, a child's basic emotional needs' (H.M. Government, 2018:108)
Public Law Outline	The Children and Families Act 2014 introduced legislation in relation to public law cases that set a 26-week time limit for all care proceedings (Ministry of Justice, 2014:6). In response to this change, Public Law Outline (PLO) (legislative practice guidance) was revised. The purpose of PLO is to assess whether alternatives to care proceedings have been explored to prevent escalation to proceedings. Where this is not possible that timely decisions are made for the needs of children (Ministry of Justice, 2014)
Significant Harm	The Children Act (1989) refers to Significant Harm as the threshold for statutory invention. Defining significant harm under section 31 as both the impairment of a child's emotional and physical development and of the likelihood of harm. 'Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must

	make enquiries and decide if any action must be taken under section 47 of the Children Act 1989' (H.M. Government, 2018:16)
Team Around the Child (also known as child in need)	'a child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Children in need may be assessed under section 17 of the Children Act 1989 by a social worker' (H.M. Government, 2018:22). In the local authority where this research was conducted, the term 'child in need' is replaced by 'team around the child'.
Universal Services	'… child's need is relatively low level' 'Universal services include services available to **all** children and families, including schools, GP's, health services' (H.M. Government, 2018:16)

Appendix 3- Participation information sheet for parents of child participants

Participant Information Sheet

(Parents of child participant)

A research study to understand children's views on what helps them when they are worried about someone they love who has a problem with alcohol and/or drugs.

1. Invitation to research

Hello, my name is Hannah Todman, I am a studying for a PhD at Manchester Metropolitan University. I also work part time for Mosaic supporting children and families who are worried about a loved one who has problems with drugs and/or alcohol.

Below is information on a research study I am carrying out, which with your consent I would like to invite your child to take part in.

Please take your time to read the information below carefully and feel free to ask me any questions before making your decision.

2. Why have I been invited?

Your child has been invited to take part in this research study, to share their thoughts on what they feel helps them when they are worried about their parent's using drugs or alcohol. Up to 10 children who have a Mosaic Family Worker are being invited to take part.

3. Do I have to take part?

It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

4. What will I be asked to do?

If you consent to your child taking part in the research study, and your child wants to take part too, please contact me on the details at the end of this form so we can arrange a convenient time and place to meet in person. I can then answer any questions you might have.

If you consent, your child will be invited to meet with me on two occasions. These two appointments will take place in the rainbow room at Mosaic and will be a week apart. It is expected that the appointments will last approximately one hour, plus travel time to and from Mosaic.

If you are unable to bring your child to and from Mosaic, transport can be arranged via your child's Mosaic Family Worker who can provide pickups and drop offs.

If you would like me to and you think it will help, I can also come and visit you and your child together before these appointments.

To help me to understand from children taking part what they feel helps them when they have worries about drugs and alcohol, I will ask children if they can share their thoughts with me. Unless I ask I won't know.

To ensure that I don't forget anything important I will be audio recording the appointments, which I will later write up, the recording is then deleted and the write up, known as the transcription will not include any names. This is explained in more detail under section 7.

I will make sure that there are arty things if your child prefers to draw. I have supported children and families who are worried about somebody they love who is using drugs and/ or alcohol for over 10 years. I know that sometimes taking can be hard to do and I will try my best to make sure the appointments are fun and I will do my best to avoid difficult questions.

5. Are there any risks if I participate?

If your child becomes upset or they do not want to carry on with the appointment, this is ok and I will bring the appointment to an end. If they need me to, I can ask for their Family Worker to come.

Your child will have support from their Mosaic Family Worker before, during and after they have taken part in the research study participation in the research study.

If you are worried about anything during the research study please contact me or your child's Mosaic Family Worker and we can let you know what support services are there for you.

6. Are there any advantages if I participate?

There will be no direct benefit to you and your child. However, if your child takes part in the research this will hopefully help us to understand things better and help to develop services in areas where children do not have access to support like Mosaic.

7. What will happen with the data I provide?

If you agree to participate in this research, we will collect from you personally-identifiable information.

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.

The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

We will not share your personal data collected in this form with any third parties.

If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**

We will only retain your personal data for as long as is necessary to achieve the research purpose.

All information which is collected as part of this research study will be kept confidential. With your child's permission, their appointments with me will be recorded using a Dictaphone and then typed up by myself, this is called a transcript. The recording will then be deleted.

All transcripts will be anonymised, meaning that your child's name will not be used in the transcriptions. Each transcription will be password protected and stored on a password protected computer only accessible by myself and my research supervisor.

Some direct quotes and drawings maybe used in the final research study report, related articles and in presentation, but under no circumstances are any names included. However, it may be possible if a picture/drawing is included in an article that your child can be identified by those close to them based on their drawings.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

- What your child talks/ draws about in the research study will remain confidential to your child and me. No information will be shared by me with you, your family or anybody working with your family. However it is up to your child if they want to talk about it afterwards.

- The only exception to this is if anything your child has shared with me, suggests you, your child or someone else is at significant risk of harm. Then I would have to **break confidentiality**. In doing so this is to ensure that the right support is put in place to safeguard you and your child. I will where possible inform you of any decision relating to a break in confidentiality.

What will happen to the results of the research study?

At the end of this PhD study, a summary of the findings will be part of the final report, known as a thesis. A summery and some direct quotes from children who have participate maybe used in the thesis, in research papers and at conference and training events. However, your child will not be identifiable, all information is anonymised.

Who has reviewed this research project?

This research project has received ethical approval from the ethics committee at Manchester Metropolitan University and has been reviewed by the researcher's Director of Studies.

Who do I contact if I have concerns about this study or I wish to complain?

If you have any questions about the study, please contact the main researcher:

hannah.todman@stu.mmu.ac.uk

Alternatively, if you have a concern and do not wish to speak to the researcher you can contact:

Professor Hugh McLaughlin- Director of Studies

Department of Social Care and Social Work
Manchester Metropolitan University
Brooks Building, Birley
53 Bonsall Street, Manchester
M15 6GX
Hugh.McLaughlin@stu.mmu.ac.uk

Faculty head of Ethics via HPSCresearchdegrees@mmu.ac.uk

Manchester Metropolitan University

Birley Campus

M15 6GX

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 4- Parental Consent Form

A research study to understand children's views on what helps them when they are worried about someone they love who has a problem with alcohol and/or drugs.

Prior to completing this form, please ensure that you have read and understood the participant information sheet.

Please sign points 1-7 with your initials and sign the consent form at the bottom if you agree to participate. If you are unsure or have any queries please do not hesitate to speak with the researcher before consenting.

1. I have read the information sheet for parents and for children, and fully understand the content.	
2. The researcher has answered any questions I have about the research study, to my satisfaction.	
3. I understand that my child's participation is voluntary. I can withdraw consent at any time without having to give a reason.	
4. I understand that if I withdraw consent information all recordings and identifiable information will be destroyed. However, data collected up to withdrawal including transcripts and drawings will be used.	
5. I understand that any information my child provides will remain anonymous and remain confidential. I to will not receive details from the researcher of information my child has shared.	
6. I understand that my child's confidentiality will be breached if the researcher is led to believe that there is a risk of harm to myself, my child or to others.	
7. With my child's agreement I am aware that their involvement will be recorded, once this recording is written up and anonymised the recording will be deleted.	
8. I am aware that the researcher will securely hold anonymised information for up to two years and that this anonymised information will be used in research publications.	

Name of Parent_____Signature_____Date_____

Signing consent

on behalf of_____Signature_____Date_____

Name of Researcher_____Signature_____Date_____

Appendix 5- Child Participation information sheet/ assent

Can you help?

Hi my name is Hannah, You might have seen me at Mosaic, I work there on a Monday and Tuesday but the rest for the week I study (a bit like school) at Manchester Metropolitan University.

I'm going to be writing a report, it's about what children feel they need when they are worried about somebody they love who has problems with drugs and alcohol.

I hope you might be able to help me to understand what it is like to have this worry and what helps you to feel better. This can then help me to understand how people like support workers, social workers and teachers can do a better job to help children and their families.

Your parents have said it is ok for me to meet you. But it's completely up to you, you don't have to talk to me if you don't want to.

If you decide you would like to take part then I will ask you to come to two meetings with me and they will take place in the rainbow room at Mosaic after school. Unless it is in the school holidays then it might be during the day. I'll fit in around you and a time that's best for you and your mum or dad.

I'll try not to ask you any hard questions and if you don't like talking much, this is ok I will have lots of art things so you can draw and make pictures instead.

Do I have to say yes?

No, you have a choice. You can say no and you don't have to give a reason why you said no. If you do say yes, you can still change your mind at any time.

Will what I say or draw be shown to anybody?

When we are talking, I will put a tape on, this records what we both say. It's just so when I am writing the report, I won't forget anything important but I won't use your name.

What we talk about and draw in the meetings stays between me and you. Its confidential, which is just a posh word for **private**. I won't share

anything you say, write or draw with your family, your Mosaic family worker or anyone else supporting your family. Now this is the really important bit,

Only if you share something with me that makes me think you or somebody in your family is not safe, then I would have to share what you told me with somebody who can help. I will try my best to talk with you first before I do this.

What will happen to my drawings afterwards?

If it is ok with you, your drawings and the information you have shared with me will be used in special reports. Nothing will have your name on it but your parents might want to see the reports. This means that people you know well might be able to tell what drawings are yours.

If you don't want your drawings and pictures to be in the report, you can say no.

If you have any questions you can ask me when I meet you for the first time, or you can ask your Mosaic family worker if there is anything you are unsure about.

If your parents are happy for you to take part and you are ok with it too, and you have read all the information on this form and are still ok to say yes then please can I ask you to sign this form.

My Name is……..

I would like to take part in the research and I understand everything on this form because I have read it or someone has read it to me.

If I get upset during the meetings with Hannah, these are the people you can tell I have been upset and that I might need some extra support:

Name of the person	**Relationship, e.g. mum, dad, mosaic worker, teacher in school.**

My signature……**Todays date**……..

Appendix 6- Participation information sheet for older children/assent

Can you help?

Hi my name is Hannah, You might have seen me at Mosaic, I work there on a Monday and Tuesday but the rest for the week I study at Manchester Metropolitan University.

I'm going to be writing a report, it's about what children feel they need when they are worried about somebody they love who has problems with drugs and alcohol.

I hope you might be able to help me to understand what it is like to have this worry and what helps you to feel better. This can then help me to understand how people like support workers, social workers and teachers can do a better job to help children and their families.

Your parents have said it is ok for me to meet you. But it's completely up to you, you don't have to talk to me if you don't want to.

If you decide you would like to take part then I will ask you to come to two meetings with me and they will take place in the rainbow room at Mosaic after school. Unless it is in the school holidays then it might be

during the day. I'll fit in around you and a time that's best for you and your mum or dad.

Sometimes talking can be pretty hard to do and so if you prefer you can draw how you feel. I'll try not to ask any hard questions but I might ask you to tell me about your drawing.

Do I have to say yes?

No, you have a choice. You can say no and you don't have to give a reason why you said no. If you do say yes, you can still change your mind at any time.

Will what I say or draw be shown to anybody?

When we are talking, I will put a tape on, this records what we both say. It's just so when I am writing the report, I won't forget anything important but I won't use your name.

What we talk about and draw in the meetings stays between me and you. Its confidential, which is just a posh word for **private**.

I won't share anything you say, write or draw with your family, your Mosaic family worker or anyone else supporting your family. Now this is the really important bit,

Only if you share something with me that makes me think you or somebody in your family is not safe, then I would have to share what you told me with somebody who can help. I will try my best to talk with you first before I do this.

What will happen to my drawings afterwards?

If it is ok with you, your drawings and the information you have shared with me will be used in special reports. Nothing will have your name on it but your parents might want to see the reports. This means that people you know well might be able to tell what drawings are yours.

If you don't want your drawings and pictures to be in the report, you can say no.

If you have any questions you can ask me when I meet you for the first time, or you can ask your Mosaic family worker if there is anything you are unsure about.

If your parents are happy for you to take part and you are ok with it too, and you have read all the information on this form and are still ok to say yes then please can I ask you to sign this form.

My Name is……..

I would like to take part in the research and I understand everything on this form because I have read it or someone has read it to me.

If I get upset during the meetings with Hannah, these are the people you can tell I have been upset and that I might need some extra support:

Name of the person	**Relationship, e.g. mum, dad, mosaic worker, teacher in school.**

My signature……**Todays date**……..

Appendix 7- Interview schedule for primary school aged children

Creative interview guide- Primary school aged children

Introduction

- Recap participation sheet
- Re-cap understanding of confidentiality
- Explain to the child their parents and Mosaic worker have told me a little bit about how drugs/alcohol are a worry (giving child permission that its ok to talk)
- Describe the activity- sometimes talking about things that worry us is really difficult to do, especially when the worry is about your family. Sometimes drawing what worries you can be a little bit easier. Explore with the child if they like drawing and/or if they would like to just talk.
- I'm going to ask you to help me to understand how you feel about drugs/alcohol are you ok with those words or would you like to change drugs/alcohol to something else, it can be a made-up name?

Opening exercise- getting to know you

- Can you draw who you live with?
  E*xploratory questions about family, names, any pets, is school nearby, friends/ family etc.*

Opening questions

Prompt- sometimes talking about X in your family isn't easy to do, to help me understand how you feel I'm going to ask you to draw another picture;

- If drugs/ alcohol (or use made up name X) could turn into an animal what would it look like?
- Can you tell me about x?
  Prompt: how would it talk, walk, what does it like to do?
- If the weather could be a feeling what would the weather be like around X?

In-depth exploratory questions

- How does X behave?
  Prompt- does it always behave like this?
- What makes you know that x is around?
- How does this make you feel?
- Can you tell me about a time/memory when X made you feel the most worry?
  Prompt; what happened, how did it feel?
- Can you tell me about some of the positive things about X?
  Prompt; does is laugh, play, is it silly?
- How do you think other people in your house feel when they can see x?

Ending questions

- When X makes you feel …. (use words child has already shared) what helps you to feel better?
- If you had a problem and were worried about X who are the trusted people in your life that can help?
  Prompt- explore proximity, are they nearby, phone contact, does child have a phone or access to a phone, neighbours, school, friends etc.
  Is X ok with you asking for help?
- Do you think there is anything that could help X to feel better?
  Prompts- what do you think X would like to do in the future?

Before creative interview comes to an end;

- Check with the child if they have had enough time, is there anything else that they would like to share but that I haven't asked them
- Are there any questions they think I should have asked them?
- Check with the child if there is anything, they need help with today that I can ask their Mosaic worker to help them with.
- Thank you for taking the time to share your feelings with me to today, its not an easy thing to do…..

Appendix 8- Interview schedule for high school aged children

Creative interview guide

Introduction

- Recap participation sheet
- Recap understanding of confidentiality
- Explain to the child that their parents and Mosaic worker have told me a little about how drugs/alcohol are a worry for them and that parents are ok with them meeting me today (giving child permission to talk)
- Explain the process- I will ask them questions about how they feel about their parent's drug/alcohol use and what helps them to feel like they can cope.
- Sometimes talking, especially to somebody they don't know can be tough and so if they prefer, we can use art as a way to draw their thoughts and feelings. Check their preference.
-

The Resilience tree- for children you would prefer to draw

This exercise supports children, partly older children to explore their worries/ stresses as well as what helps them to cope

Interviewer- draws a tree, and talks about the tree. How the roots draw water from the earth to keep it alive and keep it upright in high winds, the thicker stronger roots help to keep it rooted to the ground, roots grow throughout the trees life.

The trunk is also strong and stable and what helps the tree to be sturdy even when the wind blows.

The branches are the wobbliest part of the tree and in gusts of winds they can break, in Autumn the leaves fall but with the help of the roots it can grow back.

Prompt the child to think about the roots that help to keep them safe. Next the trunk which is the strong part of them, what makes them feel good about themselves and then the branches- the worries, what shakes your branches.

Encourage the child to draw their tree

Opening questions

- Can you tell be about the worries you have drawn/written on the branches?
  Prompt*- when you look at them what thoughts come to mind*
- Can you tell me about how you feel about drugs/ alcohol being in your family's life?
  Prompt*- frequency- how often is it around, how does this makes you feel?*
- Can you tell me about a memory you have about drugs/alcohol and what happened?
  Prompt*- how did you feel? How did you cope?*
- Do drugs/alcohol link up with other worries you have drawn on the branches?
  Prompts*- money, food, friends, parents, teachers, school*
- How do you think other people in your house feel when they can see drugs/alcohol?
- What are the positives if any of drugs/alcohol being in your life?
- What would you say the negatives are?
- Has problems with drugs /alcohol in your family changed the way you think or feel about yourself?
  Prompt- What do you think your family thinks you feel?

Trunk

- *What helps you to cope when drugs/alcohol is a worry?*
  Prompts- school, friends, pets, hobbies, beliefs, future goals, Mosaic worker

- *Can you tell me about if you think there is anything missing in your life that you think would help you to cope?*

Roots

- When drugs/alcohol makes you feel (use language already used by child)… who are the trusted adults in your life that can help? ***Prompts****- proximity, phone, does child have access to a phone, how often do you see them, do they understand what you need?*
- How do you think your mum/dad feel about you asking for support?
- What do you think are the most important things that children who have the same worries as you need, to be able to feel they can cope?

Before creative interview comes to an end;

- Check to see if the child feels they have had enough time, is there anything else that they would like to share but that I haven't asked them?
- Are there any questions they think I should have asked them?
- Check with the child if there is anything, they need help with today that I can ask their Mosaic worker to help them with.
- Thank you for taking the time to….

Appendix 9- Participation information sheet- focus group participants

Understanding the needs of children living with parental substance misuse: perspectives of children and professionals.

1. **Invitation to research**

Hello, my name is Hannah Todman, I am a Social Work PhD student at Manchester Metropolitan University. You may have met me before in my role as a Mosaic Family Worker, where I continue to work two days per week.

I am conducting a research study which seeks to understand the needs of children living with parental substance misuse. This study also seeks to understand how better we as professionals can respond to the needs of these children.

I would like to invite you to take part in this study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Take time to decide whether or not to take part.

2. **Why have I been invited?**

You have been invited to participate in this research project, as the study requires information from front line professionals in direct contact with children and families, where parental substance misuse is a concern. You are being invited to attend a focus group which will consist of 6-8 professionals, where it is hoped naturally evolving conversations and discussions can take place.

Your participation will provide insight and understanding in order for this study to answer the following research questions;

-What do children need in order to promote and strengthen their emotional resilience and enable them, where appropriate to live safety with parents who misuse substances?

-What changes are considered to be necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

3. Do I have to take part?

It is up to you to decide. We will describe the study and go through the information sheet, which we will give to you. We will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

4. What will I be asked to do?

If you decide to take part, please contact me on the details at the end of this form. I will then send you details including the date, time and location of the focus group. It is anticipated that this will take place in a confidential venue within Stockport.

Your participation will require you to attend one focus group, which will last for a maximum of two hours. This time includes preparation at the start for the research study information to be described and for the completion of consent forms. This time allocation also includes time to de-brief at the end if required.

You will be encouraged to share your experiences of coming into contact with and supporting children living with parental substance misuse.

5. Are there any risks if I participate?

During the focus group sensitive and emotive issues will be explored. There is a risk information discussed and explored could be upsetting to listen to and to talk about. There will be time at the end of the focus group if you wish to debrief with members of the focus group. Each participant will be provided with a list of resources/ contacts able to provide support.

Whilst every effort will be made to protect your anonymity, it is possible that when direct quotes are used in publications those present in the focus group may be able to identify that the quote was something you said.

6. Are there any advantages if I participate?

It cannot be promised that the study will help you on a personal level. However, the information gathered from your participation in the focus group will contribute to a better understanding of professional's experience of working this group of children. As well as contribute to the development of practice tools to aid professionals when supporting families where parental substance misuse is a safeguarding concern.

7. What will happen with the data I provide?

If you agree to participate in this research, we will collect from you personally-identifiable information.

The Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.

The University is registered with the Information Commissioner's Office (ICO), and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

We collect personal data as part of this research (such as name, telephone numbers or age). As a public authority acting in the public interest we rely upon the 'public task' lawful basis. When we collect special category data (such as medical information or ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained.

We will not share your personal data collected in this form with any third parties.

If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**

We will only retain your personal data for as long as is necessary to achieve the research purpose.

The focus group will be recorded by a Dictaphone and later transcribed by the researcher. The data collected for this study will be password protected and stored securely on the University server.

The information obtained through the focus group will be anonymised; direct quotes from the focus group will be used in the final PhD thesis and in articles published or presented elsewhere.

Care will be taken to ensure that any potentially identifying information contained in quotes is removed or altered to protect anonymity.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages.

If information which is discussed in the focus group causes me to think that you or another person is at significant risk of harm, I will have to breach confidentiality and follow the local authority safeguarding procedure. Where possible I will endeavour to inform you of any decision made to breach confidentiality.

What will happen to the results of the research study?

At the end of this PhD study, results will be summarised, analysed and submitted as part of the final thesis as well as being submitted for publication in an academic

journal. You will not be identifiable, unless as stated above a direct quote is used and those present in the focus group remember that it was you who said this.

Findings from the focus group and direct quotes may also be disseminated at conferences and training events, all information will be anonymised, meaning no information which could identify you will be used.

Who has reviewed this research project?

This research project has received ethical approval from the ethics committee at Manchester Metropolitan University and has been reviewed by the researcher's Director of Studies- Professor Hugh McLaughlin.

Who do I contact if I have concerns about this study or I wish to complain?

If you have any questions about the study, please contact the main researcher:

hannah.todman@stu.mmu.ac.uk

Alternatively, if you have a concern and do not wish to speak to the researcher you can contact:

Professor Hugh McLaughlin- Director of Studies

Department of Social Care and Social Work
Manchester Metropolitan University
Brooks Building, Birley
53 Bonsall Street, Manchester
M15 6GX
hugh.mclaughlin@stu.mmu.ac.uk

Faculty head of Ethics via HPSCresearchdegrees@mmu.ac.uk

Manchester Metropolitan University

Birley Campus

M15 6GX

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 10- Focus Group Participants consent form

Understanding the needs of children living with parental substance misuse: Perspectives of children and professionals

Manchester Metropolitan University

Prior to completing this form please ensure that, you have read and understood the participant information sheet.

Please sign parts 1-7 using your initials and then sign the consent form at the bottom if you agree to participate. If you are unsure or have any queries, please do not hesitate to speak with the researcher before consenting.

1. I have read the participation and information sheet and fully understand the content.	
2. I have had the opportunity to ask any questions regarding the content of the participation sheet and any other questions I may have regarding my participation.	
3. I understand that my participation is voluntary. However, information I have already provided cannot be withdrawn.	
4. I understand that my contribution within the focus group will be recorded and transcribed, that information will be anonymised. Anonymity cannot be guaranteed as direct quotes maybe used in publications and be identifiable by those who were present in the focus group.	
5. I understand that any information I provide will remain confidential. I understand that my confidentiality will be breached if the researcher is led to believe that there is a risk of harm to myself or to others.	
6. Anonymised transcripts will be kept securely for a minimum of two years following my participation in the study.	

Name of Participant_____Signature_____Date_____

Name of Researcher_____Signature_____Date_____

Appendix 11- Focus Group schedule

Focus Group guide

Welcome

Introduce self….thank you for taking the time to join the focus group today.

Invite participants to introduce themselves and their professional role.

Our topic today is Understanding the needs of children living with Parental Substance Misuse.

When referring to parental substance misuse, this refers to both alcohol and drugs and the word misuse is in reference to substance use being the primary concern in relation to safeguarding.

Does anybody have any questions based on the participation sheet, does everybody have their signed consent forms?

Your participation will provide insight and understanding in order for this study to answer the following research questions;

- What do children need in order to promote and strengthen their emotional resilience and enable them, where appropriate, to live safely with parents who misuse substances?
- What changes are considered to be necessary in relation to legislation, policy, training and practice to respond to the needs of these children?

Guidelines

- During the focus group sensitive and emotive issues will be explored, there is a risk that information discussed could be upsetting to listen to. There will be time at the end of the focus group if you need to debrief.

- There are no right or wrong answers, only differing points of view.

- Please be respectful of one and other and allow each other time to share experiences without interruption.
- The focus group will be recorded (with your permission) to allow me to type up all the information afterwards. For the purpose of recording and to ensure I don't miss anything important please try as far possible not to talk over one and other.
- Please can everybody have their phones on silent, if you need to respond to a call, please could you do so as quietly as possible and then then re-join the group as soon as you can.
- Finally, my role as the focus group moderator is to guide the discussion, it is your experiences and your views which are important. I will ask questions to facilitate open discussion between you.

Any questions before we start?

Opening questions

- When you hear the words parental substance misuse what thoughts come to mind?
- What have been your experiences of supporting children living with parental substance misuse?

Key questions

- Think back to an experience where parental substance misuse was a safeguarding concern, can you describe your particular concerns?
- Were there challenges you faced when supporting the child/ren and their family?
- What helped or would have helped you most in supporting a child living with parental substance misuse? (in terms of services, wider family, training/ knowledge)
- What do you think children living with parental substance misuse need by way of support to lessen the impact of PSM?

- what factors do you think are most significant in helping to strengthen a child's resilience, their ability to bounce back from the impact PSM?

Follow up/ ending questions

- What's the greatest challenge you face when responding to Parental substance misuse and what should be done about it?

- Is there anything I have missed in relation to your practice supporting children living with PSM that you feel is important for me to consider?
- What changes do you think are important messages for commissioners and policy makers so we can better respond to the needs of children living with parental substance misuse?

Summary from moderator …….

- Is my summary an accurate reflection of what we have explored/ discussed today?
- Have I missed anything?

Thank you for your time and for contributing to this research project. I will endeavour to keep you all up to date and inform you of any publications once the project is complete.