



**Trinity College Dublin**

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

***Multi-perspectives of the lived experience of risk and protective factors  
of children of parental substance misuse: children, parents,  
grandparents, and service providers.***

A thesis presented to the University of Dublin, Trinity College  
Dublin, Trinity College for the  
Degree of Doctor of Philosophy

By

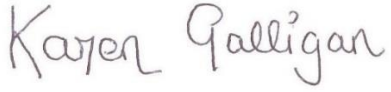
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## **Acknowledgements**

Firstly, I would like to sincerely thank my supervisory team Professor Catherine Comiskey and Dr. Jan De Vries for their relentless support, and commitment throughout this research study process. Professor Comiskey, in your role as lead supervisor, your never-ending support, both academically, and personally will never be forgotten and forever treasured. This process has changed me on a cellular level, and I cannot thank you enough for persevering with this research study. Dr DeVries and Professor Comiskey, thank you both so much.

I would also like to deeply thank the family members and the service providers who took part in this research. Without their support, this research could not have taken place. To the grandparents, the parents, and the children who participated, thank you so much for trusting me with your lived experience. To all of the service providers who participated in both the interviews and in facilitating the process of engagement with family members, thank you all so much. Thank you to the South Eastern Regional Drug and Alcohol Task force (SERDATF) and the Health Service Executive (HSE) who commissioned this research.

The completion of this thesis would not have been possible without the wide range of support, I received from a variety of people, and to them I would like to express my sincerest of gratitude:

To Dr. Sonam Banka, Trinity College Dublin (TCD) who provided unending emotional, and professional support and guidance throughout the years of this research study.

To Marie Pierre Lavergne, Senior Executive Officer, TCD, thank you for everything.

To Patrick Flynn, and to our dearly beloved Michael Kinsella (Security, TCD) thank you for your relentless patience as I repeatedly skidded to the door one second before the alarm!

To Jeni Ryan, Administrative Officer, (TCD) thank you for all your support over the years.

To Jessica Eustace-Cooke, Librarian, Trinity College Dublin thank you for ongoing help

To all my colleagues in the School of Nursing who provided help and support.

To the incredible people that work in the addiction area who provided endless insights and guidance, and in particular Marion Rackard (HSE), Pauline McKeown (CEO, Coolmine), and Paula Leonard (The Alcohol Forum).

A special thank you also to my fellow students in room 4.14 in TCD, Dr. Karin O' Sullivan, Dr. Mark Byrne, Debra O'Neill, David Mc Donagh and Marie Hyland.

And last but not least, the deepest sincerest thanks to my incredible fiancé Mark McHale for his endless support and love, to my dear father Barry Galligan, my sister Jean Monaghan, and my brother-in-law Patrick Monaghan, for years and years of being there for me.

And to my dearest friends who have always been there for me and who were my greatest champions during this process- Tina and Hugh McHale, Bridget and Josephine Flannagan, Jacqueline O'Reilly, Jennifer O'Keeffe, Nick Gibbs, Karen Hickey and Claire Burke.

## Table of Contents

|  |    |
|--|----|
| Thesis Summary.....  | 8  |
| Chapter One: Introduction .....  | 10 |
| 1.1 Overview.....  | 10 |
| 1.2 Background and rationale.....  | 10 |
| 1.3 Global perspective and the emergence of “Hidden Harm” .....  | 13 |
| 1.4 Prevalence and scale of the challenge .....  | 19 |
| 1.5 Different outcomes for different children? – Defining risk/protective factors, and resilience .....    | 22 |
| 1.6 Considerations in choosing a conceptual framework .....  | 25 |
| 1.7 Additional complexities in understanding risk and protective factors.....                              | 28 |
| 1.8 Additional complexities in understanding protective factors.....                                       | 33 |
| 1.9 A review of three specific studies on protective factors and their relationship with resilience .....  | 38 |
| 1.10 Widening the sources of perspectives.....   | 43 |
| 1.11 Capturing the voice of grandparents.....  | 44 |
| 1.12 Capturing the voice of service providers .....  | 46 |
| 1.13 Using multi-perspective research design to explore phenomena .....                                    | 49 |
| 1.14 Summary.....  | 54 |
| 1.15 Research question, aims and objectives of the thesis.....   | 56 |
| 1.16 Structure of the thesis .....   | 57 |
| Chapter Two: Narrative review of multi-perspective research on parental substance misuse and children..... | 59 |
| 2.1 Introduction .....   | 59 |
| 2.2 Reviewing the literature .....   | 59 |
| 2.3 Purpose of the literature review.....  | 59 |
| 2.3.1 Defining the key subject areas .....   | 60 |
| 2.3.2 Sourcing information and the development of search terms.....  | 60 |
| 2.4 Running the searches .....   | 62 |
| 2.5 Managing search results: endnote .....   | 62 |
| 2.6 Reviewing and screening: covidence.....  | 63 |
| 2.7 Relevant literature .....  | 64 |
| 2.8 Conclusion.....  | 82 |
| Chapter Three: Study design and methodology .....  | 87 |
| 3.1 Introduction .....   | 87 |

|  |     |
|--|-----|
| 3.2 Aims and research questions .....  | 87  |
| 3.2.1 Objectives .....   | 87  |
| 3.2.2 Research question.....   | 87  |
| 3.3 Design overview.....   | 88  |
| 3.4 Quantitative method - prevalence estimates .....   | 89  |
| 3.4.1 Definitions of quantitative methodologies.....   | 90  |
| 3.4.2 Data sources .....   | 91  |
| 3.5 Qualitative method.....  | 93  |
| 3.5.1 Introduction to interpretative phenomenological analysis.....  | 94  |
| 3.5.2 Ontological and epistemological positioning .....  | 95  |
| 3.5.3 Phenomenology, Interpretation, and Idiography .....  | 95  |
| 3.5.4 Innovations in IPA - Multi-perspectival designs.....   | 100 |
| 3.5.5 The choice of IPA.....   | 101 |
| 3.5.6 Grounded theory .....  | 104 |
| 3.5.7 Ethnomethodology .....   | 105 |
| 3.5.8 Conceptual framework Bronfenbrenner’s Ecological Systems Theory .....  | 105 |
| 3.6 Research design.....   | 110 |
| 3.6.1 Ethical considerations .....   | 110 |
| 3.6.2 Context of the Research Study .....  | 112 |
| 3.6.3 Sample.....  | 112 |
| 3.6.4 Participation rates.....   | 114 |
| 3.6.5 Data gathering .....   | 115 |
| 3.6.6 Data analysis.....   | 115 |
| 3.6.7 Quality and Validity.....  | 118 |
| 3.6.8 The Researcher .....   | 120 |
| 3.7 Conclusion .....   | 120 |
| Chapter Four: Estimating the prevalence of the number of children in the region with parents who use substances..... | 122 |
| 4.1 Introduction and definitions.....  | 122 |
| 4.2 Findings on the prevalence of illegal drug use in the region in the last year.....                               | 123 |
| 4.3 Findings on the prevalence of children with parents who use illegal drugs .....                                  | 124 |
| 4.4 Findings on the prevalence of children with parents with problem alcohol use .....                               | 124 |
| 4.5 Conclusion .....   | 125 |
| Chapter Five: Qualitative research findings from parents’ perspective.....   | 126 |

|   |     |
|---|-----|
| 5.1 Introduction .....  | 126 |
| 5.2 Profile of parents and their children .....                                       | 126 |
| 5.2.1 Living situation of children.....   | 127 |
| 5.3 Parents own lived experience.....   | 132 |
| 5.4 Themes identified in relation to parent interviews .....                          | 134 |
| Theme 1: Secrets, suspicions, and solid disclosures – Unpacking the façade of non-use | 136 |
| Theme 2: Riding the ghost train – children enduring isolation and the unknown .....   | 140 |
| Theme 3: What could help protect the children? .....                                  | 145 |
| Theme 4: Fragility of recovery .....  | 151 |
| Theme 5: Protective factors in recovery .....   | 155 |
| 5.5 Conclusion.....   | 158 |
| Chapter Six: Qualitative research findings from adult children’s perspective .....    | 160 |
| 6.1 Introduction .....  | 160 |
| 6.2 Profile of adult children: Family context- adult child and grandchildren .....    | 161 |
| 6.3 Themes identified by Adult Children interviews.....                               | 164 |
| Theme 1: The whole is greater than the sum of its parts.....                          | 164 |
| Theme 2: Weathering the storm -Protections growing up .....                           | 175 |
| Theme 3: On the road to recovery – Succeeding yet scarred.....                        | 181 |
| 6.4 Conclusion.....   | 188 |
| Chapter Seven: Qualitative research findings – grandparents’ perspective.....         | 191 |
| 7.1 Introduction .....  | 191 |
| 7.2 Profile of grandparents: Family context- adult child and grandchildren.....       | 192 |
| 7.3 Themes identified by grandparent interviews.....                                  | 196 |
| Theme 1: Families struggling to cope.....   | 196 |
| Theme 2: Shifting priorities and role reversals.....                                  | 201 |
| Theme 3: Living in a house of cards: .....  | 204 |
| Theme 4: Shaky scaffolding – service response.....                                    | 216 |
| Theme 5: The need for comprehensive integrated services .....                         | 224 |
| 7.4 Conclusion.....   | 226 |
| Chapter Eight: Qualitative research findings – service providers’ perspective.....    | 227 |
| 8.1 Introduction .....  | 227 |
| 8.2 Profile of service providers .....  | 229 |
| 8.3 The themes .....  | 229 |
| Theme 1: Risks to children and impact- living in a house of cards .....               | 230 |

|   |     |
|---|-----|
| Theme 2: Sweeping statements- an unfair narrative when void of context? .....   | 235 |
| Theme 3 When Worlds Collide –Merging Silos of expertise .....   | 251 |
| 8.4 Conclusions.....  | 269 |
| 8.5 Summary of findings across stakeholders.....  | 270 |
| Chapter Nine: Discussion .....  | 273 |
| 9.1 Parents’ perspectives.....  | 275 |
| 9.2 Child perspectives (adult children) .....   | 277 |
| 9.3 Grandparents perspective.....   | 279 |
| 9.4 Service provider perspective .....  | 280 |
| 9.5 Overarching issues.....   | 285 |
| 9.6 Strengths and limitations .....   | 288 |
| 9.6.1 Strengths .....   | 288 |
| 9.6.2 Limitations .....   | 290 |
| 9.7 Researcher Reflections.....   | 292 |
| 9.8 Conclusions: Implications for Policy, Practice and Research.....  | 298 |
| Bibliography .....  | 304 |
| Appendices.....   | 323 |
| Appendix 1: Participant Information Sheet.....  | 323 |
| Appendix 2: Interview Schedule/Questionnaires.....  | 330 |
| Appendix 3: Consent.....  | 333 |
| Appendix 4b Mapping of Themes.....  | 340 |
| <br>  |     |
| Table 1: Protective factors and resilience in children affected by parental substance misuse, as revealed in the literature (Velleman & Templeton 2016, p.111)..... | 36  |
| Table 2: Search Details Embase Example .....  | 61  |
| Table 3: Overview of Search Results .....   | 62  |
| Table 4: Summary of Results.....  | 65  |
| Table 5: Estimates of Numbers Using Any Illegal Drug in the Last Year * .....   | 123 |
| Table 6: Service User Profile: Age, Gender, No of Children and Age Range of Children .....  | 127 |
| Table 7: Age Range of Children aged 18 and under .....  | 127 |
| Table 8: Males service users by type of drug, stage in recovery, and age range/living situation of children .....   | 129 |
| Table 9: Female service users by type of drug, stage in recovery, and age range/living situation of children .....  | 130 |
| Table 10: Significant Life Events of Parents .....  | 133 |
| Table 11: An overview profile of family structure and environment growing up.....   | 163 |

|  |     |
|--|-----|
| Table 12: Profile of Grandparents’ adult children, grandchildren, current living status and care status: Focus Group 1 ..... | 194 |
| Table 13: Profile of Grandparents’ adult children, grandchildren, current living status and care status: Focus Group 2 ..... | 195 |
| Figure 1: The hermeneutic circle in IPA analysis .....   | 97  |
| Figure 2: Ecosystems surrounding the child in Bronfenbrenner’s Ecological Systems Theory (EST)....                           | 106 |
| Figure 3 Summary of Themes by Stakeholder groups .....   | 272 |
| Figure 4 Overall Summary of Themes and Sub Themes.....   | 339 |
| Figure 5: Bronfenbrenners conceptual fraemwork map of themes.....  | 340 |



## Thesis Summary

### **Background:**

Globally, the problem of hidden harms to children of parents who use drugs and alcohol has been recognised, yet international literature has highlighted the difficulties with estimating the prevalence of this challenge. There exists a clear information gap at local level in relation to the numbers of children potentially adversely affected by parental substance use. However, it is at a local community level that resources must be allocated. There is a particular concern for the potential risks for these children and a desire to build upon and understand protective factors and enablers for children.

**Aim:** The overall aim of this research was to identify and explore lived experiences of the risks and protective factors of children of parental substance misuse from an intergenerational and service provider perspective. The objectives of this research were to estimate of the prevalence of children impacted by parental substance misuse, across the communities of a regional area; identify and explore lived experiences of the risk and protective factors of children of parental substance misuse from the perspective of their parents, and from the perspective of adult children of parental drug misuse, and grandparents; and to identify and explore experiences of the risk and protective factors of children of parental substance misuse from child and family service and drug service providers.

**Method:** This study design was based on a concurrent quantitative and qualitative multiple method design, with the qualitative aspect dominant and informed by Bronfenbrenner's framework. The design measured quantitatively the prevalence of children of parental substance misuse, and, qualitatively, explored intergenerational (adult children, parent, and grandparent) and service providers lived experiences of the risk and protective factors for children of parental substance use. Multisource enumeration and benchmark multiplier methods were used for the prevalence estimates, and semi structured interviews and focus groups were used to explore the lived experiences.

**Results:** Using an indirect benchmark multiplier method we found that a minimum of 2% of children were estimated to be possibly impacted by parental substance use and a maximum of 13% children were estimated to be possibly impacted by parental illicit drug use in the region. With regards to alcohol use we estimated that 14.5% of children in the region may have a parent who is alcohol dependent. A total of 37 people self-selected to take part in the qualitative aspect of the study. Sixteen parent service users, 2 adult children, and 7 service providers took part in one-to-one interviews. Twelve grandparents participated in two separate focus groups (N=7, 5). The multiple stakeholder perspectives of the lived experience of risk and protective factors for children of parental substance misuse provided an in-depth holistic insight into the area under investigation. Risk and protective factors were reported across multiple levels of the Bronfenbrenner's ecological system. Risks identified for the child across stakeholders included trauma, children being taken into care, children acting as carers, and emotional and physical neglect. While risk factors from parental substance misuse reported by the adult children echoed those of the other stakeholders, in addition to this, the participants also highlighted the critical role of factors not specific to the parental substance misuse per se, that exacerbated their lived experience. These risks included more than one parent misusing substances, mental health issues, parental death, community environment, and peers. Existing protective factors for children consisted mainly of one good adult, and of community level interventions including youth clubs, sports, and community services. Scarcer but highly valued protective factors included peer support, trauma informed interventions and targeted support for the children in terms of having someone to talk to. A significant risk factor for children that

transcended all stakeholder interviews related to the service level response for parents who misuse substances, with many stakeholders reporting a service system under immense pressure, operating from siloes of expertise, manifesting from historical origins, differing models of addiction, a lack of understanding of how to respond to parents and or children respectively. The issue of stigma was reported by all stakeholders, with a specific targeted stigma reserved for mothers who misuse substances, a stigma often perpetuated by a negative media, policy and professional narrative. Grandparents similarly reported significant challenges with child service systems, limited capacity to assist child in school settings, and significant challenges with justice systems. Supports for grandparents were reported as being extremely limited and impacted by a culture of being taken for granted by services, resulting in differing supports being available for kinship care relative to non- relative carers.

**Conclusion:** The findings from the study contextualise our knowledge of risk and protective factors that influence children of parental substance misuse, from multiple perspectives. While both policy and practice have made steps in recognising children of parental substance misuse as one in need of prioritisation, with promising ways of supporting these children being designed and implemented to varying degrees. Future research is needed to explore and monitor the extensive implementation challenges of the systemic change initiatives currently recommended. The widening of the focus of the lens through which we examine risk and protective factors of children of parental substance misuse is imperative. This study's findings have practical implications and recommendations for social service. agencies and other contexts such as early childhood environments, schools, and community-based programs.

## Chapter One: Introduction

### 1.1 Overview

This chapter sets the foundations for this thesis on risk and protective factors for children of parental substance misuse, outlining below the background and rationale for the study, the overall aims and objectives, and concluding with the structure of the thesis.

### 1.2 Background and rationale

For decades the experiences of children living with a parent who uses drugs or alcohol had been ignored (Hogan 1998, Advisory Council on the Misuse of Drugs 2003, Moe *et al.* 2007, Velleman & Templeton 2007, Horgan 2011, Velleman & Templeton 2016, Comiskey 2019). Earlier research in relation to substance misuse predominantly focused on the impact on the individual person who used, creating a gap in research in terms of the wider effects on children, young people and other family members (Corbett 2005). More recently, over the last three decades, a body of literature in relation to parental substance misuse on children has developed (Horgan 2011). This research has resulted in growing awareness that this is an issue upon which our attention should be focused (Corbett 2005). This body of literature has focused on different aspects of parental substance misuse on children, and consists of different methodological approaches (Hogan 1997, Hogan & Higgins 2001, Horgan 2011, Hill 2012).

Barnard & Barlow (2003) in their research on children growing up in families of parental drug use highlight that most of what we know about children and young people living with parental drug dependence is contained in statistics, either on their elevated likelihood of being taken into some form of care, or their likely poor outcomes as adults, with precious little consideration being given to the broader range of experience of children in the community. Primarily the focus of the research has been on the ways that adults live with their drug dependency problems and only tangentially, has concern been with its impact on children. The lived experience of parental drug dependence as seen through the eyes of children has rarely been considered (Barnard & Barlow 2003). In response to this gap, these authors carried out qualitative research with young people and reported that the children as living in a world of mirrors under the weight of forced silence. A disjunction between what parents thought their children knew about their drug use versus what children actually knew emerged in the findings, and the authors argued that this needs to be addressed in policy terms, with children liable to be doubly affected both

by the effects of parental drug use and the reticence of most parents to acknowledge it directly (Barnard & Barlow 2003). Furthermore, the authors argue that this is further exacerbated by the problem's adult-based services have in recognising and catering for the needs of children. The first problem therefore lies in designing services that attract these vulnerable children. The second problem lies in providing meaningful help that might also facilitate disclosure. The authors conclude that there is a growing population of children of parental substance misuse whose needs must be recognised and whose voices must be heard (Barnard & Barlow 2003).

Templeton *et al.* (2006) in their scoping review – 'Looking beyond risk - parental substance misuse' reported that the needs of family members have largely been neglected within an historical focus on the treatment of those individuals with the alcohol or drug problems themselves. The authors draw attention to the fact that family members, including children can be hard to engage with, because they feel too ashamed about their situation, are used to keeping the substance misuse a secret, or simply do not know where to go for help or what to do if help is available to them. In addition to this, professionals, either specialists working in the addiction field or generic staff working in children and family services, schools or primary care for example, can feel uncertain, and lack training and confidence in how to respond to the needs of children and families of substance misusers (Templeton *et al.* 2006). Key gaps in the literature reported by Templeton *et al.* (2006) included children's views (particularly in relation to impact, resilience factors, service needs, or views on existing service provision), fathers, siblings, service needs, service provision, mental health, rurality and ethnicity. The authors also highlighted that it is clear that it is often the problems that are associated with or arise from (parental) substance misuse that can have a greater negative impact on the family than the misuse per se, and hence there is a need to view parental substance misuse as part of a far wider, multi-dimensional picture. Clear and methodologically sound attempts to measure and validate the numbers of children and families affected by substance misuse are severely lacking. Furthermore, while in the overall literature, the impact and risks associated with parental substance misuse have been well mapped, there are studies that have found no evidence of heightened risk for children stemming from parental substance misuse alone, and that following on from this, a philosophical shift in the literature towards resilience is occurring and that this has clear potential when applied to children and other family members affected by parental substance misuse.

The relationship between parental substance misuse and neglectful parenting is far from straightforward (Huxley & Foulger 2008). Parental substance misuse through acts of omission

or commission may present the child with a range of difficulties that can affect emotional, behavioural, cognitive and psychological development (Huxley & Foulger 2008). Children of parents who misuse substances may be at risk of neglect, physical and emotional abuse and to a lesser extent sexual abuse (Health Service Executive & TUSLA 2019). From a developmental perspective, deficits in early life would be expected to be more pervasive and severe in their effects than later parenting problems. The reason for this is because from this perspective, developmental competencies build up over time, each are dependent and reliant upon successful negotiation of previous stages (Cleaver & Unell 2011). Individual variations in how children respond are, in part, a function of the severity, characteristics and social and cultural context of their parents' problems (Cleaver & Unell 2011).

Parental intoxication (from either drugs or alcohol) may present acute risks to the child due to incapacity to supervise and guard from hazardous situations, although this may not cause ineffective parenting outside of this isolated occasion. Chronic and prolonged substance misuse may affect the individual's ability to parent safely and effectively and may also be influenced by a number of environmental factors (Hogan 1997, Hogan & Higgins 2001, Huxley & Foulger 2008, Carrà *et al.* 2017, Galligan & Comiskey 2019). The relationship between substance misuse and parenting is complex, involving the acute and chronic effects of the substances used, the dispositional characteristics of the substance misusing parent, the characteristics of the individual child and the surrounding environmental factors in which the substance misuse takes place (Huxley & Foulger 2008). The frequently complex nature of the problems of parents who misuse substances often makes it difficult to disentangle the specific contribution of drugs on parenting capacity (Barnard & McKeganey 2004).

Scaife (2008) in their literature review of risk and protective factors for children of parental substance misuse argue that it is important to avoid implicitly adopting a model of parental drug misuse which locates all risk factors for child outcomes in the skin of drug-misusing parents and highlights the value of adopting Bronfenbrenner (1979) ecological framework as a useful conceptual framework for reminding researchers to avoid this pitfall. This model proposes that factors contributing to child development are variously located (e.g. in a child's individual biology, immediate environment, socioeconomic and cultural context; (DeHart *et al.* 2000)) and that events in one location may influence events in another.

Researching the links between parental substance misuse and child maltreatment is complicated by some of the shifting definitions used, the sample (whether clinical or community), study design and contradictory findings (Kroll 2004). Other factors which need to be taken into account include sample bias, how 'child of alcohol or drug user' status is established, and the way in which other factors that influence development and adult adjustment are considered. Therefore, only cautious conclusions can be drawn (Kroll 2004). Any consideration of parental substance misuse, child welfare and child maltreatment, needs to be placed in context by defining a number of terms and acknowledging some of the methodological land mines that litter this area of research (Kroll 2004). The term 'substance misuse' is generally understood to refer to alcohol, drug or polydrug use 'which leads to social, physical and psychological harm' (Kroll 2004). It is also less about quantity than patterns of use, motivation for use and consequences (Kroll & Taylor 2003), and encompasses both the licit (alcohol, prescribed drugs, including methadone, and solvents) and illicit (heroin, amphetamines, cocaine, crack, cannabis, ecstasy, etc.). 'Child welfare' encapsulates the totality of child well-being at every level which depends on the often complex dynamic between parenting capacity, environmental factors and individual development (Department of Health 2000). Child maltreatment – defined as neglect and abuse, and encompassing acts of omission as well as commission ((Health Service Executive & TUSLA 2019) – can occur for a range of reasons and it is only relatively recently that the part played by parental problems, including substance misuse, has been fully acknowledged (Kroll 2004). Throughout this introduction and literature review, the term used to describe the substance use will vary to reflect the terminology used in the literature under review.

### **1.3 Global perspective and the emergence of “Hidden Harm”**

Globally the problem of potential harms to children of parents who use drugs and alcohol has been recognised. The 2016 World Drug Report highlights the impact of drug use not only on individuals, but also on communities, families, and in particular on women and children (United Nations Office on Drugs and Crime 2016). Within the United States, the 2016 National Drug Control Strategy highlights that many challenges remain since the inaugural National Drug Strategy in 2010, not least the challenge of preventing the early onset of illegal substance use among youth at risk (Executive Office of the President of the United States 2010, 2016). At a European level, the European Action Plan on Drugs has specifically noted the need for further action in the area of family circumstances within its demand reduction objectives (European Union Institutions 2017).

In the United Kingdom (UK) concern about the risks to children from parental substance use has become a central tenet of social policy over recent years (Flacks 2019), following the publication of an influential seminal UK report, *Hidden harm: Responding to the needs of children of problem drug* (Advisory Council on the Misuse of Drugs 2003). In this report, the authors warned that “parental problem drug use can and does cause serious harm to children at every age from conception to adulthood” and that “Reducing the harm to children from parental problem drug use should become a main objective of policy and practice” (Advisory Council on the Misuse of Drugs 2003, p. 3).

The phrase ‘Hidden harm’ has since entered policy parlance as a description for the potential damage to children from parental substance use (Flacks 2019). The experience of children living with and affected by parental problem substance use, has become widely known as Hidden Harm (Flacks 2019, Health Service Executive & TUSLA 2019).

The term Hidden Harm encompasses the two key features of that experience:

- Firstly, that the children are often not known to services and,
- Secondly, that they may suffer harm in a number of ways as a result of compromised parenting which can impede the child’s social, physical and emotional development (Advisory Council on the Misuse of Drugs 2003).

The authors of this inaugural Hidden Harm report (Advisory Council on the Misuse of Drugs 2003) warn that the effects of substance misuse are complex and vary enormously, depending on both the drug, and the person who uses, and that while there is probably no drug that is entirely harmless in all circumstances, it is important to accept that not all drug use is incompatible with being a good parent. The consequences for the children are variable, often very damaging, and are typically multiple and cumulative and will vary according to the child’s stage of development. These consequences can include failure to thrive; blood-borne virus infections; incomplete immunisation and otherwise inadequate health care; a wide range of emotional, cognitive, behavioural, and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment. Consequences can range greatly in severity and may often be subtle and difficult to detect (Advisory Council on the Misuse of Drugs 2003).

A total of 48 recommendations arose from this 2003 AMCD report and cut across drugs, children's health, and criminal justice sectors, and addressed a broad range of issues. Within these recommendations the authors note that by comparison with adult drug users, the children of problem drug users have largely escaped the attention of researchers and that whilst research in this area is extremely difficult, it is important that high quality studies are undertaken to help better understand the impact of parental problem drug use on children and to assess the effectiveness of interventions designed to help them (Advisory Council on the Misuse of Drugs 2003). Specific recommendations included the need for the voices of children of parental substance misuse to be heard and listened to, the need for research examining the impact of parental problem drug use on children, which should include assessing the circumstances of and consequences for both those living with problem drug users and those living elsewhere. Service related recommendations included the need for drug and alcohol agencies to recognise their responsibility towards the dependent children of their clients with an aim to providing accessible and effective supports for parents and their children, either directly, or through inter-agency work, and to incorporate training with a specific focus on learning how to assess and meet the needs of clients as parents and their children. Similarly, service providers working with children are to recognise their role in exploring possible parental substance misuse and identifying ways to respond to this need (Advisory Council on the Misuse of Drugs 2003). This report has since become the bedrock for Hidden Harm research, policy and service practice across the UK (Health Service Executive & TUSLA 2017). The ACMD subsequently established a specific working group to monitor and promote the implementation of the recommendations in the United Kingdom, demonstrating its commitment to the cross-cutting recommendations (Kearney 2017).

Within Ireland, in more recent years, following on from the work in the UK, steps have also taken place to begin to address the issue of Hidden Harm. These steps have consisted of a combination of strategy, policy practice and research developments. The key steps are articulated chronologically below.

In 2009, the National Drugs Strategy (Interim) 2009-2016 underlined the need to target the child's needs in relation to parental substance misuse (Department of Community Rural and Gaeltacht Affairs 2009). In 2011, the National Advisory Committee for Drugs published a key literature review report on Parental Substance Misuse: Addressing its Impact on Children (Horgan 2011). In this review the author reported that problem substance use clearly undermines the potential of families, and that the effects of parental drug use can continue into



subsequent generations (Horgan 2011). It was found that drug misuse in the family is often associated with disruption, conflict, violence and a breakdown in the relationship a child has with their parents and other family members. A consequence of this is a greater likelihood that children are taken from the family and placed in care, which increases the risk of emotional and social isolation of the child (Horgan 2011). The review also focused on child health outcomes and found that children of drug users are more likely to experience a wide range of negative outcomes in terms of their physical and mental health, cognitive and behavioural problems, and future substance use and outlined the impact of parental substance misuse on children, from the unborn, through early years and on to adolescents, with differing responses needed across the age brackets (Horgan 2011). The review concluded that the impact of the report must be that it reinforces the need to renew all our efforts to break the cycle of substance misuse in families and across generations (Horgan 2011). Research recommendations from this report included the need for further research with parents in treatment and what effect being in treatment has on their children, understanding the perspectives of fathers, establishing estimates of the number of children of parental substance misuse, and research involving input from service providers, and family members (Horgan 2011).

In 2013, additional steps to adopt the Hidden Harm agenda from the UK, within Ireland, began to take place commencing with the establishment of a Hidden Harm national steering group. This step was in part instigated by an action in the National Drug Strategy 2009-2016 which directed the Irish Health service executive (HSE), and Tusla, the National Child and family agency, to consult with the objective of learning from the Hidden Harm model under implementation in Northern Ireland (Department of Community Rural and Gaeltacht Affairs 2009).

In addition to this, Hidden Harm was included as a theme within 'Better Outcomes, Brighter Futures; The National Policy Framework for Children and Young People 2014- 2020' (Department of Children and Youth Affairs 2014). The importance of recognising Hidden Harm and ensuring that children living with parental problem alcohol and other drug use are identified and supported within Tusla and the HSE, is now included under the transformational goal of earlier intervention. This framework document illustrates a new direction for childhood in Ireland, apparent through its vision to firstly protect the rights of children and listen to children, and secondly to value and support children for who they are now, and in their future (Department of Children and Youth Affairs 2014). Historically in Ireland, children were not

always cherished or protected, and this latest policy document marks a very poignant commitment from the Irish Government to work towards a better future, having learnt from the past (Hollywood 2020).

Following on from these initial steps, in 2015, following an extensive national consultation, a draft strategic statement was compiled, and 'Addressing Hidden Harm' was also articulated as an objective in Ireland's latest National Drug Strategy 2017 – 2025, Reducing Harm, Supporting Recovery (Department of Health 2017).

These steps culminated in 2019 in joint collaborative publications from the HSE and Tusla, the Child and Family Service, which heralded the first major national interagency collaboration between these two sectors- child and family, and health service addiction services. The publications consisted firstly of the 'Hidden Harm Strategic Statement', which aims to frame and acknowledge in policy and practice the primacy of safeguarding, protection, and support of children affected by parental problem substance use, their families and communities, noting that this response is needed as research suggests that children are falling through gaps in services, and those professionals, both adult- and child-focused feel increasingly ill-equipped to deal with this combination of issues, recognising that the key to success is the willingness and capacity of services to work together in a collaborative fashion (Health Service Executive & TUSLA 2017). A subsequent publication was the 'Hidden Harm Practice Guide' (Health Service Executive & TUSLA 2019). This Practice Guide is mainly concerned with the care of children who have unmet needs, where there are concerns about the health or wellbeing of the child/unborn child or young person, and where these are linked to the impact of parental problem alcohol and other drug use on parenting capacity. The authors note that many different professionals and agencies in drug and alcohol services and child welfare and protection services are now involved in the care of children who are affected by parental problem alcohol and other drug use, yet guidance is needed for professionals given the complexity of the issue which can span social, legal, economic and health related problems. Much coordination and understanding between professionals and agencies working in the area of drug and alcohol services and child welfare and protection is therefore often needed. This Guide also seeks to promote earlier intervention with children and families affected by parental problem substance use (Health Service Executive & TUSLA 2019).

The Hidden Harm agenda is underpinned by the United Nations Convention on the Rights of the child (Comiskey 2019, Health Service Executive & TUSLA 2019). According to the UNCRC children have the right to survive, to be protected from harm and exploitation, to develop fully and to participate in decisions which affect their wellbeing (United Nations Convention on the Rights of the Child (UNCRC) (United Nations Children's Fund 1999). The underpinning of the Hidden Harm agenda by the UNCRC, in conjunction with the global recognition of the problem of potential hidden harms to children of parents who use drugs and alcohol highlight the importance of addressing this issue.

The challenges facing children growing up in families where there is a parental drug or alcohol use problem are an increasing concern for policy, practice and academic research (Backett-Milburn *et al.* 2008). The children of alcohol- and drug-dependent parents represent a population at risk for poor psycho-social outcomes (Horgan 2011). A better understanding of the problems these youth experience is essential in order to promote primary and secondary prevention (Horgan 2011). Research suggests that parental substance misuse can adversely affect attachment (Brooks & Rice 1997, Klee 1998, Howe 1999, Flores 2001), family dynamics, relationships and functioning (Cleaver *et al.* 1999, Velleman & Orford 1999, Harbin & Murphy 2000) and significantly increases the risk of violence (Brookoff *et al.* 1997). This can be exacerbated where there are also mental health problems (Kroll 2004), and the combination of maternal depression and alcohol misuse has been found to be a particularly high-risk mix (Woodcock & Sheppard 2002). Neglect and emotional, sexual and physical abuse have also been linked to substance misuse (Famularo *et al.* 1992, Jaudes *et al.* 1995, Chaffin *et al.* 1996, Ammerman *et al.* 1999, Alison 2000). Children of parents with alcohol or drug use disorders (COPAD) face a higher risk of drug involvement as well as mental health and behavioural problems (Wlodarczyk *et al.* 2017).

Parental substance misuse frequently co-occurs with many other problems, the combination of which place children at heightened risk of abuse and neglect (Horgan 2011). It is well established that children raised in families with parental substance misuse often have poor developmental outcomes (Velleman & Templeton 2007, Horgan 2011).

Parental drug use can affect children's lives in at least two ways: First it has implications for their psychological development" their relationships with others, their social competence, and their success in the world of education and work. Second, parental drug use plays a role in

whether children themselves become drug users. For these reasons it is critical that the effects of parental drug use on children are studied (Hogan 1997). Little is known about the social and psychological effects on children of parental drug use, particularly in the Irish context (Hogan 1997).

Social and psychological development literature of these children generally falls into two categories: Studies of parenting and care, including child abuse and neglect, and studies of psycho-social child outcomes, including the risk of drug use (Hogan 1998). A second way in which the literature approaches the research, is in terms of two distinct approaches, negative/deficit model, and positive/adjustment model. For all approaches, limitations in relation to data collection methods, (retrospective, proxy) definitions (nature of parental drug use, type of exposure), sampling e.g., have been raised. This is in combination with variations in findings, even from within the same researchers at different points in time (Hogan 1998).

#### **1.4 Prevalence and scale of the challenge**

Whilst parental substance misuse is a significant feature in relation to children in need, presenting a range of challenges for professionals in child and family health and social care, as well as adult services (Kroll 2004), the international literature has highlighted the difficulties with estimating the number of children living with parents who misuse substances (Advisory Council on the Misuse of Drugs 2003, Comiskey *et al.* 2009, Galligan & Comiskey 2019). Key challenges that exist relate to a dearth of available systematically collected information in relation to parental substance misuse. This is in relation to both the 'children' of parents who use drug services, and the status of parental substance use for children in receipt of child and family services (Advisory Council on the Misuse of Drugs 2003, Hay *et al.* 2005, Dawe *et al.* 2008, Manning *et al.* 2009, Horgan 2011, Galligan & Comiskey 2019). Secondly, many national estimates and routine data sources may be composed of episodes of service, as opposed to unique individual cases, making accurate estimates locally difficult to apply. There is a possibility that people could be counted more than once as cases are not always named and people may enter treatment a number of times in one year. Not all treatment services provide regular or timely returns to centralized systems (Horgan 2011). Thirdly, accessibility to existing sources may be limited, with certain data sources only available with governmental level approval (Horgan 2011). An additional challenge in establishing a definitive prevalence estimate relates to the hidden and illegal nature of much drug use, with the consequent risk that children may be isolated from potential sources of support that might foster resilience (Advisory Council on the Misuse of Drugs 2003, Kroll 2004, Hay *et al.* 2005, Dawe *et al.* 2008, Manning *et al.* 2009).

Steps to address these issues are being taken to varying degrees but these changes will take time to implement (Advisory Council on the Misuse of Drugs 2003, Hidden Harm National Steering Group 2015)

Yet these very estimates are essential for the planning and provision of services. Service planning continues to be troubled by the uncertainty of the extent of possible hidden harms (Advisory Council on the Misuse of Drugs 2003). In Australia, Dawe *et al.* (2008) report that until there are accurate mechanisms for estimating the extent of the problem that change will be difficult to achieve (Dawe *et al.* 2008). There is concern that effective interventions are not adequately planned and provided for with these children in mind. This may be a contributing factor to the intergenerational transmission of problematic substance use (Horgan 2011).

Prevalence data is a requirement for both policy determination and practice implementation. In order to have appropriate, timely service provision it is important to have a reliable estimate of the numbers of children affected. Due to stigma, secrecy and the fear of repercussions surrounding alcohol and other drug use, there are clear challenges in collecting data about these children. Parents using alcohol or other drugs problematically may not present to treatment and where they do present, a parent may not disclose dependent children.

On a global level, the World Drug Report 2018 does not provide estimates of the numbers of children with, or living with, a parent who uses substance (United Nations Office on Drugs and Crime 2018). However, estimates of these numbers of children and the scale of the challenge within the United States, Australia, the United Kingdom, Scotland and parts of Ireland are available (Comiskey 2019). Within the UK, in 2003 the AMCD report reported estimates of between 250,000 and 350,000 children of problem drug users in the UK – about one child per problem drug user. This represents about 2-3% of children under the age of 16 (Advisory Council on the Misuse of Drugs 2003). These estimates are extrapolations of treatment data alone or estimates from other countries, thus in 2009 additional estimates were reported using additional data sources (Manning *et al.* 2009, Manning 2011). The revision of the United Kingdom estimates for children with a parent using alcohol estimated that 30% of children (or 3.3 to 3.5 million children) under 16 years of age in the UK lived with at least one binge drinking parent. The British Crime Survey of 2004 (Jansson 2007) and National Psychiatric Morbidity Survey (NPMS) in 2000 indicated that 2% (up to 256,000) of children lived with an adult who is a class A drug user and 7% (up to 873,000) with a class C drug user. Around 335,000 children

lived with a drug dependent user, 72,000 with an injecting drug user, 72,000 with a drug user in treatment and 108,000 with an adult who had overdosed. Elevated or cumulative risk of harm may have existed for the 3.6% (around 430,000) children in the UK who lived with a problem drinker who also used drugs and 4% (half a million) where problem drinking co-existed with mental health problems. The NPMS indicated that in 2000, 22% (2.6 million) lived with a hazardous drinker and 6% (705,000) with a dependent drinker (Social Survey Division of the Office for National Statistics 2001). Furthermore, high numbers of children live with a parent with more than one problem (alcohol/drugs/mental health difficulties), and more than 25% of babies under the age of 1 will have been exposed to at least one type of serious risk in their first 12 months (problem drinker, class A drug user, mental health disorder or victim of domestic violence). There has also been growing concern about the emergence and increasing use of a range of novel psychoactive substances ('legal highs') in this time (European Monitoring Centre for Drugs and Drug Addiction 2015).

In Ireland, currently there are no national estimates available on the numbers of children living with parental substance misuse, and whilst some research exists on children who live with parents who misuse alcohol, research on misuse of drugs is far less developed (Horgan 2011). Where figures on alcohol do exist they have identified number of children of parental drinking harms from others drinking, the role of alcohol in abuse and neglect cases, and the role of alcohol in triggering domestic violence incidents. Nationally, it is estimated that 587,000 children, over half of whom are under 15 years of age (271,000 children u15) are exposed to risk from parental drinking nationally (Health Service Executive & TUSLA 2017).

While there are no national estimates within Ireland on the number of children of parental substance misuse, to address this gap, Galligan & Comiskey (2019) designed and applied a methodological framework for estimating prevalence at a community level and provided the first estimates within an urban disadvantaged region, and results are presented within this thesis.

The prevalence data available to date in different regions, reflects a high number of children that may be at risk of harm from parental substance misuse. Additional complexities arise however when acknowledging that parental substance misuse frequently co-occurs with many other problems, the combination of which can place children at heightened risk of abuse and

neglect and poor developmental outcomes (Cleaver & Unell 2011, Horgan 2011, Templeton 2013).

From the varying studies and estimates it is difficult to generalise as definitions vary, some estimates involve children living with a parent, some estimates are for children under 16 and some are for children under 18 years. McLaughlin *et al.* (2015) also noted that estimates on prevalence are primarily from Australia, Canada, USA, UK and Ireland and this also likely reflects the cultural nature of alcohol misuse in these regions (Comiskey 2019).

### **1.5 Different outcomes for different children? – Defining risk/protective factors, and resilience**

From the issues outlined above it is easy to see why commentators have been pessimistic about the future of children brought up in such an environment (Forrester & Harwin 2006, Barnard 2007, Lander *et al.* 2013). However, in recent years it has become evident that, for some children, rather different outcomes might be possible (Dawe *et al.* 2008, Velleman & Templeton 2016, Wlodarczyk *et al.* 2017). It seems that not all individuals are adversely affected, either as children or as adults.

There is considerable evidence that children can grow up in all sorts of difficult circumstances without developing significant problems, and that they sometimes demonstrate good outcomes, in spite of such serious threats to adaptation and development (Velleman & Templeton 2016). There seem to be factors and processes that can minimise the negative impact of parental drug or alcohol misuse, or protect against them, thus, some children are *resilient* and develop no significant problems related to their parents' substance misuse (Park & Schepp 2015, Velleman & Templeton 2016, Wlodarczyk *et al.* 2017).

Resilience is a term that grew out of the mental health field (Moe *et al.* 2007). Early on in this field, children were referred to as “invulnerable,” especially in the description of children who were born to schizophrenic parents and did not become schizophrenic themselves (Garmezy 1974, Garmezy & Rutter 1983, Anthony & Cohler 1987). The concept of “invulnerability” changed with some of the early work of Emmy Werner and others (Rutter 1985, Werner 1986, Rutter 1987, Werner 1989) who transformed this formerly didactic approach to one that suggested an interplay of factors that ebbed and flowed along an unknown trajectory; factors that came to be known as “risk” or “protective” (Moe *et al.* 2007).

Risk factors are those attitudes, beliefs, behaviours, or environmental circumstances that put an individual in jeopardy. In contrast to risk factors, protective factors operate to shield individuals from the adverse effects of risk. Protective factors could, for instance, be attitudes, beliefs, situations, or actions that build resilience within an individual (Moe *et al.* 2007).

Research has shown that children who are exposed to multiple risk factors do not necessarily fall victim to their associated health and social problems in the presence of counterbalancing or prevailing protective factors in their lives. The presence of protective factors can offset or mitigate risks, reducing the likelihood for later problems. Children, who succeed despite being exposed to multiple risk factors, are resilient (Moe *et al.* 2007).

A **risk factor** is defined as an enduring circumstance(s) that interact with the developing child to compromise positive adaptation and increase likelihood of poor outcomes (Templeton 2013).

A **protective factor or process** reduces or prevents the impact of a risk factor by “modify[ing] or transform[ing] responses to adverse events (Templeton 2013)

A **resilience factor or process** is something which supports a child to avoid the harms often associated with a risky environment (Templeton 2013).

It is useful to distinguish between protective factors (which make it more likely that a child will develop resilience) and evidence that the child is being resilient.

Resilience is self-perpetuating: behaving in a resilient way increases the probability of further resilient behaviour. Protective factors and resilience have been identified in a number of studies, both general and specific to parental substance misuse (Velleman & Templeton 2007).

Protective factors are now seen as being of major importance and appear to work in a number of ways (Velleman & Templeton 2016). They serve to balance out risk factors some are inconsistent with their opposite. The complexities of protective factors and how they interact with risk factors are addressed further in this chapter

The importance of identifying protective as well as risk factors is recognised in the Department of Health (DOH) Framework for the Assessment of Children in Need and their Families (Department of Health 2000).



Resilience can be difficult to define. It is conceptualised as a process, and as an outcome, as a property that individuals possess, and as something that may or may not develop and change, as a global (set of) characteristics, and as an attribute which may show itself differently in different domains (Velleman & Templeton 2016). Resilience can mean better-than-expected developmental outcomes, competence when under stress; or positive functioning indicating recovery from trauma (Velleman & Templeton 2016). Nevertheless, psychological resilience has been defined as 'the capacity to adapt to and overcome stress and adversity' (American Psychological Association 2014). Both of these definitions accept that being resilient does not mean going through life without experiencing stress and pain (Velleman & Templeton 2016). Rather, individuals demonstrate resilience when they can face difficult experiences and rise above them without major difficulty. Velleman & Templeton (2016) argue that Resilience has a number of core characteristics: Resilience is a process rather than a trait, it is not a rare ability but can be found in many (probably most) individuals, people may be resilient in some areas and not in others, it is also not something that people are either born with or not; it can be learned and developed across the lifespan through cognitive processing, self-management skills and knowledge. Supportive relationships (with parents, peers and others), as well as cultural beliefs and traditions, are all crucial. It is a fluid process; it is not a single variable. It is open to change over time and according to circumstance, and it is influenced by a range of individual, family, environmental and societal variables (p. 112).

In a literature review on Promoting Resilience – a review of effective strategies for child care services, Newman (2002) highlights that there is a worrying situation where children are seemingly being affected by an absolute increase in many serious problem areas, accompanied by an apparent weakening in their capacity for natural resistance (Newman 2002). The promotion of resilience may be an important strategy in attempting to reverse this trend, through placing more emphasis on factors that promote well-being, and not just on the identification and elimination of risk. The promotion of resilience is not simply a matter of eliminating risk factors, as the successful management of risk is a resilience promoting factor in itself (Newman 2002).

Velleman & Templeton (2016) in their review of the literature on the impact of parental substance misuse on children, argue that the concept of and theories about resilience provide a framework for studying the interplay between risk and protective factors, and highlight three

fundamentals of resilience, and key domains which underpin resilience. The three fundamentals of resilience highlighted by the authors were: a secure base (a sense of belonging and security), good self-esteem (an internal sense of worth and competence), a sense of self-efficacy (a sense of mastery and control, along with an accurate understanding of personal strengths and limitations). These fundamentals are influenced by a wide range of elements, based on three factors- attributes which the young people themselves hold, aspects of their families, and characteristics of their wider social environments (Jaffee 2007), which are then further broken down into key domains which underpin resilience- secure family attachments, education, friendships, talents and interests, positive values, and social competencies (Daniel & Wassell 2002). Velleman & Templeton (2016) conclude their section on resilience by stressing the importance of not conceptualising resilience as an all-or-nothing phenomenon, nor as being fixed in time- an individual may demonstrate major strengths in some areas and yet have difficulties in others. Sometimes the appearance of resilience can mask other difficulties, and a factor or process which may be protective in one domain may be less protective in another (Velleman & Templeton 2016).

### **1.6 Considerations in choosing a conceptual framework**

One of the first extensive studies unpacking the experiences of adults who grew up with a problem drinker was provided by Velleman & Orford (1999). The study helped to challenge the dominant 'disease' model of addiction and challenged the hereditary nature of problem substance use. Similarly, it helped problematise the perception that all children who grew up around parental problem drinking are affected in clearly identifiable ways and are affected for either 'set' periods of time or continuously throughout their lives. This study helped to address the assumption that problem drinking is the cause of problems in the family, instead adding weight to the argument that substance use problems are symptomatic of wider structural issues causing 'disharmony' within the family unit.

In a critical review of national and international research examining Maternal and Paternal Drug Misuse and Outcomes for Children- Identifying Risk and Protective Factors, Scaife (2008) highlighted the importance of the choice of theoretical models of drug use, which can subsequently influence investigations. They argue that it is important to avoid implicitly adopting a model of parental drug misuse which locates all risk factors for child outcomes in the skin of drug-misusing parents and highlights the value of adopting Bronfenbrenner (1979) ecological framework as a useful conceptual framework for reminding researchers to avoid this

pitfall. This model proposes that factors contributing to child development are variously located (e.g. in a child's individual biology, immediate environment, socioeconomic and cultural context; (DeHart *et al.* 2000)) and that events in one location may influence events in another (Scaife 2008). The author refers to a review by Hogan (1998) on the psychological development and welfare of children of drug use, who argued that some theoretical models of drug misuse (e.g. disease-based accounts) are problematic because they are biologically and individually orientated, overly simplistic, ignoring the sociocultural and political context contexts of drug use and the complexity of factors giving rise to and maintaining this, and emphasise deficit rather than competence, perhaps guiding researchers to seek evidence of inadequacy (Hogan 1998). In contrast, utilisation of a risk and protection-focused paradigm can help ensure that researchers consider the diversity of factors influencing outcomes for children in families affected by parental drug misuse. This approach is important because even in high-risk environments, factors may exist which can act to protect children from harm (Hogan 1998, Scaife 2008).

Hogan (1997) in her research on the social and psychological needs of children of parents who use drugs, highlighted that a deficit within the existing research is the lack of conceptual frameworks informing the research, and argued the value of adopting the Bronfenbrenner's Ecological model to investigate children of parental substance misuse. Bronfenbrenner's core argument is that human development is a complex process of reciprocal interaction between the individual and a multi-layered system of contexts, ranging from the immediate environment of the home to the societal level. The model considers the inter-relation between four factors : person (characteristics of the developing person), process (the mechanisms operating to influence psychological outcomes), context (persons and events at different levels of proximity to the developing person from the Microsystems of the home and local community to the macrosystem of the culture) and time (the historical time period in which the events take place) (Bronfenbrenner 1979). Hogan (1998) argued that the advantage of adopting such a model is that it can capture the complexity of influences that impinge on child development by focusing attention both on child and context as they relate to each other and produce individual child outcomes (Hogan 1998). In the case of parental drug use, it would therefore imply consideration of the interaction between individual characteristics of the child him- or herself, such as age and gender, and multiple levels of context such as their parent's drug-related behaviours and caregiving competencies in the home, relations between family and school, the support

available on the community, and the socio-economic position and service provision for drug users in the broader society in a particular time period (Hogan 1997).

Similarly, in their literature review on Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do, Dawe *et al.* (2008) argue that while it is well established that children raised in families with parental substance misuse often have poor developmental outcomes, parental substance abuse co-exists with other risk and protective factors across multiple areas of family life and it is the sum of these various influences that determine the outcomes of children. The authors highlight the importance of exploring the issues within an ecological framework:

Within an ecological model, child outcome is considered to be the consequence of a complex interaction between personal, developmental, familial and environmental factors, over time and across social contexts.....Complex behavioural problems....are seen not as stemming from a single causal variable; instead, there are several pathways to their development and various risk and protective factors can be identified (Dawe *et al.* 2008).

In 2013, Templeton carried out a literature review on Building Resilience and Reducing Risks in Children Affected by Serious Untreated Parental Mental Illness, Problematic Substance Use and Domestic Violence, and highlighted that social and ecological models (such as Bronfenbrenner's ecological systems theory) can be useful to shape an understanding of how children are affected by family and social adversity and the environments in which risk factors operate (Templeton 2013). Similarly, Moe *et al.* (2007) in their study on 'Resilience in Children of Substance Users' reported that they recognize that risk and resilience are complex concepts that require dynamic variables with multiple mechanisms and processes within ecological and transactional models (Bronfenbrenner 1979, Sameroff *et al.* 1987, Masten 1994, Kumpfer 1999, Rutter 1999).

Practically speaking, ecological theory offers a means for understanding the external influences upon the child and his/her subsequent development. The ecological model offers a way to a greater understanding of the context in which the child lives and the interrelationships between those contexts and the development. In order to understand human development, one must consider the entire ecological system in which growth occurs (Bronfenbrenner 1994). For research exploring lived experiences of risk and protective factors of children, a theoretical framework that positions the child as central, whilst concurrently facilitating the exploration of

the influence of different contexts on the child, Bronfenbrenner's Ecological systems theory provides a suitable framework for exploration and analysis (Hogan 1997, 1998, Dawe *et al.* 2008, Scaife 2008, Templeton 2013).

### **1.7 Additional complexities in understanding risk and protective factors**

A number of literature reviews exploring risk and protective factors for children have taken place (Velleman & Templeton 2007, Scaife 2008, Park & Schepp 2015, Wlodarczyk *et al.* 2017). The focus of these reviews have varied in multiple ways across the following dimensions- the adversity under consideration (parental substance use versus multiple/other adversities), the substance under consideration (drugs collectively, or one main substance, or alcohol, or both), the nature of the drug use, defining the nature of the drug use, different levels at which risk and protective factors can operate (individual/child, parent, family, social/environment/community), with some authors focusing on numbers levels, and others focusing only on one level and different outcomes that can occur for children.

Literature reviews focusing predominantly on one specific adversity (parental substance misuse), considering both risk and protective factors, in relation to multiple types of outcomes, and exploring these factors operating at multiple levels of a child's ecosystem were carried out (Velleman & Templeton 2007, Velleman & Templeton 2016). Other literature reviews focused on drug misuse only and focused predominantly on risk and protective factors mainly at one level of the child's ecosystem i.e. family (Scaife 2008), whilst other reviews were focused solely on children of alcoholics, but explored factors operating at multiple levels within the ecosystem (Park & Schepp 2015). Other studies considered the impact of multiple types of adversities (Parental substance misuse, mental health, domestic violence), addressing both the individual, collective and cumulative impact of these adversities for children (Cleaver & Unell 2011, Templeton 2013), while others focused mainly on protective factors operating at multiple levels of the ecosystem but in relation to one type of outcome- mental health outcomes (Wlodarczyk *et al.* 2017). Regardless of the specific focus of the studies, all of these literature reviews highlighted the importance of the consideration of both risk and protective factors, whilst simultaneously drawing attention to both the different levels at which these factors can interact and operate and the importance of consideration of these issues when exploring parental substance misuse, the complexities inherent within risk and protective factors and subsequent impact on children, of the bi-directional nature of interaction between the child and the environment and child agency, and of the 'collision of circumstances' that can pervade the lives of parents who use substances, resulting in a complexity of issues that often makes it difficult

to disentangle the specific contribution of substances on parenting capacity and subsequent impact on children.

Scaife (2008) highlighted other research supporting a risk and protective paradigm by exploring the work of Rutter (1999). Rutter (1999) considered how both risk and protective factors contribute to outcomes for children. A risk factor inflates the likelihood that a person will experience some negative outcome and a protective factor reduces it, but accumulated risk factors seem more predictive of outcomes than single risk factors, reflecting a complex relationship between risk and protective factors in determining outcomes, one which is compounded by variations in the extent to which individuals are vulnerable or resilient to adversity (Rutter 1999). A particular whole-family event may have a different impact on different children and particular factors may act to risk or protect depending on context. Existence of positive and negative chain reactions amongst risk and protective factors must be recognised (Scaife 2008). Increasing the presence of positive chain reactions and reducing the presence of negative ones may ultimately promote positive outcomes (Scaife 2008). Scaife (2008) also highlights that research needs to identify the protective factors that exist in families where there is parental drug misuse; thus, systematic detailing of factors which can act to risk and/or protect children is a necessary starting point for beginning to understand how such factors then combine to determine outcomes (Scaife 2008). The literature review by Scaife (2008) focused on both maternal *and paternal* contributions because to date, research has focused on maternal rather than paternal drug misuse, which the authors argued has been highlighted as representing a significant short coming in the literature. Similarly, Velleman & Templeton (2016) in their review of the literature identified that Parental gender will influence the role of a protective factor and that it is believed that research has not done enough to consider the specific impact on children, and fathering, where paternal problems are present.

In 2007 Velleman & Templeton carried out a literature review on Understanding and modifying the impact of parents' substance misuse on children (Velleman & Templeton 2007). In 2016 the authors

carried out an updated review of the literature on the Impact of parental substance misuse on children, to establish how research over the past decade, (since their 2007 literature review), both supports existing knowledge about the risk factors that children affected by parental substance misuse face, and adds to knowledge about the protective factors, protective

processes and evidence of resilience which can reduce the likelihood that children will experience poor outcomes.

In the 2016 paper, the authors briefly considered prevalence, impact and risk factors, before concentrating on recent findings and emerging understanding relating to protective factors/processes and to resilience (Velleman & Templeton 2016). They also examined what practitioners and services can and are doing to modify the impact of parental substance misuse on children, and finally clarified what has been learned over the past decade and what gaps remain. An overview of key learnings from their studies are presented below.

In relation to impact on children, the authors confirmed that recent evidence corroborates the conclusion that parental substance misuse can have numerous negative consequences for children (Velleman & Templeton 2016). Negative effects reported included emotional and mental health problems, development of alcohol and drug problems in adolescence and beyond, early sexual relationships and relationship difficulties later in life, academic underachievement and conduct and behavioural problems (Velleman & Templeton 2016).

In relation to Risk, the authors identified that there are two main pathways through which children are at increased risk of poor outcomes- parenting and wider family environment, and children's exposure to additional risks (Velleman & Templeton 2016). In terms of factors in parents lives and relationships which have the potential to exacerbate children's problems, the authors refer to the findings from 2007 and confirm that as with the 2007 paper, these factors have a cumulative effect, and that the more present, the higher the risk of negative outcomes. In the 2007 article the authors highlighted an explicit range of factors in parents lives and relationships that have the potential to exacerbate the children's problem. The authors highlighted that there are a number of structures and functions within the family often disrupted by alcohol or drug misuse. These were identified as Rituals, Roles, Routines, Communication, Social Life, Finances, and relationships and interactions. The authors argued that being a child of parental substance misuse could lead to a number of negative experiences for children including experiencing violence and abuse, neglectful parenting, inconsistency from parents, negative emotions such as shame, fear embarrassment, and possible neurodevelopmental consequences. These and other disruptions can have a strong impact on children at all stages of their development, placing them at risk of developing a wide range of problems. Problems identified for children included behavioural disturbance, antisocial

behaviour (conduct disorders), emotional difficulties, behavioural problems and underachievement at school, social isolation, and precocious maturity. In relation to adolescent's, the authors articulated two common patterns that can emerge- increasing introspection and social isolation, friendship difficulties, anxiety and depression, and attempts to escape home. Secondly, development of strong peer relationships, which may involve sub-cultures of anti-social activity, risk taking, and substance use. The authors concluded that these negative effects could continue into adulthood (Velleman & Templeton 2007). Finally Velleman & Templeton 2007 highlighted risk factors that can lead to worse outcomes under the headings of general factors (family disharmony, domestic violence, abuse, neglectful or ambivalent or inconsistent parenting, absence of stable adult figure, parental loss, material deprivation and neglect, and family not seeking help); substance specific factors (both parents are misusing substances, substance use taking place in the home, nature of severity of drug use; and drug related factors (exposure to/awareness of criminal activity, witnessing injecting and paraphernalia accessible).

In the 2016 review, the authors highlight key points in relation to risk factors for children of parental substance misuse (Velleman & Templeton 2016). These risk factors included potential impact of relapse on children, the presence of mental illness and or domestic violence, wider environmental factors including poverty, discrimination, housing, social exclusion, unemployment, the presence of risk factors at multiple levels (individual, parent, family and environment), the presence of multiple problems, the duration and severity of problems, the gender of parent, the impact of subsequent conflict and disharmony arising for problems, children living in an atmosphere of fear, chaos, uncertainty, secrecy and shame, which can be compounded by barriers to seeking help including a loyalty to parents. Finally, how children are affected is influenced by variables such as gender, age, development and culture, with problems which are present at key developmental stages or transition periods believed to be particularly influential.

In the 2016 review, the authors highlight key points in relation to risk factors for children of parental substance misuse (Velleman & Templeton 2016). These key points included:

- All areas of a child's life can be negatively affected - in both the short-and the long-term.
- Relapse cycle can impact children



- Co-occurring parental mental illness and or domestic violence raises risks significantly. Domestic violence is believed to be a significant risk factor.
- Wider environmental risk factors (poverty, socioeconomic disadvantage, housing, social exclusion, unemployment and public health concerns)
- Risk factors arise at each of the individual, parental, familial and environmental levels.
- No two children (and no two families) are the same. Siblings are affected differently. This means that although there are clear probabilistic associations between various risk factors and poor outcomes, these associations are not straightforward or generalisable for any given child
- Multiple problems present greater risks for children. This risk is cumulative. Duration and severity of problems influences child.
- The presence of various combinations of the issues above can greatly affect parenting, relationships and attachments between parents and children, and everyday family life which can lead to family conflict and breakdown. Children can be more affected by these issues than they are by the problem themselves.
- Children are affected is influenced by variables such as gender, age, development and culture. Key developmental stages and transitions periods are particularly influential.
- Parental gender influences how a child is affected- but less research available on the paternal impact.

However, in concluding the risk section in the 2016 review the authors argue while children can be impacted, children and families are unique so rules about risks and outcomes are not generalisable.

Velleman & Templeton (2016) summarise that what is clear is that risks are greater if:

- There is exposure to multiple problems (the presence of domestic violence and abuse noted as particularly potent),
- The child lives with two parents with problems
- There is greater length and severity of the problems
- There is significant 'fall out' associated with problems, both within the family (e.g. Disharmony) and outside (e.g. Significant disruption, association with the criminal justice system) (p 109).

## 1.8 Additional complexities in understanding protective factors

In relation to protective factors specifically, Velleman & Templeton (2016) reported that over the past decade much more is now understood about protective factors, and that protective factors are now seen as being of major importance. The authors highlighted that protective factors, like risk factors, exist at multiple levels- Individual (child), Parent, /Family, and Community/Environment. However, when exploring the research on protective factors, the authors highlighted that there have not been many studies undertaken into protective factors and their relationship with resilience specifically with children living with parental alcohol/substance misuse.

The key protective factors in various domains, as revealed in the literature reviewed in their article, were summarised and are presented in Fig 1 below (Velleman & Templeton 2016). The list is an extensive list of multiple factors existing across different levels, including factors intrinsic to the young person. This list of protective factors highlights a number of factors at the level of the young person that can mediate the impact of parental substance misuse- these include the young person's own active agency, internal locus of control, personal qualities and social skills, hobbies, talents, own substance use, religious faith, coping skills, intellectual capacity, and achieving a balance between looking after themselves and supporting the parent.

At the level of the family the authors identified general factors and factors specific to the parent who misuse substances. At the general level, factors included knowledge of protective factors, supportive trusting relationship with a stable non substance using adult e.g., grandparent, early and compensatory experiences, consistency and stability in everyday life, small family size, large age gaps between siblings, adequate finances, good home environment, absence of domestic violence/abuse and family breakdown, positive care style of parents, and parental modelling of expected behaviours.

Factors specific to parental substance problems included problems of milder duration and shorter intensity, parent being in treatment, one parent who does not have problems, drug paraphernalia is kept away from children, and substance misuse happens away from the home.

The final list of factors identified exist at the community/environmental level. These include community engagement, supportive social network, strong bonds with local community, strong

friendships and relationships with peers, support from an adult, teachers' expectations and discipline, and support from key community services.

The authors highlight evidence of resilience that these protective factors encourage, including active agency, high self-esteem, good self-efficacy, problem solving skills, feeling that one has choices, previous experience of success and achievement, feeling safe, secure and loved.

Key points relating to the relationship between resilience and the range of factors which may serve to protect children of problem substance users were articulated by the authors (Velleman & Templeton 2016):

- It is not a foregone conclusion that children living with parental problematic substance use (even if associated with other parental or family problems such as parental mental illness or domestic violence) will be adversely affected and have poor outcomes. Many children have the potential to be resilient
- Protective factors and processes can reduce the likelihood of poor outcomes for children and build their resilience. There are no straightforward and generalisable associations between a protective factor and a better-than-expected outcome or resilience. A protective factor is not necessarily the opposite of a risk factor.
- Protective factors are influenced by their interactions with each other, by the number and severity of risk factors, and by variables such as age, development, gender and culture. The most important protective factors are believed to be the presence of a significant caring adult in the child's life, the child's own temperament, engagement with school and other community activities, positive parenting and peer support, and a swift resolution to parental problems. Relationships, particularly with parents (and/or other primary caregivers) and particularly in a child's early years, are thought to be the 'roots of resilience'.
- Parental gender will influence the role of a protective factor. It is also believed that research has not done enough to consider the specific impact on children, and fathering, where paternal problems are present.
- Resilience may be complex. A protective factor in youth may not operate as such in adulthood; the same factor (e.g., avoidance as a coping strategy) may be both beneficial and detrimental at different times and stages (p. 113).

Within these key points, the authors draw attention to what are believed to be the most important protective factors. What is immediately evident from this list, is that these protective factors range across the different levels and incorporate internal protective characteristics of the young person. When comparing the protective factors identified in 2007 with those identified from the literature in 2016, it is clear that the number of protective factors at the level of the individual grew significantly between the 2007 paper and the 2016 paper. In addition to this, the list of protective factors identified in 2007 did not contain an explicit list of factors at the community/environmental level. In the 2007 paper, the body of protective factors were reported as residing within the family level. This highlights the growing body of knowledge in relation to both the importance and the complexity of protective factors and the need to be vigilant to explore factors external to the parent who uses substances. However, in relation to this issue, Velleman *et al.* (2016) did report that although more recent research is beginning to focus on internal protective characteristics, and that as such the evidence of the active agency of children is an important concept for service models to adopt, it is still the case according to the authors, that protective factors located within the family, particularly in terms of parenting and parent–child relationships, seem to be central. The early years and key stages of a child’s development appear to be critical times at which children can be at increased risk of poor outcomes and when a protective factor or process can be most influential. In addition, the importance of external support needs to be acknowledged (Velleman & Templeton 2016). The authors conclude that more research is needed in this area to build on this growing body of research.

Table 1: Protective factors and resilience in children affected by parental substance misuse, as revealed in the literature (Velleman & Templeton 2016, p.111)

| Individual factors  | Family  | Community/environmental factors   |
|---|---|---|
|   | <b>General</b>  | Cultural connectedness, values and identity   |
| <b>Internal locus of control</b> – a sense that they can make a difference to their circumstances and have the power to change their situation                                      | Supporting and trusting relationship with a stable (non-substance misusing) adult (e.g., uncles, aunts, grandparents)   | Support from an adult/adult role model (e.g., teacher, neighbour)   |
| <b>‘Active agency’</b> in adopting coping strategies, seeking support and choosing what to share and with whom.   | Close positive bond with at least one adult in a caring role (e.g., parents, older siblings, grandparents)  | Strong friendships and relationships with peers, including those who a young person can talk to about the problems at home      |
| <b>Personal qualities/ social skills</b> (e.g., expression of feelings, knowledge, life choices, self-reflection, easy individual temperament/ emotional regulation, self-efficacy) | Early & compensatory experiences/good relationship with primary carer(s) in 1st yrs. of life; low levels of separation from the primary carer in 1 <sup>st</sup> Yrs. of life | Living in a community where there is a sense of caring, mutual protection   |
| <b>Having a hobby/creative talent/outside activities/interests</b>  | Demonstration of affection from members of extended family  | Community engagement, supportive social networks;   |
| <b>Self-monitoring skills and self-control</b>  | Parental self-efficacy and good parental self-esteem  | Positive school experiences and influences; opportunities through education and employment – out-of-school/community activities |
| <b>Coping and problem-solving skills</b> – ability to think about and make decisions about coping   | Family observing traditions and rituals (cultural, religious, familial)   | Attendance at school, achievement, monitoring of progress and acknowledgement of success  |
| <b>Plans for the future/yearning for a better future</b>  | Consistency and stability in everyday family life   | Teachers’ expectations and discipline   |
| <b>Intellectual capacity</b>  | Openness and good communication within the family   | Positive opportunities at times of life transition  |
| <b>A sense of humour</b>  | Child having family responsibilities  | Support from key community services such as healthcare  |
| <b>Sense of self-strength</b> relative to parent  | Small family size, larger age gaps between siblings   |   |
| Perceptions of ‘substance misuse’ behaviour. <b>Good knowledge and understanding of the parental problem(s)</b>   | Adequate finances/employment /income; good physical home environment  | <b>Evidence of resilience that these protective factors encourage</b>   |
| <b>Not taking drugs or drinking</b>   | Constructive coping styles, deliberate parental actions to minimise adversity   | Deliberate planning by the child that their adult life will be different  |
| <b>Achieving a balance</b> between supporting the parent(s) and looking after themselves  | Knowledge of protective factors   | ‘Active agency’: see Individual factors a   |
| <b>=Religion or faith in God</b>  | Strong family norms and morality  | High self-esteem and confidence   |

|  |  |  |
|--|--|--|
|  | Characteristics & positive care style of parents                       | Good self-efficacy   |
|  | Parents having high expectations of child, clear communication of same | A sense of direction or mission  |
|  | Parental modelling of the behaviours expected                          | Skills (both verbal & cognitive) & values that lead to good use of personal abilities to achieve |
|  | Absence of DV/abuse, family breakdown and associated losses            | A range of problem-solving skills  |
|  | <b><i>Specific to parental substance problems</i></b>                  | An ability to deal with change   |
|  | Parental problems are of mild intensity and shorter duration           | Feeling that there are choices   |
|  | One parent does not have problems                                      | Feeling in control of own life   |
|  | Parent is receiving treatment  | Previous experience of success and achievement   |
|  | Drug paraphernalia, activity/associates are kept away from children    | Feeling safe and secure, loved and cared for<br>An ability to play                               |
|  | Substance misuse occurs away from the home                             | a. 'Active agency' is both a protective factor in itself and also evidence of resilience         |

As mentioned earlier above, when exploring the research on protective factors, Velleman & Templeton (2016) highlighted that there have not been many studies undertaken into protective factors and their relationship with resilience specifically with children living with parental alcohol/substance misuse. The authors identified three important and more recent qualitative studies in this area are from the USA (Moe *et al.* 2007), Israel (Ronel & Levy-Cahana 2011) and Scotland (Backett-Milburn *et al.* 2008). All three studies talked directly to children and young people, who offered their perspective on what might be important protective factors which can create resilience in relation to parental substance misuse. These studies draw out some of the complexities in this area (Velleman & Templeton 2016). Velleman & Templeton (2016) recommend further research into the protective factors for children that can create resilience. For the purpose of this thesis, each of these individual studies are reviewed below.

### **1.9 A review of three specific studies on protective factors and their relationship with resilience**

Moe *et al.* (2007) in their study on ‘Resilience in Children of Substance Users’ reported that to date, the empirical studies on understanding what children of alcoholics and parents who use other substances experience, have relied primarily on quantitative data to understand the individual and environmental factors associated with the lives, the developmental trajectories, and the growth of children, with very few studies having used qualitative techniques to collect data. The authors argue that while qualitative techniques are not necessarily the most popular approach in psychosocial research, in part because research traditions discount this method in favour of quantitative techniques that give us data more amenable to sophisticated modelling procedures, qualitative data can make substantial contributions to ones understanding of resilience by studying resilience in its specific context and gives a voice and meaning to the phenomena (Moe *et al.* 2007).

The authors also noted that many of these studies focus on their risks, and very few of them focus on their strengths. Despite the obvious risk of growing up with a parent who drinks too much or abuses illicit substances, many children of alcoholics and substance users do not become substance users themselves, and many move on to live healthy, adaptive lives as adults (Moe *et al.* 2007). The authors highlight that research that contributes to an understanding of factors that lead to resilience has enormous implications for practitioners and researchers alike, and caution against the tendency to use a deficit framework in characterizing children of alcoholics and substance users.

In their study Moe *et al.* (2007) address a number of gaps identified in the literature, by adopting a qualitative design, by including the voice of the child, and by adopting a strengths-based approach. The themes in the findings included the need for children to relieve themselves of the blame for their parents drinking, the importance of the parent attending treatment, and the internal resources of the children (expression of feelings, knowledge about the parent's addiction, and life choices). The children identified three important paths that educators and health practitioners can use to help them arrive at discovery of their own unique resilience characteristics- providing a venue in which to express their feelings, educating them, and showing them that there are other ways to live. Moe *et al.* (2007) argue that Intervention and prevention programs that attempt to promote and maintain success might enhance development and promote healthy outcomes despite adversity by providing a venue in which children of alcoholics and other types of substance users are able to find opportunities for expression, education, and lives without alcohol or the use of other psychoactive substances. While this study aimed to respond to the highlighted gaps in the existing research methodologies, and the predominant tendency for research to be deficit based, the findings from this particular study were drawn from one interview question of a total of 8 questions. The question aimed to elicit the child's perception of what it would mean to be resilient, - what helps children of parental substance misuse have a good life. Eight sub themes emerged. The authors concluded that additional research is needed to explore further the factors helps children become resilient.

Backett-Milburn *et al.* (2008) in their research on 'Challenging Childhoods-Young people's accounts of 'getting by' in families with substance use problems', highlight that in studies of parental substance misuse, concern about outcomes for children has, in the past, led to a concentration on risk and pathology. However, often such work implicitly contained a notion of resilience as some children had better outcomes than others and some appeared relatively unaffected by their experiences (Backett-Milburn *et al.* 2008). More recently, there have been attempts to understand conditions for positive outcomes and how these might be fostered. Being resilient at one point in the life course does not automatically guarantee positive outcomes at another point; resilience may be 'context sensitive' as different factors can promote/sustain resilience in different circumstances and, indeed, at different points in the life course of childhood (Backett-Milburn *et al.* 2008). Resilience has been viewed as both a *process*, routed in the social world, and an *outcome*, routed in the individual, and highlight that most



research remains essentially outcomes focused, with much less being known about the everyday social processes, interactions, and incidental events that may constitute resilience promoting contexts, or indeed, how they are made sense of at the time, or in retrospect, by the individual, or individuals concerned (Backett-Milburn *et al.* 2008).

While challenges facing children growing up in families with parental substance misuse are a growing concern, relatively little is known about the perspectives of the children themselves (Backett-Milburn *et al.* 2008). According to the authors, the social science of childhood and youth has shown that, while children's lives are constrained and influenced by sociocultural contexts and by the adults surrounding them, children nevertheless exercise their own agency, creating and recreating their own social worlds. The authors challenge the reader to avoid the compulsive urge to refer to children as a unitary phenomenon (Backett-Milburn *et al.* 2008) Furthermore, the authors point to studies that highlight that how children view and experience many issues seen by adults as 'problematic', often reveal somewhat different perspectives on the part of the child (Backett-Milburn *et al.* 2008). Where research does exist, the tendency has been to focus mainly on younger children, which the author argues limits the understanding of the nature and impact of the problem on children as they grow up, and their own responses to it. (Backett-Milburn *et al.* 2008).

Thus, in response to the gaps identified above, in their research, Backett-Milburn *et al.* (2008) carried out qualitative interviews with 38 young people aged 15 to 27. This age range was chosen as it is a transitional phase, allowing for reflection on past experiences and possible futures. An important part of their study was, to explore the practices, processes and mechanisms that young people themselves identified as everyday ways of 'getting by' and 'getting through' these challenging experiences in their childhoods, exploring their own perspectives on what helped and what hurt on a daily basis. In the study, the young people described a variety of ways in which they had protected themselves and others. However, the authors note that within these strategies, the child's agency was constrained by the spaces and places available to them. These strategies varied depending on the age of the child and supports in place. Each strategy identified had limitations for the young people.

The key strategies adopted included strategies within the home and outside of the home. Within the home, Siblings were reported as a key social resource. Observing these reactions either played a part in how respondents found their own way through the situation or were used to justify decisions respondents themselves had taken. Other strategies within the home included

challenging the user and removing oneself from the situation such as escaping to their room when younger, or leaving the home completely when a little older, Ways of 'getting by' outside the home included going to school, (as schools could offer social activities and resources of potential value to respondents e.g., Sport), friendships, and extended families. Respondents also reported the importance of family overall, and the importance of being cared about. The interviews suggested that being a parent who misuses substances seemed to be something that, if not ever accepted by their child, could, nevertheless, be made sense of, perhaps with help and especially if that child was now out of the family situation. Being a rejected or abused child was a different matter. Finally support, having someone to talk to and who makes you feel cared for was important, although closeness did not necessarily translate to discussion of problems at home as this was complicated by a need that children felt to not disclose what was taking place at home, particularly while still living at home.

The Backett-Milburn *et al.* (2008) study is important because it draws out some complexities in this area (Velleman & Templeton 2016). Their study highlights that identified coping strategies and supports could be 'a double-edged sword', further stressing that, 'the protective factors classically thought to promote resilience were seldom in place for these children unconditionally and without associated costs. Young people's reports of being children in such complex contexts suggest that practices that may be deemed resilient or active at the time are seldom without contingencies, risks and potential future problems. Moreover, while still living with their parents, many respondents feared that disclosure of parental substance misuse would result in their being taken away from home. It seemed that the risks attached to losing their families were greater for many of the sample than the challenges of continuing to live with them (Backett-Milburn *et al.* 2008). Some practices that helped the young people to 'get by' at the time often, can be physically, psychologically or socially problematic in the longer term. In this study the authors noted that they deliberately avoided consideration of the role of social services in these young people's lives. Given the key role that social services can play in the lives of children of parental substance misuse, future research in this area would benefit from exploring the practices, processes and mechanisms that young people themselves identified as everyday ways of 'getting by'. The authors concluded that Getting by in these childhoods seemed therefore to involve creating fragile webs of practices and processes that might help for a while, or at the time, but which were always potentially flawed, susceptible to damage, or open to disruption from the adult world (Backett-Milburn *et al.* 2008).

Ronel & Levy-Cahana (2011) carried out a qualitative phenomenological study to examine the experience of adolescent children of substance-dependent parents as “persons-in context” against the background of a parent’s dependence. The authors chose a phenomenological method to allow them to learn directly from the life experience of the adolescents. The objective in this study was to describe and interpret major aspects of the family experiences of adolescents with a parent who is either actively addicted or in recovery and to examine how factors of that experience influence the direction of the child’s development. The authors reported that the participants who opted for survival shared an orientation toward finding a sense of belonging and security in the world. Some of the participants sought and succeeded in finding a solution for this drive in the noncriminal, no-drug world, in some cases following the recovery of the addicted parent and the rehabilitation of family life and in others with the support of the healthy family members or by becoming part of a substitute framework. Failure to hold onto a normative framework impelled other participants to seek and find their belonging, security, and acceptance on the street, in the world of crime and addiction. The authors argued that the study provided an innovative perspective on the effect of the growth conditions on the adolescents, focusing on the development of certain perceptions among the adolescents that operate as subjective risk and protective factors. The authors note that while they were aware that substance use represents a “syndemic” (Singer 2006) and relates to a matrix of different interacting forces -psychological, legal, cultural, physiological, social- they decided in the study upon a more focused description of the perceived family relations and its impact on the adolescents, and that their method of inquiry should also be adapted to the study of the wider social context that may play a role in risk or protection.

All of these three studies highlight the need for further qualitative research exploring protective factors and processes, with phenomenologically informed approaches being specifically advocated for within one of these studies. Furthermore, the literature reviewed highlights the need for further qualitative research that incorporates where possible, the voice of *both* parents to address the limited research in relation to fathers, and the voice of the child, and where possible older children.

This research argues strongly for the need to adopt a more balanced approach in terms of capturing strengths by gathering information in relation to protective factors. Much more is known about protective factors than before, and the importance and complexity of these factors have been highlighted. The relationship between resilience and protective factors has

been highlighted with gaps remaining within this research where the focus has tended to be on outcomes, with much less being known about the everyday social processes, interactions, and incidental events that may constitute resilience promoting contexts, or indeed, how they are made sense of at the time, or in retrospect, by the individual, or individuals concerned. In particular there have not been many studies undertaken into protective factors and their relationship with resilience specifically with children living with parental alcohol/substance misuse. A key advantage of focusing on resilience is that it shifts attention from a focus on problems to developing a child's strengths. The evidence reviewed in this thesis thus far, also argues for the importance of considering these issues within an ecological framework to address the multiple levels within which risk and protective factors interact.

### **1.10 Widening the sources of perspectives**

Over the recent past, while a body of literature on qualitative studies on children of parental substance misuse has been steadily increasing, the focus of this research varies, as does, the source of perspectives. The qualitative research predominantly consists of research concerning impact, needs, and lived experiences, originating from a narrow range of perspectives (Templeton *et al.* 2006).

Predominantly this research consisted of adults' retrospective accounts of their own childhood (Velleman & Orford 1999) or reporting on behalf of their children (Hogan 1997, Barron-McKeagney *et al.* 2002). More recent research made explicit efforts to ensure the direct voice of the child was incorporated through studies consisting of either parent-child dyads (Fraser *et al.* 2009, O'Connor *et al.* 2014) or research involved solely with capturing lived experiences through the sole voice of the child/young person (Barnard & Barlow 2003, Bancroft 2004, Backett-Milburn *et al.* 2008, Bernays & Houmøller 2011, Hill *et al.* 2011).

In relation to both children's and adults' accounts Kroll (2004) in their evaluation of the existing research studies, reported that there was far more material in relation to parental alcohol use than to drug use, and highlighted significant challenges reported by researchers in accessing samples of children where parental drug misuse was involved, driven possibly by fears and anxieties around the potential for welfare intervention and the child's removal (Kroll 2004). Barnard and Barlow (2003) during the course of their two-year qualitative study with children and young people who had drug misusing parents, reported that interviewing the children

proved very difficult and time consuming, with adult gatekeepers frequently making decisions for children over the appropriateness of their participation.

Thus, qualitative research in this area evolved from predominantly capturing the parent perspective, towards capturing child and parent dyads, and also capturing solely the voice of child or young person.

A further development in qualitative research related to a recognition of the value of widening the focus of research to incorporate the key role that stakeholders external to the parent child dyad play in relation to the parental substance misuse and children. Larkin *et al.* (2019) argue that the experience of living with an adverse situation is not solely located within the accounts of those with the 'diagnosis', nor is it limited to the children of these parents. The phenomenon is also located within the accounts of other people who belong to the "lived world" (Larkin *et al.* 2019) and those who play in part in responding to the 'lived world' (Hogan 1997, Houmøller *et al.* 2011, Rostill-Brookes *et al.* 2011, Larkin *et al.* 2019).

### 1.11 Capturing the voice of grandparents

In their research exploring the role of relatives in protecting children from the effects of parental drug problems, Barnard & Barlow (2003) interviewed problem drug using parents and drew attention to the social support provided by relatives, usually grandparents, which the authors reported often plays a vital role in protecting children from being overly exposed to the risks associated with parental drug dependency problems. Barnard & Barlow (2003) also highlighted that while grandparents play a key role in protecting children of parental substance misuse, the role was not without its reported tensions and difficulties for parents, grandparents, and the grandchildren. The role consisted of a complex mix of practical and emotional concerns over children's care. The authors argued the importance of identifying and rectifying factors that can complicate the protective role of relative care, and to prevent future breakdowns in these care arrangements which further expose these already vulnerable children to more instability and damage. The input of the extended family was also reported as being informally recognized by social work and other professions to be a major part of the reason why more such children are not in the care system (Barnard & Barlow 2003). Many other authors have also reported the protective role that grandparents play in the lives of children of parental substance misuse (Horgan 2011, Velleman & Templeton 2016). Barnard & Barlow (2003) conclude by stressing that the role of relatives caring for children is a complex role, yet the tensions inherent within the role have not received the support attention and recognition that is needed. Strained family

dynamics and a lack of a supportive welfare infrastructure can all compromise the ability of kin to provide a stable, nurturing environment for children over time. The tensions within the role are rarely considered, often offset by the assumption that children's needs are best met within the family, which research supports in general. However, this does not negate the facts that these roles can be beset with challenges and difficulties that require attention and research to ensure the child is looked after in the best way possible.

Within Ireland, O'Leary & Butler (2015) explored the experience of grandparents caring for grandchildren as a result of drug dependent adult children and reported that no comparable research had been done in Ireland. The study involved qualitative interviews with 11 grandparents who had assumed full time care of their grandchildren. These grandparents had different degrees of financial and child protection support available to them as a result of the type of care role they assumed (Formal versus Informal). The main finding from their study reported that in addition to the direct stresses associated with caring for their grandchildren (responding to health and behavioural needs of grandchildren, financial difficulties, relationships with family, physical and mental health problems, and support from health and social services) participants experienced further distress because of their sense that they were being taken for granted by social services. Within this research, the authors also articulated additional challenges that can emerge in response to the different type of caring role (Formal versus Informal) that the grandparent assumes with different supports being in place in relation to these different options. Given the multiple stresses that grandparents reported, additional research with grandparents who assume a caring role for grandchildren as a result of parental substance misuse was recommended by the authors to explore the grandparent perspective further. The challenges faced by grandparents in this role are important to research further, as the grandparents are the main carers for the grandchildren, and as such the lives of the grandchildren are intertwined with the welfare of the grandparent.

There is currently a growing body of research exploring the role of grandparents who care for their grandchildren (O'Leary & Butler 2015, MacDonald *et al.* 2018, Gair *et al.* 2019). The focus of this research can vary from research which articulates parental substance misuse as being the specific reason for grandparents assuming the role of carer for their grandchildren (O'Leary & Butler 2015), to research which explores the grandparent carer role with parental substance misuse being mentioned as one of many possible reasons for the grandparent assuming the caring role (MacDonald *et al.* 2018, Gair *et al.* 2019).

MacDonald *et al.* (2018) carried out a narrative review of research on relatives who provide care for children (Kinship care), with an emphasis on those who provide this care in an informal role to address current gaps in the literature in relation to this cohort. The authors reported that while children were cared for by a range of kin - including aunts, cousins, older siblings, family friends and great-grandparents (Sheran & Swann 2007, Saunders & Selwyn 2008) - the majority of informal care was provided by grandparents (MacDonald *et al.* 2018). The broad inclusion criteria of the study permitted a wide variety of quantitative and qualitative methods in the chosen studies. In their review the authors reported that smaller scale qualitative studies complemented the findings of the large scale quantitative research providing a more nuanced examination of meaning and experience, and that these thickly described first-hand accounts provided meaningful insights into the role and transitions of becoming a grandparent caregiver (Bailey *et al.* 2009), and highlighted relevant recommendations regarding support needs (Letiecq *et al.* 2008). In terms of the focus of the studies, MacDonald *et al.* (2018) reported that the majority of the studies focused on the caregiver's experience, and as such there was an acknowledged lack of information about the needs of children living in informal kinship placements. MacDonald *et al.* (2018) reported a vital need that future research should supplement the findings from recent large-scale analyses of census data with qualitative studies that examine, phenomenologically, the needs and experiences of informal kinship carers, and the children for whom they care. Crucially, as most studies have focused mainly on carers, it is important to understand more about the needs of the children. It was axiomatic that children experienced multiple adversities leading up to placement, and continued to display a range of social, emotional, psychological and physical health needs.

Given the findings in relation to the protective role that grandparents can have for children of parental substance misuse (Barnard & Barlow 2003, Horgan 2011, Velleman & Templeton 2016), and the body of literature highlighting the complexities and potential risks for children as a result of the challenges of this role, incorporating the voice of the grandparent into research into risk and protective factors for children is critical. As with the previous section, phenomenological approaches were recommended.

### 1.12 Capturing the voice of service providers

Other key stakeholder perspectives that are important to capture beyond those of the family itself, family, in relation to parental substance misuse, are service providers that respond to

the issue. Staton-Tindall *et al.* (2013) in their systematic review of caregiver substance use and child outcomes, reported that the difference in perspectives between child protective interests and adult rehabilitation mirrors the tension in public policy between goals of child protection versus family reunification. The authors report that these dual foci are often at odds in cases when both cannot be satisfied and one interest must predominate. The authors continue that given the findings about the effects of caregiver substance misuse on children, research that concurrently examines these effects from both the caregiver and child perspective is very limited. Typically, the research has either examined maltreatment among children with some consideration for caregiver substance misuse, or it has been focused on adult substance abuse, with peripheral examination of parenting behaviours. The authors continue that the ramifications of this are that, one body of literature has taken a child protective interest as it examines caregiver substance misuse (Johnson & Leff 1999, Kroll 2004). Another very large body of research has looked at adult substance misuse patterns and the interests and needs of these individuals for treatment and rehabilitation (Magura & Laudet 1996, Testa & Smith 2009). Furthermore, the literature has done little to bridge the gap between these two perspectives by examining how integrated treatment (for substance misuse and parenting) or other interventions might serve both goals. These distinct research perspectives have yielded important information for the substance misuse and child maltreatment fields, but they pose challenges to practitioners and policymakers when converting scientific information into either policy or practice (Staton-Tindall *et al.* 2013).

Velleman & Templeton (2016) in their review of the literature also highlighted a key role that services, both addiction and child and family service, have in relation to children of parental substance misuse. The authors argue that because resilience is the product of an interaction between the individual and their social context, it is potentially open to influence by designing prevention strategies focused on increasing positive factors instead of solely reducing risk. The authors argue that instead of focusing solely on parental problems, practitioners need to focus much more on promoting resilience by developing protective factors in both young people and their families in conjunction with reducing risks. Related to this is the need for practitioners to avoid unhelpful binaries focusing on either the child's or the adult's needs – although the authors do acknowledge that bridging this gap continues to be a persistent problem. In their 2007 literature review, Velleman & Templeton (2007) highlighted that future work was needed to encourage and train professionals to respond in this evolved way. In their 2016 article they explored how far professionals have moved in using these methods of targeting protective



factors and building resilience. Noticeable growth in services and interventions to support children of parental substance misuse were reported with all incorporating some of the ideas of targeting protective factors and building resilience with guidance and toolkits having been designed to support this development. However, the authors reported that this work is scarce, is in its infancy and much more research is needed in the area (Velleman & Templeton 2016).

Specific ways identified that services could best target protective factors to build resilience in children included: operating in a child-centred and family focused way, delivering a range of therapeutic services flexibly and non-judgementally, building children's social networks, and considering the qualities which services need to work in such a way (e.g. staff selection, leadership, community partnerships and evaluation). When services work in such ways, children can benefit from feeling less isolated and better supported (Velleman & Templeton 2016).

In terms of informing national policy and resilience, the authors reported that this focus on protective factors and resilience is helpful, that ideally these approaches need to be embedded into routine practice instead of remaining the remit of research, and the importance of practitioners being aware of the different risk and protective factors and the ways in which they may affect children of different ages. Whilst steps are being made at a policy level within the UK, in terms of responding to children of substance misuse, the focus is mainly on drugs, mainly on high risk children, mainly viewing children a uniform group, and that embracing of resilience within policy is still insufficient (Velleman & Templeton 2016).

In terms of outstanding gaps, the authors highlight that more recent prevalence data is required given the importance of these figures to facilitate appropriate policy and practice responses. In addition to this, the authors highlight the importance of building on the recent research in relation to the complexities of protective factors and resilience, including the active role that children play in responding to their circumstances, the consideration of maternal vs paternal problems, the possible impact of different substances, presence of mental health problems, and the number of risk and protective factors children are exposed to (Velleman & Templeton 2016).

The authors concluded that there remain considerable challenges which practitioners, service providers, and commissioners face in meeting the needs of children, and that services and interventions need to more clearly target protective factors/processes and build sustainable

resilience. For services to be able to do this, they will need to be well supported/funded and sustainable (Velleman & Templeton 2016). Thus, it is therefore vital that practitioners who engage with these children and their families develop a full understanding of resilience and of what protective factors and processes may be present or available that can be part of the response and help offered. Teaching about the effects on children and how to develop resilience needs to become part of core training for psychiatrists, social workers and other front-line professionals (Velleman & Templeton 2016). In response to these gaps identified in both qualitative research overall, and specifically qualitative research incorporating additional key stakeholders' perspectives, a further development in approaches to qualitative research in this area relates to the use of multi-stakeholder perspectives within the one study.

### 1.13 Using multi-perspective research design to explore phenomena

Using a multi-perspective research design to explore child-care placement breakdowns Rostill-Brookes *et al.* (2011) set out to understand the shared experience of foster placement breakdown from the multiple standpoints of children in care, foster carers and social workers. Parental substance misuse was often reported as the reason for the foster placement. In this study, the authors reported that despite the wealth of research exploring risk and protective factors, little is known about the lived experience of the issue and cited findings from a systematic review of the literature by Unrau *et al.* (2008) which looked closely at the range of viewpoints that were used to frame knowledge about the issue, and found that accounts from those most intimately affected by the experience were marginalized in favour of an over reliance on case records and psychometric measures. Unrau *et al.* (2008) also argued that the majority of research had failed to elucidate the quality and meaning of the experience for children and others, and as such, may lead to the misdirection of resources. Likewise, Wilson *et al.* (2000) emphasised that the impact cannot be fully understood without considering the perspective of all the key stakeholders. In light of this, Rostill-Brookes *et al.* (2011) in their research, adopted an approach informed by hermeneutic and phenomenological approaches to psychology, in particular the idea that any process, event or relationship can only be understood from a given perspective (Larkin *et al.* 2006), to enable them to consider the perspectives of key stakeholders in a meaningful way. This concept privileges lived experience as a source of expert knowledge and suggests that researchers should engage closely with people's attempts to *make sense* of those experiences, in order to better understand their relationship to, and involvement in, a given phenomenon (Rostill-Brookes *et al.* 2011). The authors therefore adopted an Interpretative Phenomenological Analysis (IPA) (Eatough & Smith 2006) approach to the data

analysis, an approach that has been used extensively across a range of domains in psychology, and adopted a multi-perspectival method of qualitative data collection (Dallos & Denford 2008, Smith *et al.* 2009). In their research, (Rostill-Brookes *et al.* 2011) attempted to explore both the shared and distinct claims made by participant groups.

In the results, the authors reported that one of the key features of their findings was the way in which the participant groups described common experiences yet retained very distinct standpoints - that despite the many commonalities, a strong sense of fragmentation and detachment dominated many of the accounts, a fragmentation which if left unreported and unacknowledged, can lead to further issues between these groups. Examples of such fragmentation included carers who complained of feeling inconsequential within the broader system, which can result in carers giving up their role, children who felt disempowered, and social workers who also felt overwhelmed and blamed when placements ended in crisis. Fragmentation was the most dominant theme to emerge from the research, both in terms of the content and process. Differences between the participant groups seemed to amplify the negative impact of the placement breakdown and limit opportunities for reconciliation. These experiences emphasised the need for a shared dialogue and greater understanding of each other's positions before change can be achieved (Rostill-Brookes *et al.* 2011). Using hermeneutic and phenomenological approaches to inform their analysis, the authors argued, allowed a rich narrative to emerge that illustrated something of what it meant for each of the key stakeholders involved in the lived world (young people, foster carers and social workers). The intention of the study was not to provide an empirical explanation of the issue under consideration, but to explore the way in which those most directly affected by it, made sense of it, thus adding important experiential and systemic dimensions to the majority of existing research, which has been criticised in the past for de-contextualising and isolating the views of key stakeholders in the placement system (Rostill-Brookes *et al.* 2011). The authors also highlight that although there are considerable benefits to viewing a process from the perspective of everyone involved, compromises have to be made when working with highly complex systems, like those surrounding young people in local authority care, thus views of other influential groups such as birth families, foster carers' own children, and social work managers were not included.

This research above recognised the value in the use of multiple perspectives to explore the same phenomena enabling the capture of complex and systemic experiential phenomena (Larkin *et al.* 2019), and the authors conclude that the multi-perspective approach adds important

experiential and systemic dimensions to the majority of existing research, which has been criticised in the past for de-contextualising and isolating the views of key stakeholders. The multi-perspective approach enables the exploration of shared and distinct claims made by participant groups and facilitates greater understanding of the issue (Rostill-Brookes *et al.* 2011).

In relation to studies exploring parental substance misuse specifically, multiple perspectives have been sought through evaluations of specific interventions or service provision (McKellar & Coggans 1997, Velleman *et al.* 2003, Forrester & Harwin 2006, Zohhadi *et al.* 2006, Taylor *et al.* 2008). However, qualitative research using multi-perspectives in relation to the experiences of the children of parental substance misuse is very scarce. Two studies located which adopted multi-perspective approaches in relation to children of parental substance misuse specifically are discussed below.

In Ireland, in 1997, Hogan explored the needs of children of parent problem drug use (mainly Heroin), in terms of care and welfare provided to them and psychological needs through the multiple perspectives of parents, teachers, professional workers and carers. This study used Bronfenbrenner's Ecological Model (1979) as a conceptual framework to investigate the links between Irish children's social and psychological development and parental drug use. Bronfenbrenner's core argument is that human development is a complex process of reciprocal interaction between the individual and a multi-layered system of contexts, ranging from the immediate environment of the home to the societal level (Hogan 1997). Hogan (1997) argued that the advantage of adopting such a model is that it can capture the complexity of influences that impinge on child development by focusing attention both on child and context as they relate to each other and produce individual child outcomes. In the case of parental drug use, the author argued that it would therefore imply consideration of the interaction between individual characteristics of the child him- or herself, such as age and gender, and multiple levels of context such as their parent's drug-related behaviours and caregiving competencies in the home, relations between family and school, the support available on the community, and the socio-economic position and service provision for drug users in the broader society in a particular time period.

The study explored the impact on children's daily life experiences, impact on school progress, parent concerns about caregiving, and keyworkers concerns about parent caregiving. The

primary finding of the study was of substantial variation in the effects on children of parental drug misuse, depending on a number of inter-related factors, with the quality and consistency of parenting varying. There was evidence that families coped differently, depending on a number of circumstances, including the duration and extent of the drug problem, the type of services available to parents, and the degree of social support from the community and from family members (Hogan 1997). In addition, problem individual children appeared to cope differently with problems in the home associated with parental drug use, showing different levels of resilience, thus it would be incorrect, therefore, to assume that all children are exposed to the same problems, or the same degree of problems, or are at risk for the range of problems identified in the literature (Hogan 1997). While this study did not include the voice of the child directly, a number of important differences in perspectives emerged between the different cohorts, providing a fuller understanding of the issues facing children, highlighting the need to address differences in perspectives to facilitate clearer communication (Hogan 1997). Differences between parents and teacher's perspectives for example, were reported. When parents were asked about their child's performance at school, some were unable to answer the questions due to a lack of contact with their child, mainly as a result of the child being in residential care, or in the care of other family members. Where parents were able to answer questions concerning their child's school progress almost all reported no significant problems or areas of concern. This was contradicted by the teacher's reports who identified academic problems and a number of other concerns including concerns about child's cognitive and emotional development, peer relationship problems and concerns about low parental involvement in child's schooling. This illustrated the importance of interviewing other key stakeholders as well as parents about the child. Similarly, while the keyworker concern echoed, to some degree, the concerns that parents themselves voiced about their levels of parental involvement, the emphasis of the keyworkers' comments, however, was on a more global level of parental involvement. Parents were concerned about the level and quality of attention paid to children while they were physically with them, while keyworkers focused on the amount of time spent with the children, and the consistency with which that occurred. Professional workers and parents also commented on the factors that helped to support parents and strengthened their ability to care for their children while dependent on drugs. The majority of support came from other family members, such as mothers and siblings, and from drug treatment centres. In those cases where family members were providing support, the primary help came from grandmothers and from sisters.

This research by Hogan (1997) provided important developments in relation to the study of children of parental substance misuse. The study was qualitative, incorporated multiple perspectives to provide a more comprehensive understanding of the issue by the key stakeholders involved, and adopted an ecological model to explore issues at multiple levels. The study also captured parenting strengths as perceived by Keyworkers, with a main strength being when parents were engaged with treatment. There were also parents about whom no concerns were raised by the keyworkers. Limitations to the study however included the absence of the direct voice of the child, the focus solely on problem drug use and in this case mainly heroin, and the opportunity to explore in more detail the diversity in perspectives across these key stakeholders. The study provided findings from each cohort, but the opportunity to compare and contrast findings of these different cohorts was limited in the study.

Similarly, Houmøller *et al.* (2011) in a study on coping with parental substance misuse explored young people's lived experiences (daily life experiences). These experiences included family life over time; their coping strategies and ways of managing family life; parents' lived experiences of parenting; and service providers' perspectives on coping at the level of the individual and the family, and on service access and impact. In this research multiple perspectives were captured from young people, significant others, parents and service providers. The researchers chose separate groups of parents and separate groups of children i.e., parents and children who were not related to each other, to avoid ethical concerns that were anticipated around recruitment and write up if using children and parents related to each other. As above with Hogan (1997) study, the authors reported the value in capturing multiple perspectives in highlighting disparities in perceptions of and understandings of lived experiences. A key finding in this research related to the difference in perspectives between parents and children. One example of this is where parent accounts reported adopting 'protective' strategies of keeping their drug use hidden from the child - 'that which cannot be seen, cannot do harm for it cannot be known', and giving repeated emphasis to the "fact" that children had "never" seen evidence of drug use. The belief underlying this is 'unseen is unknown'. However, a number of children reported witnessing the substance use despite their parents believing they had kept it hidden, and even in cases where some children hadn't "seen" the drug use, they still reported that they were aware that something was wrong, something was going on. The protective strategy employed by the parent was not effective in the way parents perceived it. The findings reported above highlight the importance of capturing multi-perspectives in relation to children of parental substance misuse in order to address current concerns about gaps in research findings which

focus on gathering isolated voices of key stakeholders. This research is missing an opportunity to obtain a more holistic view of the phenomenon under question.

### 1.14 Summary

Although there is an expanding literature examining the risk and protective factors connected with parental substance misuse, very few studies have explored the lived experience of risk and protective factors for children of parental substance misuse, from the multiple perspectives of those most closely involved with it. Bringing together the lived experience of these key stakeholders presents a novel dimension to the existing research knowledge.

Research in the area of children of parental substance misuse consists of voices of parents, and in more recent years, children themselves, with fewer studies involving the voice of the grandparent who in many cases assumes the role of carer for children of parental substance misuse, and whilst service provision plays an important role, the voice of service providers as a key source of information is limited. The collective experience of parental substance misuse from the multi-perspectives of parents who use drugs, grandparents caring for the children of these parents, adult children exposed to parental substance misuse, and key instrumental service providers, at one point in time, across one geographical location, in relation to risk and protective factors is absent from the literature.

According to the UNCRC children have the right to survive, to be protected from harm and exploitation, to develop fully and to participate in decisions which affect their wellbeing (United Nations Children's Fund 1999). In addition, they deserve respect, information, support and prevention services, and an opportunity to help decide how to attain a healthy future. Unquestionably many of these rights are routinely undermined by problems relating to alcohol and other drugs. Problematic use of alcohol and other drugs is a complex issue and continues to be one of the most significant health and social challenges facing our society.

The research reviewed above highlights the key developments in the literature in relation to children of parental substance misuse, whilst also drawing attention to key challenges and gaps in the literature. Developments included a growing body of research refocused from solely the individual person who use substances, to incorporating research on family members as the vast majority of substance misusers exist within a social context, and the importance of recognising this and addressing this in research was highlighted. The importance of research incorporating the voice of the child directly, and where possible older children was highlighted, as was the

need to incorporate the voice of fathers when gathering parent informed data. Within this research on family members, developments were reported whereby research methodologies moved from predominantly quantitative approaches to a growing body of research incorporating qualitative approaches, an approach authors reported as being necessary to provide meaningful insights a more nuanced examination of meaning and experience, and to ensure that accounts from those most intimately affected by the experience were not marginalised in favour of an over reliance on case records and psychometric measures. Phenomenological approaches to capturing the lived experience were recommended and adopted by a number of authors.

A further development in the literature related to the importance of capturing the perspectives of other necessary key stakeholder including grandparents who adopt a caring role for the grandchildren with specific recommendations made for further research that should supplement the findings from recent large-scale analyses of census data with qualitative studies that examine, phenomenologically, the needs and experiences of informal kinship carers, and the children for whom they care. Crucially, as most studies have focused mainly on carers, it is important to understand more about the needs of the children (MacDonald *et al.* 2018).

Incorporating the voice of service providers who respond to parental substance misuse was also highlighted as important, both to address the dual foci of the child and family services and addiction services, whilst also developing a full understanding of resilience and of what protective factors and processes may be present or available that can be part of the response and help offered (Velleman & Templeton 2016). Furthermore, research highlighting the benefits of incorporating multiple stakeholder perspectives within the one study when exploring complex and experiential phenomena was reported. This approach adds important experiential and systemic dimensions to the majority of existing research, which has been criticised in the past for de-contextualising and isolating the views of key stakeholders, which can lead to unresolved fragmentation issues among key stakeholders and the subsequent misdirection of resources in responding to the issues. The multi-perspective approach enables the exploration of shared and distinct claims made by participant groups and facilitates greater understanding of the issue. Research informed by hermeneutic and phenomenological approaches which privilege the lived experience as a source of expert knowledge were reported as suitable and appropriate approaches (Larkin *et al.* 2019).



Finally, two main approaches to the literature were highlighted- a negative/deficit model, and positive/adjustment model. While in the overall literature, the impact and risks associated with parental substance misuse have been well mapped, there are studies that have found no evidence of heightened risk for children stemming from parental substance misuse alone, and that following on from this, a philosophical shift in the literature towards resilience is occurring and that this has clear potential when applied to children and other family members affected by parental substance misuse.

The research reviewed above argues strongly for the need to adopt a more balanced approach to research into children of parental substance misuse in terms of gathering information in relation to protective factors. Much more is known about protective factors than before, and the importance and complexity of these factors have been highlighted. The relationship between resilience and protective factors has been highlighted with gaps remaining within this research where the focus has tended to be on outcomes, with much less being known about the everyday social processes, interactions, and incidental events that may constitute resilience promoting contexts, or indeed, how they are made sense of at the time, or in retrospect, by the individual, or individuals concerned. In particular there have not been many studies undertaken into protective factors and their relationship with resilience specifically with children living with parental alcohol/substance misuse. A key advantage of focusing on resilience is that it shifts attention from a focus on problems to developing a child's strengths. The evidence reviewed in this thesis thus far, also argues for the importance of considering these issues within an ecological framework to address the multiple levels within which risk and protective factors interact.

### **1.15 Research question, aims and objectives of the thesis**

The overall aim of this research is to identify and to explore for the first time, intergenerational and both addiction and child service provider experiences of the risk and protective factors for children of parental substance misuse. The voices of three generations have been incorporated into this work, from that of the grandparent to parent to adult child each experiencing hidden harm from their own unique yet related perspective. The voices of both adult addiction services and child protection services are also included giving a unique contribution of five individual perspectives.

#### **Objectives**

- 1.1 Estimate of the prevalence of children impacted by parental substance misuse, across a local community.

- 1.2 Identify and explore lived experiences of the risk and protective factors of children of parental substance misuse from parents who use drugs, adult children of parental drug misuse, and grandparents.
- 1.3 Identify and explore intergenerational experiences of the risk and protective factors of children of parental substance misuse from child and family service providers and drug service providers.

### **Research Questions:**

The specific research questions which this study aims to answer are:

1. What are the risk and protective factors for children of parental substance misuse from the lived experience perspective of key stakeholders from both within the family, and those external to the family who are involved with playing a part in responding to the issue?

### **1.16 Structure of the thesis**

This thesis is divided into nine main chapters.

Chapter 1 introduces the thesis, provides the background and rationale for the study providing an overview of existing literature, and clarifies the definitions, aim and objectives of the thesis.

Chapter 2 builds on the literature of the first chapter and provides a systematic approach to a specific and targeted narrative literature review of multiple perspective research of children of parental substance misuse.

Chapter 3 describes the methodology and research design, provides a rationale for the choice of methodology and describes how the study was undertaken

Chapters 4-8 presents the findings from the research. Separate chapters were provided to report the findings from each of the groups interviewed. The research findings are arranged thematically.

- Chapter 4 reports the findings on Objective 1.1 Estimates of the prevalence of children impacted by parental substance misuse, across a local communities of a regional drugs task force area.
- Chapter 5 to Chapter 8 report the qualitative findings of the study covering objectives 1.2 and objectives 1.3.
- Chapter 5 presents the findings from the parents interviews.
- Chapter 6 presents the findings from the adult children.
- Chapter 7 presents the findings from the grandparent interviews.

- Chapter 8 presents the findings from the service provider interviews. A summary of findings from the qualitative data is presented within Chapter 8.
- Chapter 9 discusses these findings in the light of the pre-existing research and explores the implications, addresses the strengths and limitations of this current study and implications of the study findings.

## **Chapter Two: Narrative review of multi-perspective research on parental substance misuse and children**

### **2.1 Introduction**

In order to further demonstrate the gap in the literature that this thesis specially addresses, within this chapter we present a focused narrative literature review on research on parental substance misuse and children, that incorporated perspectives from two or more different stakeholder types. As previously discussed in the introduction the experience of living with an adverse situation is not solely located within the accounts of those with the ‘diagnosis’, nor is it limited to the children of these parents. The phenomenon is also located within the accounts of other people who belong to the “lived world” (Larkin 2018) and those who play in part in responding to the ‘lived world’ (Hogan 1997, Houmøller *et al.* 2011, Rostill-Brookes *et al.* 2011, Larkin *et al.* 2019). This research approach recognises the value in the use of multiple perspectives to explore the same phenomena enabling the capture of complex and systemic experiential phenomena (Larkin *et al.* 2019). The review is presented using the IMRAD format (Introduction, Method, Results and Discussion), as it is the most commonly used structure of reporting narrative reviews (Ferrari 2015). The objective of this narrative review is to identify studies that investigate risk and protective factors for children of parental substance misuse from the perspectives of two or more stakeholder types.

### **2.2 Reviewing the literature**

There exists some debate within qualitative research regarding the optimal point in time to conduct the literature review. Some researchers believe that conducting a literature review before data collection will influence the researchers’ perception of their chosen phenomena whereas others believe that conducting a preliminary literature review sets the scene for the researcher in relation to their chosen topic (Polit & Beck 2008).

### **2.3 Purpose of the literature review**

For the study presented in this thesis, a narrative review of the literature was conducted to establish the body of knowledge related to the lived experience of risk and protective factors of children of parental substance misuse from the perspectives of two or more stakeholder types. A narrative review was chosen by the author as it seeks to identify what has been previously accomplished in a particular field of study, it avoids duplication and identifies existing gaps or omissions (Grant & Booth 2009).

### 2.3.1 Defining the key subject areas

While a review of the seminal and key literature was initially conducted this systematic approach with a narrative review of this chapter was conducted using two key concepts for the search these were:

Concept 1: 'parental substance misuse'

Concept 2: 'risk OR protective factors'

### 2.3.2 Sourcing information and the development of search terms

In conjunction with the Librarian a search strategy which utilised database index terms and keywords was developed. Six key databases were selected for searching, EMBASE, CINAHL Complete (1937-), Medline (1946-), Global Index Medicus, Applied Social Sciences Index & Abstracts: ASSIA (1987-) and the Web of Science. This database spectrum ensured a comprehensive coverage of the literature ranging from journal articles to conference proceedings and monographs.

Scoping searches were run in CINAHL, Medline and Embase, to identify the appropriate index, or control language terms for the search. The indexes, and associated synonym lists, author keywords and bibliographies were reviewed to identify the keywords for each concept. Due to the complexity of the subject matter, and the wide variety of terminology used to describe both parental substance misuse and risk or protective factors both concepts applied an additional proximity operator. This allowed for an increased sensitivity in the search and thus more targeted results

A three-strand search was developed using a combination of both index terms, and keywords were utilised in the search to return the maximum number of relevant articles. It was only possible to utilise the index terms for the second concept. The literature search was conducted on the 10<sup>th</sup> of July 2020 and all article numbers are correct for this date. Below please find an example of the applied search strategy in EMBASE and the search details are detailed in Table 2.

Table 2: Search Details Embase Example

| Key Subject Area                 |  |
|----------------------------------|--|
| Parental<br>Substance<br>Misuse  | <p>Concept 1: 'parental substance misuse'</p> <p>EMBASE - no appropriate term<br/>EMBASE &amp; Web of Science: (Parent* OR mother* OR father* OR maternal* OR paternal* OR famil*) NEAR/4 ("substance misus*" OR "Substance-Related Disorder*" OR "substance abuse disorder*" OR "substance abus*" OR addict* OR "drug misus*" OR "drug abus*" OR "alcohol misus*" OR "alcohol abus*" OR "medication misus*" OR "medication abus*" OR "drug addict*" OR "alcohol addict*" OR "medication addict*" OR cocaine OR heroin OR methadone OR opiate* OR codine OR amphetamines OR "crystal meth" OR GHB OR ketamine OR ecstasy OR MDMA OR morphine OR "illicit drug*" OR amphetamine* OR opioid OR opium OR psycodell* OR "banned substance*" OR psychotropic* OR sedative* OR tranquili* OR cannabis OR cannaboid OR hashish OR marijuana* OR marihuana* OR weed OR poppers OR uppers OR downers OR hallucinogen* OR phencyclidine* OR LSD OR lysergic-acid OR "designer drug*" OR "club drug*" OR drug-dependen* OR alcohol-dependen* OR "narcotic abuse*" OR "narcotic misuse*" OR narcotic-depend* OR alcoholic* OR alcoholism OR junkie* OR druggie* OR substance-abus* OR "heavy drink*" OR "drug dependen*" OR "prescription abuse*" OR "binge drink") – title and abstract in EMBASE</p> |
| Risk or<br>Protective<br>Factors | <p>EMBASE: 'child abuse'/exp OR 'child abuse survivor'/exp OR 'child welfare'/exp</p> <p>EMBASE &amp; WoS: (risk* OR protect* OR experien* OR impact* OR effect* OR safe*) NEAR/3 (child* OR youth* OR "young people" OR adolesc* OR teen* OR "preschool child*" OR "pre-school child*" OR toddler* OR infant* OR baby OR babies OR neonate* OR "new born*")</p>   |

|  |  |
|--|--|
|  | OR newborn* OR school-aged OR "school aged" OR offspring OR sibling* OR son* OR daughter*) |
|--|--|

## 2.4 Running the searches

The two concept searches were run across the six databases. Table 3 outlines the list of the results based on each of the searches and the final combined number. After running the searches and combining the terms, the database searches returned a total of 9,583 articles.

*Table 3: Overview of Search Results*

|                                   | <b>CINAHL</b> | <b>Medline</b> | <b>Embase</b> | <b>ASSIA</b> | <b>Web of Science</b> | <b>GIM</b>                    |
|-----------------------------------|---------------|----------------|---------------|--------------|-----------------------|-------------------------------|
| <b>Parental substance misuse</b>  | 5,564         | 13,355         | 14,201        | 10,111       | 11,785                |                               |
| <b>Risk or Protective Factors</b> | 149,385       | 263,311        | 259,277       | 3511         | 151,705               |                               |
| <b>Total articles located</b>     | 1,308         | 2,181          | 2,113         | 1,593        | 1,969                 | 419<br>(single string search) |

## 2.5 Managing search results: endnote

The researcher chose Endnote X9 to help to manage the search results. Separate Endnote Libraries were created for each of the databases. A seventh combined library was created to centralise the results. After all the searches were completed a total of 9,583 articles were identified. The results of each database search were exported into their own Endnote Library set up to exclude duplicates at the import stage, this reduced the number to 5829 articles. Endnote identified 4294 duplicate articles across the 6 databases, and these were removed. Secondary visual de-duplication was also run which identified a further 296 duplicate articles were identified and removed. This resulted in a total of 4993 articles for abstract and title screening, and these were imported into Covidence.

## 2.6 Reviewing and screening: covidence

Covidence is an online software product which assists evidence synthesis by streamlining the review process. For this research, the screening process was conducted by the researcher. Covidence software was adopted for use primarily for practical issues associated with screening the large volume of references obtained. Utilising Covidence facilitated the collective management of all of the references and their full-text files in one place. It also enabled the researcher to screen each reference and review each full text, one by one and divided the reviewing task into three separate stages, thus making the process more manageable.

Studies firstly excluded at this stage were studies that did not have a focus on substance use. Secondly, studies that did not have a focus on parental substance use. Thirdly, studies beyond the scope of this thesis study including studies focused around genetic and biological factors, studies that focused solely on children developing their own substance misuse issues, studies that focused on prenatal chemical exposure. This left 324 studies assessed for full eligibility. studies consisted of a range of methodologies including literature reviews and quantitative and qualitative studies and included a wide range of areas of focus beyond the scope of this thesis e.g., studies that focused solely on one aspect of substance use, studies that focused solely on impact on the person using substances, studies that focused solely on one type of program or intervention.

In light of the aim of this thesis to explore lived experiences of risk and protective factors for children from multiple stakeholder perspectives, a second exclusion criteria needed to be applied to include only studies that consisted of a qualitative design and incorporated multiple stakeholder perspectives. Of the 324 studies, this resulted in a total of 76 articles. Full text review of these articles continued. On second round screening, 315 of these studies were excluded. This resulted in the initial exclusion of 4916 articles. For the remaining 76 studies only 7 of these qualitative studies incorporated more than one stakeholder perspective.

Once the screening process was complete, the researcher reviewed and critiqued the yielded works to generate a map of the evidence (Munn *et al.* 2018). This task was carried out manually with paper and pen; one critique memo per yielded published piece of work. Wakefield (2014) advises that it is essential to create a logical structure base to themes generated from a literature review and the decision to organise the themes around the study aim and objectives provided such structure. The literature will be presented in the next section.



## 2.7 Relevant literature

This section provides a review of the 7 eligible studies that met the inclusion criteria. As articulated above, these studies are eligible for inclusion because they explored the lived experience of parental substance misuse from the perspective of two or more stakeholder types.

Across these seven studies, the stakeholders engaged ranged from parents, foster carers, service providers, youth, and grandparents. Three studies incorporated three or more stakeholder perspectives and 4 studies incorporated two type of stakeholder perspectives. Three of the studies had the role of grandparents as carers as the main focus of their research (Gair 2018, Davis *et al.* 2000, Zuchowski *et al.* 2019). In the study by Offiong *et al.* (2020), while grandparents were not the central focus of the study, the role of grandparents as an important protective factor, was a key finding. This study focused on connectedness among youth affected by parental drug use. The remaining three studies explored additional aspects in relation to children of parental substance misuse, with service systems as a key focus (Barnard & Bain 2015, Scott *et al.* 2002, Smith *et al.* 2002). These studies included examining obstacles to family reunification (Smith *et al.* 2002), early intervention and the complexities of its inextricable links to monitoring child welfare, the role of power inherent within these responses, and subsequent engagement issues with parents as a result of fear of consequences (Barnard & Bain 2015) and finally Scott *et al.* (2018) explored parent recovery and how it is framed and responded to in terms of what it means for parents and child protection workers.

These studies are summarised briefly in Table 4, including key recommendations and limitations (see Table 4 for Summary of Results). Following this, the studies are reviewed and discussed below.

Table 4: Summary of Results

| Author                                      | Title   | Aim   | Participants   | Methods                              | Key findings   |
|---|---|---|--|--------------------------------------|--|
| 1. Gair <i>et al.</i> 2018<br><br>Australia | Grandparents matter: Optimizing grandparents' involvement after child safety concerns | Explore and identify ways to optimize the inclusion of grandparents where there are child safety concerns or children are in out of home care/kinship care; to document participants narrative, perceptions and recommendations, and to contribute to current knowledge and practice in partner organisations, social work education and professional social work | 77 participants: <b>4 participant types</b> <u>51 grandparents, six foster carers</u> (nonfamily), <u>12 parents, and eight workers</u> . In total, 26 participants in the study identified as Aboriginal Australian and one participant identified as Torres Strait Islander. | In-depth interviews and focus groups | <p>Themes derived were driven by grandparents. Findings revealed grandparents yearned to maintain a significant role in grandchildren's lives after child safety issues emerged, however, they often felt powerless, unsupported, and side lined from decision-making in the best interests of their grandchildren. Participants made strong recommendations for more inclusive processes.</p> <p>6 related themes. grandparent relationships and involvement is vital; seeing the problem and taking action to fix it; grandparents felt unheard, side lined, and powerless; grandparents in the firing line; workers: some good ones, some nasty ones; and feeling like hostages in the system.</p> <p><b>Recommended:</b></p> <ol style="list-style-type: none"> <li>1.Increased facilitation of grandparent involvement, for more inclusive decision-making in child protection practice in the best interests of children.</li> <li>2.Future research capturing children's views about maintaining relationships with grandparents may be useful,</li> <li>3.Research further exploring workers' perceptions regarding inclusive decision-making in the best interests of children seems warranted.</li> </ol> <p><b>Limitations:</b> Sample may be biased in that grandparents satisfied with their level of involvement may not have participated, over 1/3 of the sample were Aboriginal who are a group with a historical background of deep mistrust in child services. In the findings it was not possible to ascertain which stakeholder group informed the findings, and no information on the type of workers was provided. Finally, the reasons for grandparent assuming care role were multi-faceted although in the literature review</p> |

| Author   | Title  | Aim  | Participants  | Methods                     | Key findings   |
|--|--|--|---|-----------------------------|--|
|  |  |  |   |                             | parental substance misuses was highlighted as a main reason.   |
| 2,<br>Zuchowski<br><i>et al.</i> 2019<br><br>Australia | Convenient Yet Neglected: The Role of Grandparent Kinship Carers | To explore how contact between grandparents and their grandchildren could be optimised after child-safety concerns | The final sample (n=77) A total of 39 interviews in 2016: 28 individual interviews, 3 couple interviews<br>7 focus group interviews.<br>A total of 43 participants attended the focus groups. | Focus groups and interviews | <p>5 key themes - grandparents as kinship carers were</p> <ol style="list-style-type: none"> <li>1. The multiple stresses of being a kinship carer</li> <li>2. Kinship carers are convenient but not supported</li> <li>3. Kinship carers felt scrutinised and dispensable</li> <li>4. Kinship carers are potentially in danger' and</li> <li>5. Participants' key recommendations</li> </ol> <p><b>Recommendation:</b></p> <p><u>Participants:</u></p> <ol style="list-style-type: none"> <li>1. Grandparents receive recognition as kinship carers.</li> <li>2. Place children in families,</li> <li>3. Support grandparents as kinship carers and</li> <li>4. Restore family relationships.</li> </ol> <p><u>Author Recommendations:</u></p> <ol style="list-style-type: none"> <li>1. Child-protection systems increase family-inclusive practices that provide better support to kinship carers</li> <li>2. Future evaluations of CPS could audit whether and how the prioritising of kinship care is evident in practice, evidence of engagement with grandparents in the decision making about care of children under orders</li> <li>3. CPS to introduce more simplified kinship care assessments</li> <li>4. ncreased transparency regarding implementation of family inclusive practices with extended families.</li> <li>5 A unique support model for families in these situations – a child centred relationship supportive, family and culturally responsive and system focused model of care practice for kinship care that is different to that of foster carers</li> <li>6. Social workers in CP are well placed to advocate for, support, recognise and value grandparents as key players in family-inclusive practices to support children and preserve family relationships and cultural networks.</li> </ol> |

| Author                                       | Title  | Aim  | Participants  | Methods                      | Key findings  |
|--|--|--|---|------------------------------|---|
|  |  |  |   |                              | <p>6. Child Protection Departments cannot end when children are placed with kin due to high support needs.</p> <p>.</p> <p><b>Limitations:</b> Sample bias- grandparents satisfied with their level of involvement may not have participated, main voice reported is grandparents, other voices much less visible.</p>  |
| <p>3.Davis <i>et al.</i> 2020</p> <p>USA</p> | <p>Parenting a 6-Year-Old Is Not What I Planned in Retirement: Trauma and Stress among Grandparents Due to the Opioid Crisis</p> | <p>This research aims to answer two questions: what the circumstances are under which grandparents become guardians of grandchildren whose parent has OUD, and what the grandparents' experiences are over time with a focus on stress, financial planning, and social supports.</p> | <p>Total Participants: 24</p> <p>a)9 stakeholders (stakeholders who are providing services to grandparents and grandchildren or advocate on their behalf.)</p> <p>b)15 grandparents (a primary caretaker of grandchildren, grandchildren were under 18 years old when they came to live with their grandparent, and parental opioid use was the cause of a change in guardianship</p> | <p>Interviews (in-depth)</p> | <p>Grandparent concerns: Legal status, financial security, housing, support services. loss of peer/family support.</p> <p><b>Recommendation:</b></p> <p>1.Policymakers need to be aware of the impact parenting grandchildren has on systems related to health and welfare of, children, the aging population, and financial security. 2.Existing services and programs are designed to support the parent and child, but little attention to custodial grandparents. There are support groups, but no coherent national strategy to address the ongoing issues related to custodial grand parenting.</p> <p>3.Systems break down on a number of levels, and custodial arrangements due to parents' OUD status does not map onto existing support or benefit systems. Social workers need to be more aware of ongoing grandparent crisis.</p> <p>4. Inclusion of specific intervention, such as trauma-focused cognitive-behavioural therapy, which helps children and grandparents process thoughts and feelings related to the traumatic event and enhance a sense of safety within the family unit, and an overall approach of trauma-informed care to provide both the grandparent and the grandchildren with positive support networks and access to resources</p> <p><b>Limitations:</b> Findings may not represent experiences in general, grandparents already connected to service system which can limit generalizability, interview process relied on memory of initial crisis which on average 13</p> |

| Author                                  | Title  | Aim   | Participants   | Methods   | Key findings   |
|---|--|---|--|---|--|
|   |  |   |  |   | years previously, all grandparents lived independently which may differ from those less able. The multi-perspectives not clearly demarcated in the findings  |
| 4. Offing <i>et al.</i> 2020<br><br>USA | “1 missed open arms”: The need for connectedness among Black youth affected by parental drug use | Explore connectedness among Black youth affected by parental drug use and identify the consequences of when connectedness is missed | 30 Participants<br><b>3 participant types:</b><br><u>parents</u> with a history of drug use (11), <u>young adults</u> (14) (18-24yo) who had a biological parent with a history of drug use <u>youth providers</u> (5) who had experience working with families affected by drug use | Interviews- semi structured<br>Analysis: Content analytic approach<br>Phenomenological approach | Themes derived were driven by the youth participants. (1) missing parental connections, (2) the desire for consistent, trusted adults and (3) the consequences of missed connections. All participants emphasized the limited emotional support and guidance provided to youth affected by parental drug use. However, extended family members (e.g., grandmothers, aunts, and older siblings) and community mentors stepped in to fulfil unmet needs, when possible. Unfortunately, little to no support was provided for the child or caregiver in informal living arrangements. The consequences of missed connections were increased involvement in risky behaviours, fewer basic necessities and a missed childhood. Findings from the study deepen the understanding of how to support the well-being of youth impacted by parental drug use and highlight the value of including the voices of vulnerable families in research.<br><br><b>Recommendations:</b><br>1. Care for youth affected by parental drug use requires a long-term commitment which needs to have increasing supportive connections at its core.<br>2. Interventions and policies should consider strengthening the capacity of existing spaces, resources, and people to sustain a lasting impact on the lives of young people and their families.<br>3. Participants emphasized the sense of connectedness grandmothers and older adults provided. However, due to unforeseen circumstances like death or poverty, they struggled to sustain the supports needed by the young person. Therefore, additional local and community level supports are necessary to ensure that youth and their |

| Author                            | Title   | Aim   | Participants  | Methods      | Key findings  |
|-----------------------------------|---|---|---|--------------|---|
|                                   |   |   |   |              | <p>caregivers have access to resources, which have the potential to result in interpersonal and behavioural improvements.</p> <p><b>Limitations:</b> Generalisability, the framing of the introductory literature chosen in this study reflected a deficit focus approach, lack of success stories in this particular study could be in part have been informed the perspectives of participants, influenced by the additional social and environmental issues at play in addition to the parental substance misuse, In relation to the inclusion criteria for parents in this study, in terms of defining drug use, the requirement was that parents “report a history of drug use” but no further requirements were stipulated. This is open to interpretation.</p>   |
| 5.Smith <i>et al.</i> 2002<br>USA | Reunifying Families Affected by Maternal Substance Abuse: Consumer and Service Provider Perspectives on the Obstacles and the Need for Change | To examine the views of consumers and service providers - regarding the obstacles to family reunification and recommendations for change. Research questions - What are the perceptions and experiences of the key participants in family reunification programs for chemically dependent mothers? Specifically, what | 107 participants Two stakeholder types- Consumers (Chemically dependent mothers) and two Service provider systems- Child Welfare Service agencies and Substance Abuse Treatment programs. A total of 15 focus groups were conducted, with five different child welfare worker groups, substance abuse treatment groups, and mothers’ groups each. | Focus groups | <p>Two themes</p> <p><b>1. Obstacles identified within the system</b></p> <ul style="list-style-type: none"> <li>- <i>Intra-agency</i> Obstacles (obstacles within substance abuse treatment centres and obstacles within the child welfare delivery system) (Key obstacle with each service blaming the other)</li> <li>- <i>Inter-Agency</i> obstacles (Infrequent visitation, lack of communication and coordination between system participants, and limited services for children), and thirdly</li> <li>- <i>Obstacles specific to the mothers’ process of addiction</i> (an increase in substance use once the children are removed, and the role of crack cocaine).</li> </ul> <p><b>2. Recommendations identified for change.</b></p> <ul style="list-style-type: none"> <li>- <i>Intra-agency</i> Recommendations (A stronger family focus in substance abuse treatment,</li> </ul> |

| Author                                       | Title   | Aim  | Participants   | Methods                    | Key findings  |
|--|---|--|--|----------------------------|---|
|  |   | are the perceptions and experiences of child welfare workers, substance abuse counsellors, and chemically dependent mothers?   |  |                            | <p>substance abuse training for child welfare service providers),</p> <ul style="list-style-type: none"> <li>- <i>Inter-agency</i> recommendations: (Aftercare and support, and increased system coordination and communication).</li> </ul> <p><b>Limitations:</b> Findings not generalizable, Perceptions relate to what's not working with the system as participants would not answer the question – what is working with the system, no rebuttal opportunities for the various stakeholders, findings limited to only three stakeholder groups, no demographic analysis, only one researcher thus limited inter-rater liability. Finally, the research was limited to foster care thus information in relation to informal kinship care and grandparents is lacking. It was also not possible to decipher if any of the foster carers were indeed family members. The voice of the child would have strengthened this study.</p> |
| 6. Barnard & Bain 2015<br><br>Scotland<br>UK | Resisting your good intentions: substance-misusing parents and early intervention to support and monitor children in need | This research aimed to examine how families responded to the entreaties of service providers to engage with services through these voluntary protocols. A particular focus was on how a dual agenda of support and supervision would play out in | n = 20 professionals. with a small number of families (n = 6) defined as in need of supportive intervention. | Semi-structured interviews | <p>Protocols in Action: - a key finding - over the 6-month study period there was no recorded change in the substance misuse or other targeted behaviours of any of the parents in any of the families.</p> <p>Enquiring gaze: Workers and parents understood the protocol's monitoring function to be of equal, if not greater, significance to support. While the workers interviewed expected to use their contacts with clients under these protocols to monitor the child's welfare, they recognized that this created parental wariness</p> <p>Parental Resistance: One of the key dynamics in how parents responded to the protocols and service providers concerned their reaction to the monitoring function underpinning them.</p> <p>Concealment: The extent to which people will conceal information to avoid further service involvement.</p>  |

| Author  | Title   | Aim  | Participants   | Methods    | Key findings  |
|---|---|--|--|------------|---|
|   |   | the context of a voluntary family engagement with services.  |  |            | <p>Non-Co-Operation: Parent did not respond to any attempts by services to engage,</p> <p>Talking the Talk – Disguised compliance with services: The ways in which the client gives the impression of co-operating with agencies whilst in reality diverting or diffusing professional attention. In this study two parents appeared to interact with services in this way.</p> <p><b>Recommendations:</b> Two linked possibilities to overcome parental resistance:</p> <ol style="list-style-type: none"> <li>1. Better communication skills on the part of those delivering services</li> <li>2. Exploration of the possibility of putting some distance between the offer of support and an often all too close link with the threat of punitive action.</li> </ol> <p><b>Limitations</b> Results not generalisable, only 2 parents participated in the final study, voice of parents scarce in findings, and focus on child limited,</p>   |
| 7 Scott <i>et al.</i> 2018<br><br>New Zealand | What does “recovery” from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress | To explore what recovery from mental illness and/or addiction means from the perspectives of child protection social workers (11), and parents (13) living with mental health illness and or addiction who have been involved in child custody investigations. | <i>26 Participants<br/>13 parents who have been involved in child protection investigations or family court disputes where mental illness or addiction has been a focus<br/>11 child protection social workers</i> | Interviews | <p>Findings presented firstly from the perspectives of the 11 child protection social workers and secondly from the parents perspectives, Disparities were highlighted in terms of their understanding and use of recovery approaches, and the subsequent consequences of these disparities. Finally, they consider the structural context of social work practice in the child protection sector, arguing that a disciplinary neoliberalism in a resource-poor environment makes it difficult to put a ‘recovery perspective’ into practice.</p> <p><b>Social worker perspectives:</b> 1. Parents situations were constructed in a deficit framed manner, with the issue of risk being repeatedly reported, 2. Treatment and coping strategies must be expert driven, and 3. Mental illness or addiction was chronic or chronically relapsing.</p> <p><b>Parents' perspectives</b> 1. Ability of parents with mental illness or addiction to recover, 2. The centrality of self-determination for recovery, 3. Experiences engaging with</p> |



| Author | Title | Aim | Participants | Methods | Key findings   |
|--------|-------|-----|--------------|---------|--|
|        |       |     |              |         | <p>risk-focused care and protection services, and 4. The relationship between parenting and recovery.</p> <p><b>Recommendations:</b></p> <ol style="list-style-type: none"> <li>1. Child protection social workers are trained in recovery model,</li> <li>2. Are given the time and resources to build relationships with parents and children, and to get to know their strengths.</li> <li>3. Structural change to child protection practice might be necessary to recognise the non-linear timeframes by which recovery occurs for parents and other family members.</li> <li>4. Family reunification must be held out as a possibility and parents must not be abandoned without support.</li> </ol> <p><b>Limitations</b> Generalisability limited. The larger study also incorporated the perspectives of many different stakeholders including extended family, legal &amp; health care professionals, (but on contacting the author, it was not possible to obtain this study). The focus on the child was limited.</p> |

The following section provides a review of these seven studies above exploring key findings, limitations and recommendations.

A dominant cross cutting issue that presents in the studies above relates to the critical protective role of kinship care, that is provided by Grandparents to grandchildren, in cases where the parent is unable to care for the child (Davis *et al.* 2000, Gair *et al.* 2018, Offiong *et al.* 2020, Zuchowski *et al.* 2019). However this role is complex, and while acknowledged by many stakeholders as being critically important to the child's well-being, the role remains unsupported, undervalued, and riven with challenges including the interaction between child protection service systems and grandparents, and in relationships between grandparents and the parent, which equally, if left unaddressed, can and do impact on the well-being of the child being cared for (Davis *et al.* 2000, Gair *et al.* 2018, Offiong *et al.* 2020, Zuchowski *et al.* 2019).

The number of children being cared for by grandparents is reported to be on the rise, as a result of many complex interconnected reasons (Gair *et al.* 2018), including a frequently cited reason of the parents use of drugs and/or alcohol (Backhouse & Graham 2012). Gair *et al.* (2018) define Kinship care as a growing, unique but under-resourced out-of-home care option where children are placed, formally or informally within family networks (Gair *et al.* 2018 p.2).

In their study of the experiences of grandparents assuming a caring role for grandchildren where the parent has opioid use disorder, carried out in the United States, Davis *et al.* (2020) referred to two main methods that grandparents followed to assume responsibility of their grandchildren: (*Formal* (permanent or temporary custody granted by the court) or *Informal* (without court or child welfare involvement)) (Davis *et al.* 2020 p .9) Grandparents reported receiving limited or no information about different guardianship options by the legal system during the crisis period (Davis *et al.* 2020).

The status of the grandparents care role, in relation to formal versus informal, highlights tensions inherent within these different options, in particular the latter situation accommodates the parent being able to revoke authorisation at any time, and a situation whereby grandparents can neither access the child's educational or medical records, nor enrol the child in activities or schools , a situation which can have a significant impact on the child, and one which causes a constant tension for the grandparent (Davis *et al.* 2020). Grandparents reported that they have to firstly find the parent and secondly ask for their permission, but often without success (Davis

*et al.* 2020). The option to engage in informal rather than formal arrangements was often based on a number of reasons - fear of the grandchild being taken away if formal guardianship was sought but not awarded, hope of recovery of the parent, protecting the adult child from the harm that may be caused by applying for formal guardianship (Davis *et al.* 2020).

In relation to formal guardianships (which can be temporary or permanent), this option is determined by the courts (Davis *et al.* 2020). The authors report however that while the grandchild and the Department of Children and families are entitled to Free Legal representation in guardianship hearings, the grandparent is not. The cost of legal representation was reported as a barrier for many grandparents. Grandparents in their study also reported being unaware in advance of the situation that they would need a lawyer (Davis *et al.* 2020). Stakeholders in this study confirmed that *temporary* guardianship does not guarantee the child can remain with the grandparents, and child and parent advocate participants reported that courts favour the rights of the parent and child even if they have been apart for many years. The authors continue to report that the courts position can destabilise the grandchild's life. In addition to this, Davis *et al.* (2020) highlight that under temporary status, the grandparent cannot prevent the parent from re-entering the child's life.

An additional complexity to kinship care is raised in the research by Zuchowski *et al.* 2019, which was carried out in Australia, where they emphasise research by (Irizarry *et al.* 2016) which highlighted the "kinship care paradox"; where it can be in the child's best interests in terms of maintaining family and cultural connections, those connections can be problematic in maintaining the child's safety' (Irizarry *et al.* 2016, p. 207).

Core concerns for grandparents reported in the studies in this narrative review, were Legal status, financial security, housing, and support services (Gair *et al.* 2018, 2020, Zuchowski *et al.* 2019, Davis *et al.* 2000). Challenges with finding and accessing suitable services were also reported, with discrepancies also emerging between services available for informal guardians versus formal guardians (Gair *et al.* 2018, 2020, Zuchowski *et al.* 2019, Davis *et al.* 2000). Access to day care slots was one of the examples provided and accessing psychological supports for the grandchild was reported as a particular gap in service provision (Gair *et al.* 2018). Lack of capacity to interface with technology was also reported as impacting on capacity to respond to key developmental issues for the grandchild including medical appointments, and school conferences. Systems that serve children and grandparents are on the front line yet are not

prepared to support grandparents either during the crisis or throughout the years. The health of grandparents can also be impacted due to the burden of caring for grandchildren (Gair *et al.* 2018).

In relation to both child protection services, and in many instances parents themselves, Grandparents reported feeling undervalued, isolated, not seen as a legitimate stakeholder, excluded from decision making, powerless, disbelieved, left to their own devices in responding to the complex situation of caring for their grandchildren, and then upon reunification, often being cruelly discarded, with significant impact for both the grandparent and the grandchildren (Gair *et al.* 2018, Zuchowski *et al.* 2019, Davis *et al.* 2000,). It was further reported that not being viewed as a legitimate stakeholder had ramifications in terms of being side-lined and excluded from decision making processes in relation to the well-being of the grandchild, a position which grandparents and others felt compromised the well-being and safety of these grandchildren. Participants reported not being believed when reporting abuse, and of having to deal often with an environment within which the grandparent was viewed as being the source of the problem in terms of intergenerational parenting inadequacies (Gair *et al.* 2018).

Grandparents felt isolated and unsupported in terms of emotional, financial, and practical supports, that reflected an approach whereby social work often believed their own role in relation to the grandchild was over once the grandchild was in the care of the grandparent (Gair *et al.* 2018, Davis *et al.* 2020, Zuchowski *et al.* 2019, Offiong *et al.* 2020) This unsupportive environment was reported as continuing at the point of re-unification of the grandchild and parent with participants reporting that this approach had damaging ramifications for the grandchild's development (Gair *et al.* 2018).

In relation to social work specifically, given the front line role of social workers in responding to the crisis events that lead to grandparents assuming care roles, Davis *et al.* (2020) emphasise that social workers need to be more aware of the *ongoing* crisis in grandparent led families, and their need for support around child-rearing and developmental issues. Grandparent stress can also result in poor parenting practices that in turn can precipitate poor grandchild adjustment and family dysfunction. Social workers are well positioned to screen for traumatic stress and engage in evidence-based practices and psychoeducation. Davis *et al.* (2020) recommend the inclusion of specific intervention, such as trauma-focused cognitive-behavioural therapy, which helps children and grandparents process thoughts and feelings related to the traumatic event

and enhance a sense of safety within the family unit, and an overall approach of trauma-informed care to provide both the grandparent and the grandchildren with positive support networks and access to resources (Levenson 2017).

Offiong *et al.* (2020), in their study in the United States, which aimed to explore connectedness among Black youth affected by parental drug use and identify the consequences of when connectedness is missed, also reported on the critical yet under supported role of grandparents as carers. All participants emphasized the limited emotional support and guidance provided to youth affected by parental drug use (Offiong *et al.* 2020). However, where possible, extended family members (in particular grandparents) and community mentors stepped in to fulfil unmet needs. However, this support infrastructure was reported as not being available to all the youth interviewed, and unfortunately, when this support was available and occurred, participants reported that little to no support was provided for the child or caregiver in informal living arrangements. This finding resonates strongly with the finding in the three previous studies in relation to lack of supports in place for child and the grandparent, in particular in cases of informal care arrangements. The authors further added that while participants emphasized the sense of connectedness grandmothers and older adults provided, often, due to unforeseen circumstances like death or poverty, they struggled to sustain the supports needed by the young person. Therefore, the authors recommend that additional local and community level supports are necessary to ensure that youth and their caregivers have access to resources, which have the potential to result in interpersonal and behavioural improvements. A second key recommendation for the study overall highlighted that care for youth affected by parental drug use requires a long-term commitment which needs to have increasing supportive connections at its core. Interventions and policies need to consider strengthening the capacity of existing spaces, resources, and people to sustain a lasting impact on the lives of young people and their families. These findings speak strongly to the complexities in relation to protective factors and our need to develop a greater understanding of the nuances in relation to these and other factors.

Finally, participants reported significant challenges with managing complex family dynamics and relationships as a result of their new role, and challenges with isolation from their existing friendship networks (Gair *et al.* 2018, Zuchowski *et al.* 2019, Davis *et al.* 2020,). In regard to the dynamic between parents and the grandparent in relation to the care role for the grandchild, grandparents reported that this dynamic can be hostile, that grandparents can be targets of

abuse from the parents, and that this can culminate in the exclusion of the grandparent from the life of the grandchild at the point of reunification between parent and child. Grandparents felt unsupported and isolated at this juncture in terms of service support also (Gair *et al.* 2020)

A number of grandparents reported having to sever ties with their own child, to protect the grandchild from future contact (Davis *et al.* 2020). This disengagement with adult child was often continued by the grandparent even if the adult child was sober, driven by a fear of relapse and subsequent impact on the grandchild. The grandchild however often also faced losing contact with one side of his family completely in that care of the grandchild rarely was shared by both sets of grandparents, and family tensions often prevented cooperative arrangements between families (Davis *et al.* 2020). Grandparents reported difficulties they experienced in terms of socializing with parents from school due to significant age gaps between the parents and the grandparents, as well as experiencing isolation from friends, events, and natural support networks. This was reported as one of the most profound changes when the grandchild moved in.

These findings speak strongly to the complexities in relation to risk and protective factors and our need to develop a greater understanding of the nuances in relation to these and other factors. The findings illustrate a complex set of circumstances revolving around children of parental substance misuse and the role of grandparents, Grandparents who are raising grandchildren need immediate and longer-term supports, but these are not forthcoming at multiple levels including family and system levels (Gair *et al.* 2018, Zuchowski *et al.* 2019, Davis *et al.* 2020, Offiong *et al.* 2020).

The literature reviewed also speaks of factors external to the immediate and extended family, including factors that constitute a “perfect storm” - political conservatism, early intervention, a risk averse environment, poverty and mistrust, all of which can lead to an unabated removal of children from parents and challenges with reunification (Gair *et al.* 2018, Zuchowski *et al.* 2019). The authors continue to highlight that while risk has emerged as a dominant, defining dimension in decision-making in child protection, the growing literature identifies the increased assessing of “risk” of harm and even the identification of “dangerous” care givers to prevent worst case scenarios for workers, organizations, and children, as problematic and can lead to increased numbers of children ending up in care (Gair *et al.* 2018, Zuchowski *et al.* 2019). In addition to this, the reliance on detailed risk assessment tools may be “incompatible” with an

inclusive family approach (Buckley, 2017, p. 85). In such contexts, optimizing grandparents' involvement may be overlooked even though it might be in the best interests of many children that they were involved (Gair *et al.* 2018, Zuchowski *et al.* 2019).

Similarly, Scott *et al.* 2018, in their research exploring recovery, emphasise the structural context of social work practice in the child protection sector, arguing that a disciplinary neoliberalism in a resource-poor environment makes it difficult to put a 'recovery perspective' into practice (Scott *et al.* 2018 p.2)

The authors highlight that the concept of recovery, has hope at its heart, with self-determination, a positive approach to risk, and a strengths perspective also as core elements, and argue that an understanding of this concept is necessary for child protection workers engaging with parents who live with mental illness or addictions (Scott *et al.* 2002). The authors then highlight however that more generally, recovery and recovery-orientated practice, remain fraught with different understandings within different contexts of practice, and that clinicians and managers often understand 'recovery' through the notion of 'clinical recovery' (Scott *et al.* 2002).

Throughout the research reviewed in Chapter 1 and 2, many authors highlighted the predominant deficit focus framing of parental issues, and its subsequent impact on prospects for recovery, which can impact the children, including reunification. A number of authors also highlight that child protection is an under resourced service, whose child -centric focus can render children as isolated from their broader family, or community system, and raise the question of how ethical it is to have such a critical service focus on rescuing children and leaving parents behind in a society riven by inequalities.

Smith *et al.* 2002 in their research on reunifying families affected by maternal substance misuse note upfront in their research, that the findings reported in their study, relate specifically to what is *not working* within the current system and the recommended changes, and that as a result of this, only two of the three research questions were answered- Participants did not respond to the first question: what *is* working within the current system? The authors report that within each focus group, participants avoided this question on numerous occasions despite repeated prompts from the interviewers and despite interviewer's re-direct back to this question. The authors hypothesised that the simultaneous presentation of an opposing

question may have served as a distraction. Therefore, discussion within each focus group centred on what is *not working* within the current system and recommendations for change.

In this research by (Smith *et al.* 2002), the findings resulted in two themes- Obstacles identified within the system and recommendations for change (Smith *et al.* 2002). A distinction in first theme was made between Intra agency (obstacles within substance abuse treatment centres and obstacles within the child welfare delivery system), and inter agency obstacles ((Infrequent visitation, lack of communication and coordination between system participants, and limited services for children).

The participants in this study regarded intra-agency obstacles as the number one factor contributing to the failure of the current system (Smith *et al.* 2002 p.8). But within this convergence, divergences were also evident, whereby child welfare system were attributing blame to the substance abuse treatment and vice versa. Chemically dependent mothers however viewed the service system inadequacies as lying more within the child welfare system (Smith *et al.* 2002). The substance abuse treatment system was criticised in the findings for its provision of services with a predominant focus on the individual, a lack of preparation of parents to re-engage with their children, and a lack of parenting education or family inclusive treatment (Smith *et al.* 2002).

Concerns regarding the child welfare system were the second most frequently discussed obstacle to family reunification, with most of the complaints coming from the mothers and substance abuse service providers (Smith *et al.* 2002). The child welfare service delivery system was criticized for its lack of information and training in the area of chemical dependency, and of unfair treatment towards chemically dependent mothers, involving stereotyping and discrimination. The latter was noted by a large proportion of the mothers (Smith *et al.* 2002).

The inter-agency obstacles identified in this study concern both service delivery systems, with obstacles related either to the communication and coordination between the two service systems, or to services that both substance abuse and child welfare provide in the family reunification process (Smith *et al.* 2002). The inter-agency obstacles identified included Infrequent parent/child visitation, the lack of communication and coordination between system participants, and limited services for children (Smith *et al.* 2002)



In relation to *The Lack of Communication and Coordination Between System Participants*, the family reunification service delivery system was viewed as providing separate and conflicting treatment goals that do not reflect a family focus in working towards a goal of family reunification, and of not communicating with one another during the process, with an absence of formal decision-making processes in relation to reunification of families. Finally, in relation to limited services for children, all three types of stakeholders identified the lack of specially designed services for children affected by maternal substance abuse (Smith *et al.* 2002).

In relation to the recommendations, the intra-agency recommendations suggest a stronger family focus in substance abuse treatment and increased substance training and education for child welfare service providers and the inter-agency recommendations emphasize aftercare and support, and increased communication and coordination between the systems (Smith *et al.* 2002). The mothers' most identified problems with the child welfare service delivery system. In addition, they strongly voiced their desire to have their children included in treatment and to have parenting preparation in their substance abuse treatment program (Smith *et al.* 2002).

Barnard & Bain (2015) in their study in the UK explored professional decision-making over 6 months ( $n = 20$  professionals) with a small number of families ( $n = 6$ ) defined as in need of supportive intervention, an early intervention option for children from substance misusing families, using semi-structured interviews. Early identification of such families offers the possibility of early supportive intervention, either to help prevent or divert potential parenting deficits that are deleterious to children or, to act swiftly to remove children where these deficits appear systemic (Barnard & Bain 2015).

In the results the authors presented 5 themes that arose - The enquiring gaze, parental resistance, concealment, non-co-operation, and Talk the Talk: disguised compliance with services. The themes, according to Barnard & Bain 2015, highlighted an unresolved dilemma inherent in the existing protocols which relates to the fact that the support offered to families is inextricably linked to an intention to monitor child welfare, that naturally evoke resistance, based on previous parental experiences of stigma and judgement, and fear of consequences of engagement, creating a dynamic of fear of the potential consequences of that oversight, resulting in a lack of meaningful engagement with services, which can have consequences for the welfare of the children. Whilst the monitoring component is driven by the desire to know what the circumstances for the child are, the approach can produce counter measures of

concealment, disguised concealment, resistance and or disengagement. An inherent power dynamic is also at play. (Barnard & Bain 2015).

Barnard & Main (2015) in their summary, argue that the key question that arises from this study is how to ensure that such help is provided in a voluntary system that relies to a significant degree on the willingness of parents to engage with services in order to even reach the children, and offer two linked possibilities here to overcome parental resistance: firstly, better communication skills on the part of those delivering services; and secondly, exploration of the possibility of putting some distance between the offer of support and an often all too close link with the threat of punitive action.

A key main finding from the studies reviewed relates to the pervasive dominant risk focused agenda, explicitly raised by a number of authors, highlighting how this is at odds for both the parent in recovery, the child, and the grandparent (Gair *et al.* 2018, Scott *et al.* 2018, Zuchowski *et al.* 2019).

In concluding their research, Scott *et al.* (2018) raise two pertinent questions for future consideration: Firstly, whether the current child protection system is too focused on risk to support a recovery vision? They cite literature that argues that the system in New Zealand, involves a disciplinary neoliberalism, which focuses exclusively on children, treating parents instrumentally – not as ends in themselves but simply as a means of caring for children - or and understanding them as feckless and risky (Hyslop 2017, p. 4). Secondly citing Featherstone *et al.* (2014), they ask “Is it ethically desirable to focus on rescuing children and leaving their parents behind in a society riven by inequalities?” (Featherstone *et al.* 2014, p. 3).

Smith *et al.* 2015 also spoke of how participants would not answer the question relating to what works within the system. Offiong *et al.* 2020 spoke of how the lack of success stories in their particular study could be in part have informed the perspectives of participants, influenced by the additional social and environmental issues at play in addition to the parental substance misuse. Furthermore, in their study, the inclusion criteria for parents was ‘a history of drug use’. This is a very broad concept and as such may have influenced the findings. In addition to this, the literature review in the study was predominantly deficit focused (Offiong *et al.* 2020). Similarly, Gair *et al.* 2018 and Zuchowski *et al.* 2019 highlighted that over 1/3 of the sample were Aboriginal who are a group with a historical background of deep mistrust in child services which may also have influenced the findings. In Barnard & Bains 2015 study, while they set out to

interview 6 family members in addition to the 20 service providers, only 2 participated – this appears to be reflected in the findings where the voice of the parents seems limited.

In relation to the use of multi-perspectives, variations in the application of perspectives was evident in the studies. For a number of the studies, it was not always possible to ascertain which stakeholder perspective was involved in the findings being presented. Additionally, in a number of studies, the findings reported were driven by one particular cohort and other voices supported or contested this often in a secondary minor role. Other studies however clearly demarcated the unique stakeholders' perspectives in the findings effectively highlighting discrepancies and convergences (see Table 4 for detailed breakdown). A consistent finding across all studies rested on the disconnect between child protection services and drug treatment services, with each system acknowledging challenges inherent in the systems but each pointing the finger at the other in terms of a resolution. Many challenges remain unresolved and require further examination.

Despite the limitations reported above, the studies reviewed above using multi-perspectives to explore the phenomena under investigation, add significantly to the existing literature both by its use of multi-perspectives, but also through the reporting of the findings that utilised the different stakeholder perspectives to highlight disparities that underpin challenges experienced by parents who use substances, in particular in relation to their critical interface experience with child and family social work services and addiction services. Multi-perspective approaches add important experiential and systemic dimensions to the majority of existing research, which has been criticised in the past for de-contextualising and isolating the views of key stakeholders. The multi-perspective approach enables the exploration of shared and distinct claims made by participant groups and facilitates greater understanding of the issue (Rostill-Brookes *et al.* 2011). Finally, the multi-informant perspective allows for triangulation and credibility of the findings. The ability to capture the lived experiences of a vulnerable, and often hard to reach population permits researchers and health professionals to develop strategies and resources that are human centred (Offiong *et al.*, 2020).

## 2.8 Conclusion

In summary, the literature reviewed in Chapters 1 and 2 provide a strong rationale for the current study. While globally, children of parental substance misuse have become recognised as a distinct group in need of specific attention (United Nations Office on Drugs and Crime 2016,

Executive Office of the President of the United States 2010, 2016, European Union Institutions 2017), the literature reviewed also highlights that in the area of parental substance misuse and children, a dominant risk focus and deficit framing approach and narrative pervades, emphasising the extent to which this can impede not only the parent, but the child, the grandparent and all other family members (Moe *et al.* 2007, Scaife 2008, O' Gorman 2016, Velleman & Templeton 2016, Gair *et al.* 2018, Scott *et al.* 2018, Zuchowski *et al.* 2019, Davis *et al.* 2020, Offiong *et al.* 2020). Key risk factors external to the immediate and extended family identified in the literature referred to a potent "perfect storm" of political conservatism, early intervention, a risk averse environment, poverty and mistrust, all of which, if unaddressed, can lead to an unabated removal of children from parents and challenges with reunification (O' Gorman 2016, Gair *et al.* 2018, Scott *et al.* 2018, Zuchowski *et al.* 2019).

While there is an expanding literature in relation to the protective factors connected with parental substance misuse and children, gaps remain within this research where the focus has tended to be on outcomes, with much less being known about the lived experiences, the everyday social processes, interactions, and incidental events that may constitute resilience promoting contexts, or indeed, how they are made sense of at the time, or in retrospect, by the individual, or individuals concerned. In particular there have very few studies undertaken into protective factors and their relationship with resilience specifically with children living with parental substance misuse (Moe *et al.* 2007, Backett-Milburn *et al.* 2008, Velleman & Templeton 2016). Research that contributes to an understanding of factors that lead to resilience of children of parental substance misuse has enormous implications for practitioners and researchers alike (Moe *et al.* 2007, Backett-Milburn *et al.* 2008, Dawe *et al.* 2008, Scaife 2008, Velleman & Templeton 2016).

The literature reviewed highlights the need to build on the existing emerging qualitative data, to provide meaningful insights, a more nuanced examination of meaning and experience, and to ensure that accounts from those most intimately affected by the experience are not marginalised in favour of an over reliance on case records and psychometric measures (Moe *et al.* 2007, Velleman & Templeton 2016, MacDonald *et al.* 2018). Phenomenological approaches to capturing the lived experience were recommended and adopted by a number of authors (Ronel & Levy-Cahana, 2011, Rostill-Brookes 2011, Mac Donald *et al.* 2018, Offiong *et al.* 2020). This concept privileges lived experience as a source of expert knowledge, and suggests that researchers should engage closely with people's attempts to *make sense* of those experiences,

in order to better understand their relationship to, and involvement in, a given phenomenon (Smith *et al.* 2009).

Very few studies have been conducted on the lived experience of risk and protective factors from those most intimately affected, in particular studies that capture the critical multi-perspectives of the key stakeholders belonging to and responding to the lived world (Rostill-Brookes *et al.* 2001, Templeton *et al.* 2006, Moe *et al.* 2007, Staton-Tindall *et al.* 2013, MacDonald *et al.* 2018, Velleman & Templeton 2016, Larkin *et al.* 2018).

Research in the area of children of parental substance misuse consists mainly of the voices of parents, and in more recent years, children themselves. Within the parent studies however a key gap identified related to research which has predominantly focused on maternal contributions, rather than also incorporating paternal contributions, which the authors argued represents a significant short coming in the literature (Scaife 2008). Similarly, Velleman & Templeton (2016) in their review of the literature identified that Parental gender influences the role of a protective factor and that it is believed that research has not done enough to consider the specific impact on children, and fathering, where paternal problems are present. In relation to children as a stakeholder focus, researchers have also highlighted that where research does exist with children of parental substance misuse, the tendency has been to focus mainly on younger children, which the author argues limits the understanding of the nature and impact of the problem on children as they grow up, and their own responses to it (Backett-Milburn *et al.* 2008).

There have been fewer studies involving the critical voice of the grandparent who in many cases assumes the pivotal role of carer for children of parental substance misuse (O'Leary & Butler 2015, Gair *et al.* 2018, Zuchowski *et al.* 2019, MacDonald *et al.* 2018, Davis *et al.* 2020). Where studies have included the voice of grandparents, limitations to these studies include a focus solely on the grandparent's caregiver experience, resulting in an acknowledged lack of information about the needs and experiences of the children living in these arrangements, in particular those in informal care arrangements (MacDonald *et al.* 2016). The authors highlighted a vital need that future research should supplement the findings from recent large-scale analyses of census data with qualitative studies that examine, phenomenologically, the needs and experiences of kinship carers, and the children for whom they care (MacDonald *et al.* 2016). In addition to this, whilst service providers play a key role in responding to the issue, the voice of service providers as a key source of information is limited. Typically, where service providers

are included in research, the voices of child and family services and or drug treatment services are captured separately with little being done to bridge the gap between these voices, by examining how one might serve both goals. It is important to know and understand the perceptions and experiences of both these service systems in order to deter an unintentional misdirection of resources (Staton-Tindall *et al.* 2013, Rostill-Brookes *et al.* 2011).

A final important point from the literature reviewed related to the choice of a conceptual framework or model. Many authors argued the strengths of adopting Bronfenbrenner's ecological systems theory (Bronfenbrenner 1979, 1996), as a conceptual framework, which is useful to shape an understanding of how children are affected by family, social adversity, and the environments in which risk and protective factors operate (Hogan 1998, Moe *et al.* 2007, Dawe *et al.* 2008, Scaife 2008, Templeton 2013). Adopting such a model helps capture the complexity of influences that impinge on child of parental substance misuse, by focusing attention both on child and context as they relate to each other (Hogan 1998), avoids implicitly adopting a model of parental drug misuse which locates all risk factors for child outcomes in the skin of drug-misusing parents (Scaife 2008), and steers the researcher from adopting a biologically and individually orientated, overly simplistic model, which ignores the sociocultural and political context contexts of drug use and the complexity of factors giving rise to and maintaining substance use (Hogan 1998). While it is well established that children raised in families with parental substance misuse often have poor developmental outcomes, parental substance abuse co-exists with other risk and protective factors across multiple areas of family life and it is the sum of these various influences that determine the outcomes of children. The authors highlight the importance of exploring the issues within an ecological framework (Dawe *et al.* 2008).

Practically speaking, ecological theory offers a means for understanding the external influences upon the child and his/her subsequent development. The ecological model offers a way to a greater understanding of the context in which the child lives and the interrelationships between those contexts and the development. In order to understand human development, one must consider the entire ecological system in which growth occurs (Bronfenbrenner 1994). For research exploring lived experiences of risk and protective factors of children, a theoretical framework that positions the child as central, whilst concurrently facilitating the exploration of the influence of different contexts on the child, Bronfenbrenner's Ecological systems theory provides a suitable framework for exploration and analysis (Hogan 1997, 1998, Dawe *et al.* 2008. Scaife 2008, Templeton 2013).

In summary, the literature reviewed above provides a strong collective rationale for the current study through emphasising clearly the need for a more balanced and holistic approach to research into the children of parental substance misuse. This includes exploring experientially protective factors in addition to the risk factors, capturing the perspectives of multiple key stakeholders in relation to the lived experience, and adopting a theoretical framework that captures the complexity of influences that impinge on children of parental substance misuse. The literature highlights the importance not only of the parent voice (paternal and maternal), and the child voice in relation to substance misuse, but of the grandparent as carer family and also the critical interface between family members and the services they interact with. The overall aim of this thesis research is to explore the lived experience of risk and protective factors of children of parental substance misuse from the multi perspectives of parents, children, grandparents and two key service system providers, child and family services and drug and alcohol services, using Bronfenbrenner's Ecological systems theory as a conceptual framework. This research will provide a unique contribution to the literature in this area. In addition to this, the research in this thesis will provide necessary insight within an Irish setting, contextualising further the research to date. In the following chapter we outline how we approach this unique contribution methodologically.

## Chapter Three: Study design and methodology

### 3.1 Introduction

This study design, based on a concurrent quantitative and qualitative multiple method design, facilitated exploring quantitatively the prevalence of children of parental substance misuse, and, qualitatively, exploring intergenerational (adult children, parent, and grandparent) and service providers lived experiences of the risk and protective factors for children of parental substance use. Multisource enumeration and benchmark multiplier methods were used for the prevalence estimates, and semi structured interviews and focus groups were used to explore the lived experiences.

### 3.2 Aims and research questions

The overall aim of this research was to identify and explore lived experience of the risk and protective factors for children of parental substance use from an intergenerational and service provider perspective.

#### 3.2.1 Objectives

1. Estimate of the prevalence of children impacted by parental substance misuse, across the communities of a regional drugs task force area.
2. Identify and explore intergenerational lived experiences of the risk and protective factors of children of parental substance misuse from a triad of, parents who use drugs, adult children of parental drug misuse, and grandparents.
3. Identify and explore intergenerational experiences of the risk and protective factors of children of parental substance misuse from child and family service providers and drug service providers.

#### 3.2.2 Research question

The specific research question which this study aims to answer is:

What are the risk and protective factors for children of parental substance misuse from the lived experience perspective of key stakeholders from both within the family, and those external to the family who are involved with playing a part in responding to the issue?



### 3.3 Design overview

With the development and legitimacy of both qualitative and quantitative research, the combination of both types of research is expanding (Tashakkori & Teddlie 2003). Over recent years the alternative of combining methods – the multimethod approach - has emerged in different research areas as a way of improving research process and findings (Esteves & Pastor 2004). Multiple methods are used in a research program when a series of projects are interrelated within a broad topic and designed to solve an overall research problem (Morse 2003). Qualitative and quantitative methods should not be viewed as polar opposites since their combination introduces both testability and context into the research (Esteves & Pastor 2004). Collecting different kinds of data by different methods from different sources provides a wider range of coverage that may result in a fuller picture of the unit under study than would have been achieved otherwise (Esteves & Pastor 2004). In the literature it is common to find the terms ‘mixed method’ design, ‘multimethod’ design and ‘multiple method’ design that are very often used interchangeably (Esteves & Pastor 2004). However, it is important to distinguish these terms. Tashakkori & Teddlie (2003, p. 11) define multiple method as “research in which more than one method or more than one worldview is used.” Although some authors draw a clear and sometimes opinionated distinction between mixed methods and multimethod, for others, they are synonymous (Anguera *et al.* 2018).

For this study, the researcher adopts a multimethod research design. This involves carrying out two or more research methods and each of these research methods have to be carried out complete in themselves and rigorously, under the same project (Ahmed & Sil 2012). Subsequently researchers triangulate the results for purposes of forming a complete whole. Following the continued development and increase in legitimacy of qualitative and quantitative research, researchers have been observed to continuously combine both types of research. The use of the multiple methods research design is appropriate in cases where a series of interrelated projects can be undertaken within broad topics and further designed so that they solve overall research problems. Triangulation is recognized as the main advantage of using the multi-method research design (Ahmed & Sil 2012). Triangulation involves the validation of results and data through the combination of various methods and data sources (Tobin & Ritchie 2012). When quantitative and qualitative methods are used together, testability and context are introduced into research. When researchers collect different types of data using different methods and from different sources, they acquire coverage that is wider and that results in the construction of a fuller pictures of the units that they endeavour to study than would have been

achieved had they decided to use single methods (Bush 2012). Although triangulation was considered to be specific to qualitative research due to the greater need of the qualitative researcher to show the validity and reliability of his findings, it has come to be accepted in other research designs as well (Bush 2012).

The use of the multimethod research design enables the overcoming of the weaknesses of use of single methods and their limitations as this approach combines and brings together different methods (Hunter & Brewer 2015). Because each social research method can involve a different strategy for collecting data, and can lead to potentially valid empirical and theoretical generalisations about social life, employing a single kind of method may lead to a question on whether a similar or different result would have achieved through a different method (Brewer & Hunter 2006). In this context, each type of method has its own sets of flaws or imperfections. The possibility that choice of methods may lead to different outcomes for social research has led to an understanding that instead of seeing methods as mutually exclusive alternatives, there must be a greater attempt to combine methods, which is fulfilled through the use of multi methods research design (Brewer & Hunter 2006).

For the accomplishment of the different aims set out in this study, the researcher proposed a multimethod research framework that brought together different research methods, both qualitative and quantitative. Through the use of multiple methods, the researcher managed to increase the robustness of the findings as they were able to strengthen the findings through triangulation. Giving consideration to the context of the research and the research questions, the researcher gave deep thought onto what research method would be most appropriate in addressing the various questions. This section outlines the research methods that the researcher believes are appropriate for the study.

### **3.4 Quantitative method - prevalence estimates**

Currently there are two broad categories of methods for estimating the prevalence of people using drugs, namely direct methods (e.g. enumeration (counting) of known drug users and conducting surveys), and indirect methods (estimating numbers from samples of known drug users) (National Advisory Committee on Drugs & Cox 2003).

To address Objective 1 - Estimate of the prevalence of children impacted by parental substance misuse, across the communities of a regional drugs task force area, the key quantitative

estimation methods used in this study consisted of the direct estimation method- multi-source enumeration, and the indirect estimation benchmark-multiplier method.

#### 3.4.1 Definitions of quantitative methodologies

Multi-source enumeration involves counting the number of adults or children extrapolated from existing data sources (National Advisory Committee on Drugs & Cox 2003). Multi-source enumeration provides a more accurate method of estimating prevalence than counting from one data source. However, in order to avoid an over-estimate of prevalence it is crucial that sufficient identifying data on each person counted is available to ensure that the same person is not counted more than once in each of the sources used.

The benchmark-multiplier method is a commonly applied indirect method used to establish prevalence estimates (National Advisory Committee on Drugs & Cox 2003). This method involves applying a 'multiplier' to a 'benchmark' (the total of a sub-group of the drug-using population). The benchmark is then multiplied by an appropriate multiplier to estimate the total of the whole drug-using population.

The formula is as follows:

- T is the estimated total number of problematic drug-users
- B is the total number of unique, known problematic drug users who underwent treatment in a given year
- c is the estimated in-treatment rate, that is the percentage of problematic drug users believed to be in treatment. This may be estimated from surveys or from other related publications.

$$T = B / c$$

The quantitative data component consisted of secondary data analysis of a number of key data sources. For this study, the key data sources for secondary data analysis consisted of data from the 2010/2011 National Advisory Committee on Drugs Drug Use Prevalence Study (National Advisory Committee on Drugs Drug Use in Ireland and Northern Ireland: 2010/2011 Drug Prevalence Survey (National Advisory Committee on Drugs 2011), and 2011 Census data from the Central Statistics Office (CSO) at both a national and at one regional area level (Central Statistics Office 2011). The use of multiple year sources of data was unavoidable as the most recent year for each source was used in the study.

Prevalence was estimated using the benchmark multiplier method (National Advisory Committee on Drugs & Cox 2003). Benchmarks included local results of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recommended 2010/11 general population survey of the National Advisory Committee on Drugs and Alcohol (Ipsos 2011), treatment numbers from 2014 from the Irish, EMCDDA Focal Point and data on local population sizes and ages from the 2011 national census. The multiplier was from Galligan & Comiskey (2017) which was derived from a multisource enumeration audit of 2014 records. The benchmark-multiplier method created a range of estimates from the minimum number of children known to be possibly impacted through to an estimate of a far greater number of children who were potentially impacted but are not counted currently. This latter group of children were described as being hidden from current service providers.

### 3.4.2 Data sources

Several data sources were used to derive the prevalence estimates, and these are detailed below.

#### *3.4.2.1 National Drug Prevalence Survey (2010/11): Drug Use in Ireland and Northern Ireland*

Established in 2000, the National Advisory Committee on Drugs and Alcohol (NACDA) provides advice to the Government on problem substance use in Ireland in relation to prevalence, prevention, consequences and treatment based on its analysis of reliable research and other relevant information available to it. Beginning in the year 2002/3, the NACDA commenced the process of carrying out a national drug prevalence survey. The survey is jointly undertaken between the National Advisory Committee on Drug and Alcohol and the Public Health Information and Research Branch of the Department of Health, Social Services & Public Safety in Northern Ireland and measures the prevalence of key illegal drugs as well as alcohol, tobacco and other drugs including tranquillisers and anti-depressants.

The population survey is a drug prevalence survey and is intended to reflect drug use in the general population as a whole. For the purposes of this survey, the general population refers to those aged 15-64 and normally residing in households in Ireland and Northern Ireland. It does not include those residing in institutions such as prisons, residential care, nursing homes, hospitals etc., hence the term general population. Fieldwork was carried out between October 2010 and May 2011 and the final sample comprised 7,669 respondents (5,134 in Ireland and 2,535 in Northern Ireland).

While earlier surveys included questions on alcohol consumption, the 2010/11 survey (Ipsos 2011) marked the first time a comprehensive series of questions on both the rates and patterns of alcohol consumption in Ireland and on alcohol related harm had been included. Reports from the NACDA explored the findings of Alcohol consumption and alcohol related harm from their surveys, and for the purposes of analysis, the population reported on was people aged 18-64 years. The illegal drug using population reported on was for people aged 15-64. Within our study, we calculated our estimates based on these age groups to mirror these findings.

Lifetime prevalence is a cumulative measure of the total number of people who have ever tried drugs and includes many who have done so in the past. While valuable for other purposes, lifetime prevalence is not ideal for monitoring drug use prevalence in the general population. Recent or current levels of drug use as measured in the last year or last month are more appropriate indicators. For the purposes of this study, we chose the figures representing Last year prevalence- i.e. “Recent” levels of drug use. For the estimate calculations on illegal drug use data at both the national level and the SEDATF level were referred to. For the alcohol level data, only national level data was available.

#### *3.4.2.2 ROSIE Drug Treatment Outcome Study*

The ROSIE Study (Comiskey *et al.* 2009) was a national level longitudinal study commissioned to establish the current impact of methadone treatment on the health of individuals and on offending behaviour. A total of 404 opiate users were recruited into the study. The participants were interviewed at baseline, year 1 and year 3. The main outcome measures included in the study were drug-using behaviour (including drug type, frequency and quantity of use), health (physical and mental), social functioning (employment, accommodation and family relations), harm (injecting-related risk and overdose), mortality and crime. However, this study also asked participants about the number of children they had, and if they currently lived with their children. This innovative step in data collection facilitated this study as an additional data source for the validation of the number of children to parent multiplier.

#### *3.4.3.3 Census 2011 Data*

The 2011 census data was the most recent census data available for analysis. The census is a detailed account of everybody who is in the country on census night, during which everybody in Ireland is required to enter their details on a census form. The importance of the census is

that it accounts for everybody in the country no matter where they are. The results provide invaluable information on not only population size for the country as a whole, but also about the make-up of the population of towns, villages, and other small areas across the country. As well as collecting information on the age and sex of the population, a range of different questions relating to households and individuals are also asked such as where and what people work at, how people travel to work, school and college, languages spoken, disabilities, families, housing and lots more.

For the purpose of this study, we were interested in the 2011 population data for a regional drugs task force area described previously. To amalgamate the regional drug tasks force area data, each data set for each of the relevant counties were extracted separately, and combined with one another, to create a table of amalgamated data for the area. This was repeated for the 15-64-year-olds, the 18-64-year olds and the Under 18s to facilitate estimate calculations in line with the National Advisory Committee Drug Prevalence 2010/2011 study. This data is available below in summary form.

#### *3.4.2.5 Time periods*

The different data sources referred to different time periods; in particular, data on population sizes came from the 2011 Census data (Central Statistics Office 2011), and the NACD National drug misuse prevalence estimates also referred to the years 2010/2011 (National Advisory Committee on Drugs 2011), however the NDTRS data was 2014 (National Drug Treatment Reporting System 2015), and the number of children per parent using substances multiplier was derived from other task force services and child and family services data from 2014 (Galligan & Comiskey 2019). The use of multiple year source of data was unavoidable as the most recent year for each source was used in the study.

### **3.5 Qualitative method**

The qualitative component of this study was framed using a multi-perspective interpretative phenomenological study design, that explored the lived experiences of risk and protective factors for children of parental substance misuse. For collection of data, semi structured interviews and semi-structured focus groups were utilised. Participants in the interviews included parents who used substances together with adult children, and service providers while in the focus groups, grandparents were involved. An explanation is provided of Interpretative Phenomenological Analysis (IPA) ontological and epistemological positioning together with a

discussion on why IPA is given consideration as a methodology that is the most appropriate to this dissertation with regard to its aims and objectives, the role of the researcher and the dynamics of the research.

The adoption of an innovative approach to IPA, which involves the use of the multi-perspective design approach, is also discussed. This chapter explores also two of the other methodological approaches, Grounded theory and ethnomethodology that the researcher gave consideration to providing details which they were not used for the study. Additionally, there is also an account of obtaining ethical permission, and access to and rationale for the used sample in addition to a detailed discussion of the methods that were utilized for the generation of data and its subsequent analysis. 3.5.1 Introduction to interpretative phenomenological analysis.

### 3.5.1 Introduction to interpretative phenomenological analysis

For the qualitative component of this research study, an Interpretative Phenomenological Analysis (IPA) methodology was used. IPA is a recently developed (Smith 1996) and rapidly growing approach to qualitative inquiry (Smith 2015). It was created as a specifically psychological experiential research methodology, arguing for an approach to psychology which was able to capture the experiential and qualitative, while being able to dialogue with mainstream psychology (Smith *et al.* 2009). IPA is dedicated to the detailed exploration of personal meaning and lived experience (Smith & Osborn 2015). In particular, the aim of IPA is to explore in detail how participants are making sense of their personal and social world, and the main currency of an IPA study is the meanings that particular experiences events and states hold for people (Smith 2015).

While IPA was only introduced in the 1990s, it draws on concepts and ideas with much longer histories (Smith *et al.* 2009). It is described it as a study of experience directed by three key theoretical influences: phenomenology; hermeneutics, and idiography (Smith *et al.* 2009, Smith 2015).

IPA strikes important balances between developing its (complex) philosophical and theoretical foundations while presenting them in a way which is accessible to incoming researchers; between developing clear guidelines and steps for conducting the research, while insisting on flexibility and innovation; between clear procedures for analysis and sophisticated interpretative work (Todovora 2011 p2). A key recent innovative approach within IPA, is the adoption of multi-perspective designs to explore complex experiences from more than one perspective (Larkin *et al.* 2018).

### 3.5.2 Ontological and epistemological positioning

IPA, dedicated to the detailed exploration of personal meaning and lived experiences, adopts an interpretive ontological stance (Smith & Osborn 2015). It is concerned with revealing and bringing to light, individual personal perceptions or accounts of – events and experiences, rather than providing an objective statement of the event itself (Smith 2015). Reality is not viewed as objective in IPA. Instead, IPA is committed to comprehending the person's own experience, the meaning their experience has for them, the reality of their experience, and, critically, the interpretation which the researcher makes of the person's meaning (Smith 2015). The epistemological position of IPA rests on the person's subjective account of experience (Smith 2015). Supporters of IPA refer to this process of the researcher making sense of the participant's sense-making as the double hermeneutic (Smith 2015) and is the first definition of this concept. Engaging with the double hermeneutic is considered central to knowledge making. Knowledge also comes about through understanding, which arises through empathy, but also questioning. Thus, the second meaning of the double hermeneutic is this twofold approach to understanding. IPAs primary interest is the lived experience of the participant and the meaning they make of it. The end result is the account of how the analyst thinks the participant is thinking (Smith *et al.* 2009).

While IPA was developed as a specifically psychological experiential research methodology just over 20 years ago, IPA has both a short and long history. In addition to its ontological and epistemological positionings, IPA is a study of experience informed by three key theoretical influences: phenomenology, hermeneutics, and idiography (Smith 2015). These influences are explored below.

### 3.5.3 Phenomenology, Interpretation, and Idiography

Founded by Edmund Husserl (1859-1938), Phenomenology is a philosophical approach to the study of experience (Smith et al, 2009). For Husserl, this involves the careful examination of human experience (Smith et al. 2009). IPA is part of a small family of methods informed by Phenomenology and is situated within a continuum of phenomenology which has description at one end and interpretation at the other (Smith 2015). For psychologists, a key value of phenomenological philosophy is the provision of a rich source of ideas about how to examine and comprehend lived experience (Smith et al. 2009). While Husserl was concerned to find the essence of experience, IPA has a more modest ambition of attempting to capture particular experiences as experienced for particular people (Smith et al 2009 p1). Experience is a complex concept (Smith et al. 2009), which is explored further on in this section.



The founding principle of Phenomenological inquiry is that experience should be examined in the way that it occurs, and on its own terms, (Smith et al. 2009). Famously Husserl argued that we should 'go back to the things themselves' (Smith et al 2009 p. 12). Husserl's phenomenology involved stepping outside of one's everyday experience, putting aside ones "*natural attitude*" or *bracketing* this off, in order to examine that everyday experience. This natural attitude is said to be people's everyday assumptions about how things are. Instead, adopting a *phenomenological attitude* involves and requires a reflexive move, turning our gaze from e.g., objects in the world, directing it inward, toward our perception of those objects (Smith et al. 2009). In order to achieve the phenomenological attitude, Husserl developed a *phenomenological method*, intended to identify the core structures and features of human experience. The method which Husserl describes proceeds through a series of '*reductions*' (Smith et al. 2009). For Husserl, it is possible to get to the essence of an experience by putting aside this natural attitude (or bracketing this off) using a process referred to as the *phenomenological reduction*. Husserl articulates *reduction* as a radical self-meditative process where the philosopher "brackets" the natural world and world of interpretation in order to see the phenomenon in its essence (Finlay 2008, p2).

In IPA, Bracketing is a significant concept. It encapsulates the process by which the analyst attempts to put to one side, temporarily, their own pre-existing understandings, in order to understand the phenomenon under investigation. According to Husserl this involves putting aside the natural world and the world of interpretation in order to see the phenomenon in its essence (Finlay 2008).

Certain philosophers however, challenged Husserl's approach, claiming that the reduction purported by Husserl is not possible. and that the most that could be accomplished is Interpretation, the second phenomenological strand of IPA - Hermeneutic or Interpretative phenomenology (Smith et al. 2009).

Heidegger, the key advocate of hermeneutic phenomenology, disagrees that phenomenological reduction as Husserl views it, as achievable. On the contrary, Heidegger views phenomenology as an *interpretative* activity (Smith et al. 2009). Heidegger began his philosophical career as a student of Husserl's but diverged from Husserl in his approach to phenomenology. Heidegger questioned the possibility of any knowledge outside of an interpretative stance, whilst grounding this stance in the lived world (Smith et al. 2009).

The theory of interpretation, or Hermeneutics, originated from its concern with the interpretation of text – in the first instance biblical text, as it endeavoured to discover and reveal the authors meaning, IPA proposes that similarly, the researcher can unearth, in analysing text in detail, that which lies hidden (Smith et al. 2009).

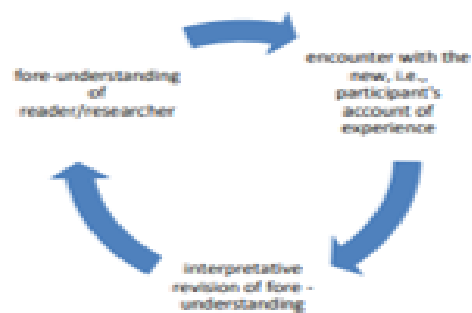
In IPA, the processes of bracketing or adopting the phenomenological attitude are also influenced by hermeneutics. The researcher or analyst thus needs to ensure that they consider their own pre-conceptions, and the way in which this leads to new interpretations, as much as is possible to do so.

The hermeneutic circle is an additional hermeneutic concept important to IPA and provides a useful way of thinking about method for IPA researchers (Smith *et al.* 2009). Fundamentally, analysis is cyclical, -the researcher tries to make sense of the participant trying to make sense of their experience, engaging in the ‘double hermeneutic’. Therefore, the researcher assumes a central role in analysis and interpretation of the participants’ experiences (Smith *et al.* 2009).

Depicted as circles, one representing the participant and the other the researcher, these circles merge at one point (Figure 1). Movement around the circle and the degree of touching alters as the analyst engages in bracketing, interpretation and reconsidering their predispositions. This impacts movement around the circle and the degree of touching. This is undertaken by the researcher who unearths meaning within the data and is an ongoing cyclical process (Figure 1). The hermeneutic circle model deals with the dynamic relationship between the ‘part’ and the ‘whole’ at numerous levels for a holistic analytical interpretation. In relation to IPA, the ‘part’ corresponds to the encounter with the participant in a research project, and the ‘whole’ the drawing of knowledge and experience of the researcher (Smith *et al.* 2009).



Gil-Rodriguez and Hefferon, 2012 p. 20



Gil-Rodriguez and Hefferon, 2012 p. 20

Figure 1: The hermeneutic circle in IPA analysis

IPA is also said to be fundamentally idiographic. Idiography is the third major influence upon IPA (Smith *et al.* 2009). Idiography is concerned with the particular, and for IPA, this commitment to the particular operates at two levels (Smith *et al.* 2009). Firstly, there is a commitment to the particular in the sense of detail, and ergo depth of analysis, which must be systematic and thorough. In the second instance, IPA is committed to understanding how particular experiences have been understood from the perspective of particular people in particular contexts.

Idiography can refer to the to the commitment to the single case in its own right or to a process which moves from the examination of a single case to more general claims. IPA does not avoid generalisations, rather prescribes a different way of establishing these generalisations (Smith *et al.* 2009). In IPA, similarities and differences across cases can also be examined, creating patterns of meaning for those reflecting on a shared experience (Smith *et al.* 2009). This thesis strives to explore the particular experience of a triad of adult children, grandparents and parents of parental substance misuse, and service providers involved in the lived world, and will undertake one case in the first instance and then similarities or differences across cases

Experience is a complex concept and requires attention in relation to IPA (Smith *et al.* 2009). Based on an explanation of experience by Dilthey (1976), experience consists of a hierarchy of different levels (Smith *et al.* 2009). The hierarchy starts with the most elemental level, whereby the person is caught up, unselfconsciously, in the everyday flow of experience. Once one becomes aware of what is happening one has 'an experience'. Finally, the comprehensive level, is where the experience has larger significance in the person's life (Smith *et al.* 2009). IPA is

concerned with this more comprehensive level of experience, in what happens when the everyday flow of lived experience takes on a particular significance for people. This most often occurs when something important happens in our lives. These comprehensive experiences consist of parts of life and these parts are the main focus of most IPA studies, with the researcher having a key role in facilitating the participants engagement with this comprehensive experience (Smith *et al.* 2009).

The concept of Lived experience is also used in IPA, which for IPA reflects an essential distinction of awareness which is more than just passing but rather is asserted (Smith *et al.* 2009). Experience is said to be lived and thus it is possible to reflect upon it. Reflection is key to the comprehension of experience and to the practice of research in IPA.

Lived experience is embodied in IPA by describing a sequence of layers, each representing an increased degree of reflection (Smith *et al.* 2009)). These layers present the 'bandwidth' for the individual when doing their reflections by themselves (Smith *et al.* 2009)). During the interview process, the participant will recount some reflection, but the researcher will ignite new reflections. For this thesis, the researcher will encourage the participants to reflect on the risk and protective factors for children parental substance misuse, engaging with the reflective loop, by stimulating recall and reflection and detailed analysis of the interview transcriptions.

Although IPA is a rapidly growing approach to qualitative enquiry, it is not without its opponents. In a critical overview of IPA, Tuffour (2017) highlighted and addressed a number of the key criticisms of IPA. Opponents have argued that it consists of ambiguities and lacks standardization (Giorgio 2010).

In the critique of Jonathon Smiths IPA, Giorgio (2011) , argues that the dual use of bracketing in IPA, (in terms of both parenthesising of the natural attitude, and putting out of play concepts or experiences coming from other sources other than the one being examined), demonstrates confusion in the use of the term "bracketing, Furthermore, that neither definition of bracketing references bracketing of the natural attitude, which is the main meaning of the phenomenological reduction, and without this, no realistic claim for phenomenological status of research can be made (Giorgio 2011). Smith however argues that the IPA methodology blends both together, allowing the adoption of a non-judgemental approach while concurrently remaining conscious of and holding back previous understandings, borrowing from the tradition, by adopting a more enlivened form of bracketing (Smith 2015).

Others have argued that IPA is mainly descriptive, not sufficiently interpretative (Larkin et al 2006, Hefferon & Gill-Rodriguez 2011). However, Tuffour (2017) argues that the ever-growing quantity of publications outlining theoretical, methodological and philosophical underpinnings of IPA have been pointed out to the critics (Tuffour 2017). Phenomenology as a research approach relies on the accounts of participants and the experiences of researchers. In relation to this, the question has been raised by critics of IPA, as to whether IPA can accurately capture the experiences and meanings of experiences rather than just opinions of it, asking if whether both the participants and researchers have the requisite communication to successfully communicate the nuances of experiences. This was suggested to be particularly the case when interviewing people about sensitive issues such as for example mental health. In their rebuttal of this, Tuffour (2017) highlight the elitist undertones of this criticism, which suggests that only those with access to the 'right' level of fluency, can describe their experiences. However, this criticism also highlights the need for acute attentiveness to collect rich and exhaustive data from participants, and ensuring adherence to the fundamental aspects of IPA, discussed previously. A final purported limitation of IPA raised, is that phenomenology seeks to understand the lived experience, but does not seek to explore the conditions that triggered the experiences, which are located in past events, histories and socio-cultural domain (Willig 2008). But Tuffour (2017) highlights that Smith *et al.* (2009) have sufficiently argued that IPA uses hermeneutics, idiographic and contextual analysis, to understand the cultural position of people's experiences.

#### 3.5.4 Innovations in IPA - Multi-perspectival designs

A key recent innovative approach within IPA, is the adoption of multi-perspective designs to explore complex experiences from more than one perspective (Larkin *et al.* 2018). Multi-perspectival designs use the building blocks of well-delivered traditional IPA designs (Larkin *et al.* 2018).

Multi-perspectival IPA retains a commitment to idiography in data collection and analysis but extends this by combining two or more focal perspectives, permitting us to consider the relational, intersubjective, and microsocial dimensions of a given phenomenon. (Larkin *et al.* 2018 p.2).

These analytic designs are however more complex (Larkin *et al.* 2018). The overarching aim is to produce an account that capitalises on multiplicity and offers a plausible interpretative perspective on how the participants' lifeworld's interact and overlap (Larkin *et al.* 2018). Researchers using interpretative phenomenological analysis (IPA) within applied research

typically use homogenous samples exploring shared perspectives on a single phenomenon of interest. In IPA, homogeneity” refers to a probable shared perspective upon the phenomenon of interest (Larkin *et al.* 2018). However, many IPA researchers are working within conceptual frameworks which recognise that an experience or process such as “living with substance misuse” is not solely located within the accounts of those with the ‘diagnosis’. The phenomenon is also located within the accounts of other people who belong to the “lived world” of the person, such as partner, children, friends, and colleagues (Larkin *et al.* 2018). Often a given group’s perspective is missing from the literature, or else it is present but misrepresented. At other times, however, it may be important to treat people’s experience as a lens for illuminating the broader meaning or consequences of an event or process to understand its wider constitution, dynamics, or mechanisms. In these situations, it can sometimes be helpful to adopt more complex designs (Larkin *et al.* 2018).

A number of studies, on topics exploring a diverse range of experiences, have used IPA to explore complex experiences from more than one perspective (e.g., Rostill-Brookes *et al.* 2011). These innovative studies open up new ways of thinking about the potential of IPA research and highlight both the challenges and opportunities within. Such an approach extends the potential reach and impact of experiential research in the “real world” (Larkin *et al.* 2018)

Phenomenologically speaking, events and processes in the world are perceived from somewhere and thus are encountered in “profile.” This means our experiences of events and processes are intersubjective and relational. Meaning is “in between” us but is rarely studied that way in phenomenological inquiry. One potential advantage to these sorts of designs is their capacity for greater impact. The convergence and triangulation of viewpoints can be more persuasive than an analysis drawn from a single sample (Larkin *et al.* 2018, p.13)

### 3.5.5 The choice of IPA

Research questions and the purpose of the particular research study require appropriate methodological approaches. When we choose an approach for qualitative research, we are choosing a perspective on the world and on our data. Understanding the theoretical underpinnings of qualitative research approaches, including IPA, is essential to any decision about which methodology is a best fit for a research study. For this thesis, fundamental considerations underpinning this choice rests on the right fit for the study in relation to its aims and objectives, the dynamics of the research, ethical implications, and the researchers owns

ontological and epistemological approach. This section of the chapter will now consider the aims and objectives of this thesis in relation to IPA.

IPA draws on many core philosophical and theoretical stances and borrows from them in different ways. While Husserl was concerned to find the essence of experience, IPA has a more modest ambition of attempting to capture particular experiences as experienced for particular people (Smith *et al.* 2009 p1).

IPA is committed to comprehending the person's own experience, the meaning their experience has for them, the reality of their experience, and, critically, the interpretation which the researcher makes of the person's meaning (Smith 2015). IPA also has an emphasis on convergence and divergence. (Smith *et al.* 2009)). This thesis study aims to do the same.

This thesis wishes to explore the human lived experience of risk and protective factors for children of parental substance misuse from each participant's and stakeholder's standpoint. It explores the intergenerational experience of grandparents, parents, and adult children, in conjunction with the experience of professionals working with children possibly impacted by parental substance misuse, and parents who are in treatment for substance misuse. The overall aim of this thesis is to identify and explore this lived experience from these multiple perspectives and specifically the sense made of the comprehensive or lived experience.

The key theoretical influences that underlie the choice of IPA for this thesis, require attention – i.e., adopting the phenomenological attitude, or bracketing. This requires the researcher to assume an open, non-judgemental approach to the data while also bracketing knowledge and past assumptions, and to retain this approach for the duration of the process. This thesis also adopts the phenomenological attitude. This is important as the researcher is abreast of the current knowledge, theory, and research on the risk and protective factors for children of parental substance misuse and has personal experience of parental substance misuse. Using the phenomenological attitude in IPA, permits the researcher to recognise and admit fore understandings and assumptions, to get to the experience under investigation. Concurrently, it is recognised that doing so is a recurring process, which is not entirely attainable. It is key therefore that the research embraces reflection and reflexivity.

As highlighted previously, the use of multiple perspectives within an IPA study is an innovative development within IPA, and the development of this approach aligns with the overall aim of this thesis. This thesis wishes to explore the lived experience of the risk and protective factors of parental substance misuse from the perspectives of those living with the phenomena and those belonging to the lived world. This approach facilitates the exploration of complex experiences from more than one perspective, extending the potential reach and impact of experiential research in the “real world. Furthermore, this innovative approach retains a commitment to idiography, in both data collection and analysis, but extends this by combining different perspectives, permitting a more comprehensive exploration of the experience, whilst also permitting synthesis of analysis not only *within* a sample but also *between* samples. The capacity to carry out analysis both within and between subject perspectives is of key importance to this thesis study. Larkin et al, (2018) argue also that persuasiveness is enhanced by incorporating the voices of two or more stakeholder groups, as is the potential contextual range of the analysis, resulting in more substantive findings in relation to the lived experience of the particular phenomenon -in the case of this thesis, risk and protective factors for children of parental substance misuse.

Both the researcher’s role, and the nature of the research, present an additional motivation for adopting IPA in this thesis, study. The professional skill set of the researcher, who has a background in psychology, extensive experience of carrying out qualitative research in applied community settings with a wide range of very vulnerable minority and marginalised groups, of interviewing in an open manner, and also of the critical analysis of information, is especially suited to IPA. This combination of skills enables the double hermeneutic through which knowledge is said to come about via empathy in the first place, and in addition to this, through questioning. The researcher also has a long-standing background in psychology and IPA was created as a specifically psychological experiential research methodology, arguing for an approach to psychology which was able to capture the experiential and qualitative, while being able to dialogue with mainstream psychology (Smith *et al.* 2009).

IPAs idiographic nature centres on the examination in detail of a particular case. For this thesis, caseness is a multi-layered concept. The challenge for the analyst is to retain IPA’s commitment to understanding participants’ claims and concerns (when, across the sample as whole, there may be more variation than in a traditional samples) whilst also illuminating those insights gained through inclusion of additional perspectives (Larkin *et al.* 2018) The skill set of the



researcher again here aligns strongly with IPA as a methodology. The researcher has extensive experience analysing and synthesising complex experiences from multiple stakeholders, including vulnerable participants. As discussed above, IPA is constantly evolving and adapting, and is a strong methodological fit for this aims and objectives of this thesis. Two other methodological approaches that were explored are discussed below.

### 3.5.6 Grounded theory

Grounded theory was developed in California, USA by Glaser and Strauss during their study—‘Awareness of Dying’ (Glaser & Strauss 1967). It is a methodology that seeks to construct theory about issues of importance in peoples’ lives. It is a research method concerned with the generation of theory, (Glaser & Strauss 1967) which is ‘grounded’ in data that has been systematically collected and analysed (Strauss & Corbin 1997).

Grounded Theory, and Constructivist Grounded Theory in particular, was considered as a possible methodology for this thesis. It is often seen as the main alternative for someone considering IPA for a research study (Smith *et al.* 2009).

Grounded theory has a strong trans-disciplinary identity. Thus, it is not necessarily either experiential or psychological, but it can be used in this way (Smith *et al.* 2009 p. 201). Grounded theory was originally developed to offer researchers a clear systematic and sequential guide to qualitative fieldwork and analysis (Glaser & Straus 1967). Grounded theory researchers generally set out to generate a theoretical account of a particular phenomenon (Smith *et al.* 2009).

There is considerable overlap between IPA and what grounded theory can do, and both have a broadly inductivist approach to inquiry. However, IPA is more likely to offer a more detailed and nuanced analysis of the lived experience of participants, with an emphasis on the convergence and divergence between participants (Smith *et al.* 2009 p. 202) and in the case of multi-perspective IPA, between and within multiple stakeholder perspectives (Larkin *et al.* 2018). In contrast to this, a grounded theory study of the same broad topic, is likely to push towards a more conceptual explanatory level, based on a much larger sample, and where the individual accounts can be drawn on to illustrate resultant theoretical claims (Smith *et al.* 2009). Both Grounded Theory and IPA focus on the individual. The focus however is on how the individual constructs and make sense of the world, or their reality and in turn a theory emerges as constructed by the researcher. IPA by contrast is concerned with the micro analysis of individual experience, with texture and nuance arising from arising from detailed exploration of

lived experience. IPA is focused on idiographic analyses of patterns in people's meaning-making rather than on producing a model or theory of an underlying process (Larkin et al. 2018).

Grounded theory as an approach also, like IPA, incorporates some degree of multiplicity in its conceptual design and sampling (Larkin *et al.*2018). Grounded theory does this via theoretical sampling, and its underpinning logic for multiplicity is driven by the need for theoretical completion (via sample saturation). The emphasis here, then, is on theoretical power. In IPA, the emphasis underpinning multiplicity overlaps to some extent with this aspect of Grounded theory, but the key component is the sense that important meanings are often located "in between" persons.

This research study aims to explore the lived experience of risk and protective factors for children of parental substance misuse, from multiple perspectives, and the aims and objectives of this thesis study are not aligned with the focus of grounded theory, and hence Grounded Theory was not appropriate.

### 3.5.7 Ethnomethodology

Ethnomethodology was developed in the 1950s and subsequently published in a pioneering collection of papers collated into one book (Garfinkel 1967). Studies using ethnomethodology are described as having a focus on "the objective reality of social facts as an on-going accomplishment of the concerted activities of daily life, with the ordinary, artful ways of that accomplishment being by members known, used, and taken for granted" (Garfinkel 1967 p. vii).

Ethnomethodology is a discursive methodology, described as the study of the methods that members use to produce recognisable social interaction. Ethnomethodology perceives the participants as actively making meaning in the interview with the interaction involving work between members to construct a mutually intelligible world. Conversely, in IPA, the interviewer prompts the participants, but refrains from sharing with the participant. The researchers role is to permit the participant to explore the sense they are making of their experience in order to provide a rich, detailed, first person account (Smith *et al.* 2009). For these reasons IPA was the preferred methodology.

### 3.5.8 Conceptual framework Bronfenbrenner's Ecological Systems Theory

This research is underpinned by Bronfenbrenner's ecological systems theory (Bronfenbrenner 1979).

Bronfenbrenner's EST was formulated by psychologist Uri Bronfenbrenner to explain how children's growth and development is affected by everything around them (Bronfenbrenner 1979). According to the theory, child development is a rather complex system of relationships that are affected by different multiple levels of the environments that surround them, from their immediate family settings to schools to customs, laws, and broad cultural values. Bronfenbrenner ecological systems theory posits that an individual undergoes certain developmental processes through interlinked social systems and that the development of an individual's ecology depends on this process (Bronfenbrenner *et al.* 2006). According to the ecological systems theory, with increase in age, the developmental processes in an individual's life increase in complexity (Bronfenbrenner *et al.* 2006).

The model originally consisted of four subsystems: microsystem, mesosystem, exosystem and macrosystem (Bronfenbrenner 1979). Bronfenbrenner portrayed these levels of environment as being nested into one another and viewed each system as arising from a setting. The model places emphasis on the importance of studying the child in the context of multiple ecological systems in order to fully understand their development and therefore presents with the child at the centre, surrounded by four influencing structures or ecosystems, the most influential and intimate of which is closest to the child (see Figure 2).

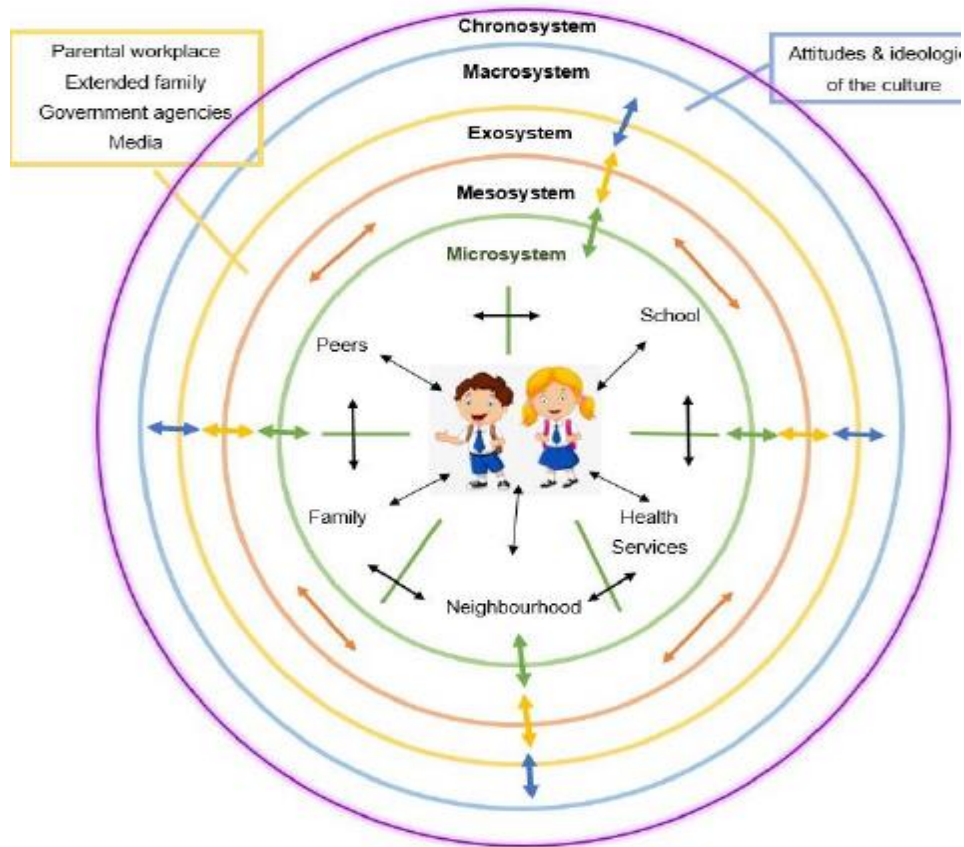


Figure 2: Ecosystems surrounding the child in Bronfenbrenner's Ecological Systems Theory (EST)

The theory posits that there are five interlinked systems in the ecological systems theory.

### Microsystem

The Microsystem is the first level of Bronfenbrenner's EST and is the system which is immediate to the child. The microsystem is the place where the face-to-face interaction occurs for the child, the position where the child plays a direct role, has direct experiences and has direct social interactions with others. The activities, roles and interpersonal relations combine together as the elements that make up the microsystem (Bronfenbrenner 1979).

"A microsystem is a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics" (Bronfenbrenner, 1979 p. 22)

The microsystem is instrumental in the development of the children with the family being the most significant influence within this system. In a microsystem, the relationships are bi-

directional which implies that other people within the same environments as the children can influence them and also have the capabilities of changing other people's actions and beliefs (Ostaszewski & Zimmerman 2006). Additionally, children's reactions to different individuals within microsystems have the potential of influencing how they end up treating them in return.

#### Mesosystem

The next system is the Mesosystem and involves the interaction of the microsystems and how these microsystems interact (Onwuegbuzie *et al.* 2013).

A mesosystem comprises the interrelations among two or more settings in which the developing person actively participates (Bronfenbrenner, 1979 p. 25).

This refers to the interconnections between the different microsystems, such as the interactions between family and neighbourhood or school. The mesosystem consists of the connections among context such as the relationship between family experiences and school experiences, and between school experiences and neighbourhood experiences (Onwuegbuzie *et al.* 2013).

#### Exosystem

The third system extends outwards to the next level and includes "other specific social structures, both formal and informal, that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which that person is found, and thereby influence" (Bronfenbrenner, 1977, p. 515).

The Exosystem, characterises links between the social setting in which the person does not have an active role to play, and the person's immediate context (Onwuegbuzie *et al.* 2013). For example, a parent's involvement in the judicial system could be a possible component of a child's exosystem because the parents involvement in the judicial system could have an impact on the child, but the child does not have direct involvement with judicial system.

#### Macrosystem

The fourth system is the Macrosystem which refers to the wider cultural environment in which the individual finds themselves. The macrosystem is the largest and most remote system from

the child. The macrosystem consists of values and cultural patterns which can change over time. It can be thought of as the blueprint for a particular societal culture or subculture (Bronfenbrenner & Ceci 1994).

The macrosystems refers to consistencies, in the form and content of lower order systems that exist, or could exist, at the level of the subculture of the culture as a whole, along with any belief systems or ideology underlining such inconsistencies” (Bronfenbrenner, 1979 p. 26).

### Chronosystem

An additional fifth system was later added to the original four core systems -i.e., the Chronosystem (Bronfenbrenner 1986). This system refers to the pattern of environmental events, transitions, and socio-historical circumstances that take place in the life of the individual (Bronfenbrenner 2009). This system represents how change, or continuity, across time, can influence all of the other systems. The main characteristic of such an experience or event is that they alter the existing relation between the person and the environment, thus creating a dynamic that may instigate developmental change (Bronfenbrenner 1989).

### **Applying Bronfenbrenner**

Bronfenbrenner EST emphasises the child’s interpersonal and social relationships. It proposes that humans develop through the processes of complex interactions between people and their immediate environment. These are known as ‘proximal processes’ and their content, power and form have a direct effect on development (Bronfenbrenner 1994). The extent by which proximal processes affect development varies according to the characteristics of the developing person, the environment and the nature of the development outcomes considered (Bronfenbrenner 1994).

Based on the theory presented by Bronfenbrenner (2006) it can be argued that in order to better comprehend the development of a child, it is always important to look at the children and also look at their immediate environments and also the interactions they have with their larger environments as well. The ecological systems theory provides a holistic and inclusive approach of the various systems that children and their families are involved in.

Scaife (2008) in their literature review of risk and protective factors for children of parental substance misuse argue that it is important to avoid implicitly adopting a model of parental drug misuse which locates all risk factors for child outcomes in the skin of drug-misusing parents and highlights the value of adopting Bronfenbrenner (1979) ecological framework as a useful conceptual framework for reminding researchers to avoid this pitfall. Multiple prominent authors in the field also reiterated this (Hogan 1997, 1998, Dawe *et al.* 2008, Templeton 2013, Brakenhoff & Slesnick 2015,).

In the case of parental substance use, it would therefore imply consideration of the interaction between individual characteristics of the child him- or herself, and multiple levels of context such as their parent's drug-related behaviours and caregiving competencies in the home, relations between family and school, the support available on the community, and the socio-economic position and service provision for drug users in the broader society in a particular time period. (Hogan 1997).

By adopting an EST framework, the study presented in this thesis embraces a whole-child perspective and enables the researcher to conceptualise the phenomena on five different levels. Bronfenbrenner's EST has been successfully utilised as the primary theoretical framework in other research concerning the lives of children (Hogan 1997, Dawe *et al.* 2008 Scaife 2008, Children of parents who misuse substances do not exist in seclusion, but rather are embedded into a larger social structure interconnected with other institutions and domains, therefore EST is a suitable framework for the research in this thesis.

### **3.6 Research design**

This section of the chapter outlines the specific research techniques that were used in the quantitative and qualitative component of this study. The chapter will begin with ethics, sampling, data gathering and data analysis.

#### **3.6.1 Ethical considerations**

Ethical approval for this research was obtained from the ethics committee of the Health Service Executive (HSE). The HSE is the publicly funded healthcare system in the Republic of Ireland, responsible for the provision of health and personal social services (Health Service Executive 2019). An additional ethical approval from Trinity College Dublin (TCD) was not deemed a requirement by TCD as the HSE Ethics was deemed sufficient.

The process for obtaining this permission involved the completion of standard ethics forms, compilation of Participant Information Sheets and Consent Forms, and attendance, in person, at a formal HSE Research Ethics Committee interview. Key ethical considerations in designing the ethics process centred on sensitivity to context, accessing participants, consent, secure handling and storage of data, confidentiality of participants, issues relating to avoidance of harm to participants, and finally the suitability of researcher. The Participant Information Sheet outlined the aims and methods of the study, including how to take part, participants rights, the consent process. measures that were to be adopted to secure the confidentiality of each participant, and of any person who may be discussed during the data generation, and of the safe storage of this data. The researcher also assured the ethics committee that as per the ethics application, confirmed supports were secured for before, during and after interviews, should any issues arise for the participants, and of the suitability of the researcher in terms of the researcher's psychology background and extensive experience researching marginalised vulnerable groups in applied community settings. The ethics committee were satisfied, and ethical approval was granted.

Following ethical approval, the process of gaining access to research participants began. Sensitivity to context was embedded in the research process throughout. In terms of accessing participants, a sensitivity to the vulnerability of the potential participants was in place. This included, an initial information session hosted by the service providers with potential participants, explaining the study in line with the information leaflet, and addressing any queries, which also facilitated the informed consent process. The contact details of the researcher were also made available to the participants, if they had any additional queries they wished to raise.

All forms were distributed through the gatekeeper at the point of access and interested participants were given 7-10 days to decide if they wished to consent to participate. This was revisited immediately prior to the start of the interview, with the researcher ensuring that the consent form was understood. The Consent Form was signed firstly by the participant and then following that, it was also signed by the researcher to acknowledge that the purpose of the research had been understood and consented to. The signed form was then securely stored separate to any data generated. A copy of all three documents is provided in Appendices 1 and 3. In addition to this, participants were also reminded before during and after the interview of their right to cease participation at any stage, to withdraw information supplied to that point,



and to omit or refuse to answer any question deemed unsuitable. During the interviews, the researcher remained vigilant for any signs of distress, checked in with participants regularly, reminding participants of the supports available, and endeavoured to ensure an open non-judgemental setting, where participants felt comfortable, safe, and could explore their lived experience in detail.

### 3.6.2 Context of the Research Study

This thesis research was carried out across a large region of Ireland, covered by the catchment area of a Regional Drug and Alcohol Task force (RDATF). This research study was commissioned by a RDATF.

The RDATF was established in the early 2000s as a result of a key recommendation arising from the National Drug Strategy 2001-2008, as one of ten Regional Drug and Alcohol Task Forces (RDATFs) in Ireland (Government of Ireland 2001). RDATFs are inter-agency bodies with representation from the statutory, voluntary and community sectors. The general aim of RDATFs is to co-ordinate an inter-agency response to the issues of substance misuse (with the recent addition of alcohol to the remit) in their areas/regions, within the context of the National Drug Strategy. RDATFs were modelled on the Local Drug Task Forces, established by the government of Ireland in 1997, but cover greater geographical areas and larger populations (Government of Ireland 2001). The overall region covered by the geographic spread of the RDATF varies both between counties and within counties, in terms of deprivation, population size, and rural versus urban composition, presenting differing challenges in relation to substance misuse across the region, including availability and access to services (Department of Health (2017). Not all areas experienced deprivation, but certain areas were rated higher than the majority of other areas in Ireland. In other areas at a county level, the deprivation was low scoring, but at a city level, deprivation was high (Teljeur et al. 2019). The steering committee for this research study consisted of nine key representatives from across both the RDATF, and child and family services.

### 3.6.3 Sample

The participant sample for this study consisted of key participants who were part of the lived world of the children of parental substance misuse. For this study, this included the adult child, the parent, the grandparent, and service providers from both drug treatment services and child and family services.

The researcher wished to access service provider participants, who were all current approved service providers who shared the same experience, of providing services to children of substance misuse or providing services to parents in treatment for substance misuse, and for whom the research question would be meaningful. In addition to this, the researcher wished to access participants who all had experience of parental substance misuse in relation to the child from the perspective of the parent in treatment, the grandparent responsible for the grandchild(ren) of that parent, and for adult children currently in treatment, who had lived with parental substance misuse. This sample method would also enable participants to give an in-depth account of the phenomenon in question. The sample was accessed, in the first instance, through the members of the steering committee. The chair, or gatekeeper, was contacted by email and also in person by the researcher to explain the purpose of the research and to seek access to participants. The gatekeeper agreed to distribute by email a request for participation to each of the service providers. The Participant Information Sheet, Consent Form were attached to the email. Participants responded direct to the researcher and offers were accepted in the order in which they appeared. This resulted in a contact with a representative of each service. In turn, this person distributed the request and those willing to participate in the study contacted the researcher direct. Again, the offer to participate was accepted in the order in which it appeared. It is suggested that studies using IPA should aim for an expert sample (Hefferon & Gil-Rodriguez 2011).

#### *Service Providers*

For this thesis study, the researcher wished to access service providers who were all current approved service providers who shared the same experience, of providing services to children of substance misuse, or providing services to parents in treatment for substance misuse, and for whom the research question would be meaningful. The steering committee members for this research study consisted of key representatives from the RDATAF, in addition to representatives from Child and Family Services, The steering committee members, were asked to take part in a semi structured one to one qualitative interview.

#### *Family Members and Current Service Users*

Family members and current service users were recruited via an initial information session provided by drugs service managers, to raise awareness of the research in their service and to establish if any existing service users or family members are interested in taking part. This information session included an information leaflet providing details of the research. Potential

participants were given the opportunity to discuss the study with the drug services manager and a member of the TCD research team in order to facilitate the informed consent process.

Inclusion criteria for the study were that:

- **Service users** needed to be a parent/guardian who is currently attending an HSE/SERDATF Drugs task force service for drug or alcohol usage
- **Family members** needed to have a member of their family currently attending an HSE/Drugs Task force service for drug or alcohol usage and that family member needs to be a parent/guardian. Potential research participants were informed of the aims of the study and told that should they agree to participate they would be asked to take part in research interviews of approximately 45 min duration. Potential participants were also guaranteed that audio recordings and transcripts of their interviews would be securely stored, and that pseudonyms would be used where interviewees were being directly quoted, so that neither they, their family members, nor their support services would be identifiable in any published research report.

#### 3.6.4 Participation rates

Following the dissemination of information and a request for cooperation from drug services to their combined client groups, there were a total of 37 people who self-selected to take part the research.

These participants consisted of

- 16 parent service users who took part in one-to-one semi structured interviews, each representing a separate family,
- 2 adult children who took part in one-to-one semi structured interviews, each representing a separate family,
- 12 self-selected grandparent family members who took part in two focus groups (N=7) and (N=5). The 12 grandparents represented 12 separate families,
- 7 of the 9 steering committee members who were available for structured one-to-one interviews.

All of the interviews took place in the local drug service centres, having confirmed with the participants that they were happy with this location, and took place at a time and date that suited the participants. The interviews were conducted by the researcher, with assistance available from an additional team member from Trinity College. There was no previous acquaintance with any of the research participants. The research interviews were conducted

with the use of a semi-structured interview schedule and transcribed and analysed by the researcher. Basic Demographic data was collected in conjunction with the semi structured questions below (See Appendix 2).

### 3.6.5 Data gathering

For this research, study data were generated in two ways. The first was semi-structured interviews. 16 parents, 2 adult children, and 7 service providers took part in the semi-structured one-to-one interviews. The second format was focus groups. Twelve grandparents took part in the focus groups. The schedule contained a preamble to the interview and information to reiterate to the participants afterwards. The topic schedule is available in full in Appendix 2. The interview took place just once in the service providers location and at a time of the participant's choosing. The interview then went ahead using the topic guide as a prompt.

Each interview was audio recorded with the participant's permission, using a digital voice recorder. This method had the benefit of being quiet and unobtrusive. The battery life was also long lived and meant that there were no mechanical interruptions. Transcription was undertaken by the researcher alone. Transcription involved typing each word spoken by both the participants and the researcher but did not include the length of pauses or other elements such as where the participant may have laughed or paused. The process of transcription allowed the researcher an opportunity to recall the interview, to become more familiar with the transcript and to begin the process of analysis. Semi-structured interviews are a recognised method for generating data in qualitative research studies where they are said to offer an opportunity to acquire in-depth first-person accounts of a participant's experience (Kvale 2007).

Moreover, for IPA they are said to facilitate the elicitation of stories, thoughts and feelings about the research phenomenon (Smith *et al.* 2009, p. 56). The interviews for this study were semi structured in that the topic guide (see Appendix 2) was used by the researcher for prompts focusing on the phenomenon, but it also meant that the interview could be flexible, adaptable and led by what the participant was saying.

### 3.6.6 Data analysis

Interpretative phenomenological analysis (IPA) is grounded in the idiographic accounts of the participants' lived experiences (Rostill-Brookes *et al.* 2011). The analyst looks for emerging patterns of experiential claims expressed within the data, before moving to a more

interpretative standpoint that aims to contextualise and make sense of the participants' personal stories (Smith 2004).

The transcript was read a number of times, and during this process a table with three columns was populated. The left-hand margin is used to annotate what is interesting or significant about what the respondent said. It is important in the first stage of the analysis to read and reread the transcript closely in order to become as familiar as possible with the account. Each reading has the potential to throw up new insights. This is close to being a free textual analysis. There are no rules about what is commented upon, and there is no requirement, for example, to divide the text into meaning units and assign a comment for each unit. Some parts of the interview were richer than others and so warranted more commentary. Some of the comments were attempts at summarizing or paraphrasing, some were associations or connections that come to mind, and others may be preliminary interpretations. Moving through the transcript, similarities and differences, and contradictions in what a person is saying were noticed in some cases. This transformation of initial notes into themes continued through the whole transcript. During this process, similar themes emerged, and the same theme title was often repeated.

At this stage, the entire transcript was treated as data, and no attempt is made to omit or select particular passages for special attention. At the same time, there was no requirement for every turn to generate themes. The number of emerging themes reflects the richness of the particular passage

### *Connecting the Themes*

The emergent themes were listed on a sheet of paper, connections between them were sought out. So, in the initial list, the order provided was chronological – it was based on the sequence with which they came up in the transcript. The next stage involved a more analytical or theoretical ordering, as the researcher tried to make sense of the connections between themes which were emerging. Some of the themes clustered together, and some emerged as superordinate concepts. Imagine a magnet with some of the themes pulling others in and helping to make sense of them. The preliminary list of themes that emerged from each transcript were noted in the right-hand margin.

As the clustering of themes emerges, it was checked in the transcript to make sure the connections work for the primary source material – the actual words of the participant. This form of analysis is iterative and involves a close interaction between reader and text. As a researcher one is drawing on one's interpretative resources to make sense of what the person

is saying, but at the same time one is constantly checking one's own sense-making against what the person actually said. The next stage is to produce a table of the themes, ordered coherently. Thus, the above process identified some clusters of themes which capture most strongly the respondent's concerns on this particular topic. The clusters were themselves given a name and represented the superordinate themes.

#### *Continuing the Analysis with Other Cases*

A single participant's transcript can be written up as a case study in its own right or, more often, the analysis can move on to incorporate interviews with a number of different individuals. One can either use the themes from the first case to help orient the subsequent analysis or put the table of themes for participant 1 aside and work on transcript 2 from scratch (Smith 2004). Whichever approach is adopted, one needs to be disciplined to discern repeating patterns but also acknowledge new issues emerging as one works through the transcripts. Thus, one is aiming to respect convergences and divergences in the data – recognizing ways in which accounts from participants are similar but also different (Smith 2004).

In this research study the former option was adopted whereby themes from the first case helped orient the subsequent analysis. By remaining aware of what had come before, it was possible to identify what was new and different in the subsequent transcripts and at the same time find responses which further articulated the extant themes. The decision to adopt this approach was informed by Smith (2004) who advise the latter option above predominantly only for research where one is working with a very small number of cases. Given the high number of participants in this study, the former option above was chosen.

Once each transcript had been analysed by the interpretative process, a final table of superordinate themes was constructed. Deciding upon which themes to focus upon required the analyst to prioritizing the data and reducing it which was challenging. The themes were not selected purely on the basis of their prevalence within the data. Other factors, including the richness of the particular passages that highlight the themes and how the theme helps illuminate other aspects of the account, were also taken into account.

#### *Writing Up*

The final process was concerned with moving from the final themes to a writeup and final statement outlining the meanings inherent in the participants' experience.

The division between analysis and writing up is, to a certain extent, a false one, in that the analysis was expanded during the writing phase. This stage was concerned with translating the themes into a narrative account.

Here the analysis became expansive again, as the themes are explained, illustrated and nuanced. The table of theme was the basis for the account of the participants' responses, which takes the form of the narrative argument interspersed with verbatim extracts from the transcripts to support the case. Care was taken to distinguish clearly between what the respondent said and the analyst's interpretation or account of it.

### 3.6.7 Quality and Validity

Addressing Quality and validity is an important component of all research. A number of guidelines in assessing the quality and validity in qualitative research have been produced and for IPA in particular, Smith, the founder of IPA, in the book *Interpretative Phenomenological Analysis – Theory, Research, and Methods*, (Smith *et al*, 2009), drew particular attention to the work of Yardley (2000, 2008), in relation to assessing quality and validity. Based on the work of Yardley (2000), there are four broad principles for assessing the quality and validity of qualitative work - sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Smith *et al*. 2009 p. 180).

Below, the criterion, and their application by the researcher are described.

*Sensitivity to context*, can be established in a number of ways by the researcher showing sensitivity to for example, socio-cultural milieu, the context in which the study is taking place, the existing literature on the topic and the material obtained from the participants (Smith *et al*. 2009 p 180). This sensitivity to context permeates right throughout the research process. Even the choice of IPA as the methodology itself, demonstrates sensitivity to context by recognising the need for close engagement with the idiographic and particular, and in terms of the recruitment of participants, to overcome the difficulties accessing these participants who share a lived experience, recognised and required sustained engagement, and rapport with a gatekeeper. For this study, interactions with, and the role of the gatekeeper was a fundamental component. During the interview process, obtaining good data requires close awareness of the interview process itself, including showing empathy, and putting participant at ease (Smith *et al*. 2009). The researchers extensive background both in psychology and previous work in applied settings with marginalised and vulnerable communities was drawn on extensively

during the interview process. This sensitivity to context continues in the analysis phase. Making sense of how the participant is making sense of their experience requires immersive and disciplined attention, both in terms of the disclosing of the account and what can be drawn from it. For the readers, Smith et al. (2009) argue that this sensitivity is assessed indirectly through the resulting compelling IPA study, in particular through a number of verbatim quotes to support arguments being made. This thesis study carried out extensive detailed analysis in its production of its themes and provided numerous supporting verbatim quotes. This brings us to the final aspect of sensitivity to context which Smith et al. (2009) discussed and referred to awareness of the existing literature both in terms of the topic under investigation and the underpinnings of the research method itself. In this thesis this sensitivity to context is reflected in the extensive literature presented and the detailed methodology section.

The second criterion refers to *commitment and rigour*. Commitment is demonstrated both through the degree of attentiveness to the participant during the interview, and in the subsequent analysis (Smith *et al.* 2009). A successful IPA study requires an extensive personal commitment on behalf of the researcher. Rigour refers to the thoroughness of the study. In this thesis study, the commitment and rigour shown by the researcher is evident through the complex innovative adoption of a multi-perspectival IPA design, with thirty-seven participants, the rich intensive data extracted during the interview process, and the extensive thorough detailed analysis and interpretations including produced.

The third principle, *transparency and coherence*, refers to how clearly the stages of the research process are described and a final coherent study. This includes the study being consistent with the underlying principles of IPA (Smith *et al.* 2009). In this thesis study each stage in the process is described at length, the degree and fit between the underlying assumptions of the research has been discussed and is in line with IPAs underlying principles, culminating in what the researcher hopes is a coherent final study on the area under investigation.

The final criterion is *Impact and importance*. However well a piece of research is conducted, a test of its real validity lies in whether it tells the reader something interesting important or useful (Smith *et al.* 2009 p. 183). The findings from this study, and their possible impact are discussed in Chapter 9.



### 3.6.8 The Researcher

In the nature of applying sensitivity to practice, it is important to denote some specific factors the researcher brought to the study, both in terms of her professional and personal background. The researcher had a deep personal interest in the area of addiction within families, and its associated risk and protective factors, prior to pursuing this PhD. Professionally the researcher also had an extensive background working with marginalised and vulnerable communities and was acutely aware of the both the stigma and the systemic challenges that pervades across multiple areas including addiction. As far back as her undergraduate degree in psychology, the researcher had researched the role of gender in relation to stereotypes and attitudes to substance use. Professionally the researcher also worked previously in a national systemic change initiative for young people, which used Bronfenbrenner's Ecological systems framework as a lens through which to assess and respond to the issue, recognising that youth development was a complex process impacted by multiple levels of an individual's ecosystem. For the last year of the PhD the researcher was working as the Fund Manager of an Equality Fund in Ireland. As such the researcher is acutely aware of how her personal bias may have an impact on interpretations in this study. Thus, throughout this PhD study, adopting the core principles of IPA was critical, the bracketing of pre-conceptions, ongoing reflection throughout each stage of the process, and applying commitment and rigour, in the analysis and interpretation of the data including adherence to the idiographic nature of IPA.

### 3.7 Conclusion

This chapter has argued that the purpose and practicalities of this research study fit best with the chosen methodology overall aim of the research was to identify and explore parents, grandparents, adult children, and service providers lived experiences of the risk and protective factors for children of parental substance misuse. Ontologically, IPA focuses on subjective reality from the viewpoint of the participants of the lived world. Knowledge emerges from the meaning participants make of their experience. IPA supports the acquisition of knowledge through meaning making, by both the participant and researcher. Its methodology is driven by a variety of influences-adopting the phenomenological attitude, engagement with the hermeneutic circle, and focus on a specific phenomenon, which fit the dynamics of this research and the role of the researcher. The methods and procedures taken up in this study have been outlined including ethical permission, accessing participants, the process for generating of data

and the analysis thereof. In the following chapters the findings from this study are presented, followed by a detailed discussion of the area of investigation.

## Chapter Four: Estimating the prevalence of the number of children in the region with parents who use substances

### 4.1 Introduction and definitions

Within this chapter we address the first objective of the thesis that is to provide an estimate of the scale of the hidden prevalence of the number of children with a parent who uses substances. This estimate is provided within one region of Ireland which encompasses a city, a number of towns and includes also rural regions. This region is a Regional Drugs task for area – covering a number of rural and urban areas across counties. The definitions of each term used, and the data sources used to derive the estimates are provided below.

*Children:* An explicit definition for child was not provided for this study during the data collection phase, as we were working under the premise that it is widely understood that the term child is understood to be a young person up to the age of 18.

*Parent:* Equally, within our data collection phase, no definition of ‘parent’ or upper age limit, for parent was provided. However, during the secondary data analysis phase, we only consider parents up to the age of 64 and we define the age of children as young people up to the age of 18. We use these age ranges for consistency with definitions used within previous studies and with readily available demographic data.

*Substance Use:* In relation to definitions of illegal drug use and problem alcohol use, we adopt the definitions of our types of data sources. There are two main sources of data, routine and non-routine. Routine data sources refer to statistics that are collected routinely i.e., in the course of duty and published in annual reports by agencies such as drug treatment services. Non-routine data sources refer to statistics that are not routinely collected but are ‘once-offs’ such as the results of studies of drug use in the general population or in a specific group. This study required data from both categories of data sources. For the non-routine data sources, we follow the definitions employed within the 2010/2011 National Advisory Committee on Drugs and Alcohol (NACDA) National Drug Prevalence Study for drug use which is ‘use of any illegal drugs.’ We also understand however, that ‘use of illegal drugs’, will not always reflect “problem drug use.”

In terms of alcohol misuse and given the national prevalence study for 2010/2011 (NACDA, 2011), we adopted the definition of dependency which results from a score from the Rapid

Alcohol Problem Screen (RAPS). This is a screening instrument which is used to screen for alcohol dependence. In relation to alcohol, a range of data sources and related case definitions could have been used, including those that examine the number of people drinking more than the recommended number of units per week or exhibit patterns of binge drinking. However, our decision to report on alcohol dependency was made as a way of distinguishing between drinking behaviours, harmful behaviour, and dependency.

For our other data sources, e.g., the National Drug Treatment Reporting System (NDTRS), The ROSIE study (Research Study Evaluating Drug Treatment Effectiveness in Ireland) and task force services, by virtue of the nature of the data source, the definition of substance misuse has the added component of the requirement of ‘being engaged with services.’

#### 4.2 Findings on the prevalence of illegal drug use in the region in the last year

In order to provide a benchmark for the numbers of persons who use drugs in the region data from the 2011 census as described above was combined with the prevalence rates on any illegal drug use in the past year from the NACDA 2010/11 general population survey. Combining these data sources provided estimates of numbers of persons aged 15-64 years using illegal drugs in the region in the last year. Details of the numbers for each county in the region are provided below in Table 5.

Table 5: Estimates of Numbers Using Any Illegal Drug in the Last Year \*

| SERDATF County          | Number of Persons Aged 15- 64 In 2011 | Point Estimate of Illegal Drug Using Prevalence in 2011 (5.9%) |
|-------------------------|---------------------------------------|--|
| Carlow                  | 36,252                                | 2,139  |
| Kilkenny                | 62,529                                | 3,689  |
| Wexford                 | 93,889                                | 5,539  |
| South Tipperary         | 57,773                                | 3,409  |
| Waterford Total         | 74,436                                | 4,392  |
| Waterford City          | 31,415                                | 1,853  |
| Waterford County        | 43,021                                | 2,538  |
| <b>Total in SERDATF</b> | <b>324,879</b>                        | <b>19,168</b>  |

\*(Based on the NACD Population Survey 2010/11, SERDTF Region, Table 15.2, page 82)

The results in the table 5 above help provide some information on the scale of the problem in the region and are an essential first step in the benchmark multiplier method of prevalence estimation on the numbers of children with parents who use substances.

### 4.3 Findings on the prevalence of children with parents who use illegal drugs

Data from a recent study on the numbers of children among adults attending services, Galligan & Comiskey (2017) found that for every unique client identified in the task force services, there was just under one child, with an exact ratio of **1 client to 0.88 children (Galligan & Comiskey 2017)**. This finding was very similar to the findings from the National Drug Treatment Outcome Research Study, the ROSIE study (Comiskey *et al.* 2009) in Ireland, which reported a figure of a ratio of 0.92 children to every one client in treatment for opiate use, and the Hidden Harm study in the UK, which found estimates reported of between 250,000 and 350,000 children of problem drug users in the United Kingdom, about one for every problem drug user (Advisory Council on the Misuse of Drugs 2003). From the National Drugs Prevalence Survey 2010/11, we saw above that 5.9% of 15-64-year-olds within the South Eastern Regional Drug and Alcohol Task Force area used illegal drugs in the past year. Using Census 2011 figures for the same period gave an estimate of 19,168 people who use illegal drugs in the region. Applying the above two data points using the benchmark multiplier method, provided an estimate of 16,868 children at potential risk of being impacted by illicit drug use. Using the Census 2011 data for children under the age of 18 in the South Eastern Regional Drug and Alcohol Task Force, this represented 13% of children at risk of being impacted by illicit drug use.

From the NDTRS 2014 data for the region a total of 2907 cases were seen by services in the region. Applying the same multiplier to this benchmark gave a minimum estimate of 2558 or 1.98% of children potentially impacted by parental substance use. In summary, these numbers show that a minimum of 2% (n=2,907) children were estimated to be possibly impacted by parental substance use and a maximum of 13% children (n=16,868) were estimated to be possibly impacted by parental illicit drug use in the area. However, it is important to note that the lower estimate is derived from treatment services and the upper estimate from a broad general population survey on illegal drug use in the past year. The lower estimate would be more appropriate for the planning and provision of direct targeted services and the upper estimate more appropriate for population-based prevention and education initiatives.

### 4.4 Findings on the prevalence of children with parents with problem alcohol use

The National Drugs Prevalence Survey 2010/11 (National Advisory Committee on Drugs 2011) used the Rapid Alcohol Problem Screen (RAPS) screening instrument to screen for alcohol

dependence. It is suggested that two positive scores from individuals responding to the screening tool *may be* indicative of dependence on alcohol by those responding. Counts of those who score three positive responses are also recorded.

From the *National estimates* of the number of alcohol users indicated to have alcohol dependency, reported from the National Drugs Prevalence Survey 2010/11, using the RAPS screening tool, it was found that 18% of 18-64-year-olds indicated dependency on alcohol defined by two positive scores.

Based on the Census 2011 data for the region the population aged 18 to 64 within the region was counted as 305,349 (Central Statistics Office 2011). Combining this population data with the prevalence rate on alcohol use gives an estimate of 54,963 adults aged from 18 to 64 indicating dependency on alcohol given two positive RAPS scores. Also, available however are prevalence data for people who scored *three* positive scores of dependencies on the tool. It was found that 7% of 18-64-year-olds indicated higher dependency on alcohol defined by *three* positive scores. Given a population of 305,349 individuals aged 18 to 64 within the region and the 7% prevalence rate of alcohol dependency this provided an estimate of 21,374 persons at possible risk of alcohol depend in the region. If the ratio of children to adults is as before this would imply that as many as 18,809 children may have a parent with alcohol dependency in the region. According to the census of 2011, there were 129,408 children under the age of 18 in the region, hence this would imply that 14.5% of children in the region may have a parent who is alcohol dependent.

#### **4.5 Conclusion**

To conclude within this chapter, we have used an indirect benchmark multiplier method to provide an approach to estimating the hidden prevalence of the number of children with parents who use substances. We have found using this broad-based approach that a minimum of 2% and a maximum of 13% of children were estimated to be possibly impacted by parental substance use in the area. With regards to alcohol use we estimated that 14.5% of children in the region may have a parent who is alcohol dependent. Within the following chapters we explore from varying perspectives the possible risk and protective factors for these children.

## **Chapter Five: Qualitative research findings from parents' perspective**

### **5.1 Introduction**

The overall aim of the qualitative research was to identify and explore intergenerational and service provider lived experiences of the risk and protective factors for children of parental substance misuse. This current chapter, and the following chapters 6-8, will detail the findings of the qualitative research, further to the data analysis process described in Chapter 3. The findings from parents in this chapter are arranged thematically. Five main themes were identified during the parent interviews.

Chapter 5 presents the qualitative findings of this research from parents who misuse substances, further to the data analysis process as described in Chapter 3. The aim of these interviews was to explore the lived experience of risk and protective factors for children of parental substance misuse from the perspective of a parent who misused substances. The findings are arranged thematically. Twenty-six subordinate themes were extracted within five superordinate themes. Each theme will be introduced and further illustrated below with participant extracts to represent and support each finding. Detailed discussion of, and recommendations from the findings will be outlined in Chapter 9. The following parent interview section begins with a profile of the research participants.

### **5.2 Profile of parents and their children**

Sixteen parent service users self-selected to take part in the research in one-to-one interviews. Inclusion criteria stated that service users needed to be a parent/guardian who is currently attending a HSE regional drugs task force service for drug or alcohol usage. Of the 16 service users who took part in the research, 11 were female (68%) and five were male (32%). Age range of males was 23-35 years, and females was 22-62 years. For the entire sample, ages ranged from 22 – 62 with an average age of 34. Seven of the 16 service users were between the ages of 22-29 (44%).

Service users reported a large range of drugs as their main drug of use, from licit (alcohol), to illicit drugs ranging from class A drugs (heroin, cocaine, ecstasy, methadone) to class c drugs (hash, cannabis, weed) and in many situations a combination of some or all. Parents were at various stages in recovery. Some parents were off all substances, some had reduced usage, with a number reporting a relapse and recovery cycle.

There was a total of 37 children between each of these 16 service users. Thirty-three children were aged 18 and under. For children aged 18 and under, the average age was 9 years. 39% of the children were aged between 7-11, 24% were between the ages of 2 – 5 (24%) and 12-15 years.

*Table 6: Service User Profile: Age, Gender, No of Children and Age Range of Children*

| <b>Age Band of Service User</b> | <b>Gender of Service User</b> | <b>No of Children (N=37)</b> | <b>Age Range of Children</b> |
|---------------------------------|-------------------------------|------------------------------|------------------------------|
| <b>Under 30</b>                 | M                             | 2                            | Under 5                      |
| <b>Under 30</b>                 | M                             | 1                            | Under 5                      |
| <b>Under 30</b>                 | M                             | 1                            | 7-11                         |
| <b>Over 30</b>                  | M                             | 1                            | 7-11                         |
| <b>Over 30</b>                  | M                             | 1                            | 15-18                        |
|                                 |                               |                              |                              |
| <b>Under 30</b>                 | F                             | 1                            | Under 5                      |
| <b>Under 30</b>                 | F                             | 2                            | Under 5, 7-11                |
| <b>Under 30</b>                 | F                             | 2                            | 7-11                         |
| <b>Under 30</b>                 | F                             | 4                            | Under 5, 7-11                |
| <b>Over 30</b>                  | F                             | 2                            | ≤ 5, 7-11                    |
| <b>Over 30</b>                  | F                             | 4                            | ≤ 5, 12-18                   |
| <b>Over 30</b>                  | F                             | 4                            | 7-11, 12-18                  |
| <b>Over 30</b>                  | F                             | 3                            | 7-11, 12-18                  |
| <b>Over 30</b>                  | F                             | 3                            | 12-15                        |
| <b>Over 30</b>                  | F                             | 3                            | 7-11, 12-15                  |
| <b>Over 30</b>                  | F                             | 3                            | Over 18                      |

*Table 7: Age Range of Children aged 18 and under*

| <b>Age Range of Children</b> | <b>Count of Children</b> | <b>% of All Children</b> |
|------------------------------|--------------------------|--------------------------|
| <b>Aged 2-6</b>              | 8                        | 24%                      |
| <b>Aged 7-11</b>             | 13                       | 39%                      |
| <b>Aged 12-15</b>            | 8                        | 24%                      |
| <b>Aged 16 - 18</b>          | 4                        | 12%                      |

### 5.2.1 Living situation of children

Of the five fathers who took part in the research, they had a total of six children between them. The ages of these children ranged from 2 to 16 (2,2,3,8,9,16). Only one father currently lived with his child(ren). The remaining fathers all had access to their children, but the child(ren) currently lived with their ex-partner. None of the male service users' children were involved with social services as the child(ren)s mother had full care of the children.



This was in stark contrast to the situation for mothers in this study. In eight of the 11 cases, social services had been or currently were, involved. Of the 11 mothers, only three lived with all of their children, and two others had one of their children living with them. The remaining six mothers did not live with their children but had varying degrees of access, some supervised, some less structured. Childcare arrangements varied according to factors such as the type of treatment the mother needed to avail of (residential versus day), in conjunction with the available alternative care options. Where family care options were available these were the preferred choice. The family care provided in this group of research participants came from partners and ex-partners, in-laws, and own mothers and grandmothers. In the absence of family support, or in the situation when capacity of family to care for child changed (e.g., grandparent became ill), direct state care resulted.

Five of the 33 children under 18 were reported by parents as having Attention Deficit Hyper-Activity Disorder (ADHD). This was 15% of the group. It is important to note here that some mothers also reported that they felt when their child was in care that social services diagnosed child as having ADHD rather than dealing with the fact that the child was distraught at being in care.

Table 8: Males service users by type of drug, stage in recovery, and age range/living situation of children

| Substance Use History of Fathers  | Recovery Stage Status   | Age Range of Children | Lives with child Y/N | Child Lives with      | Has access to child? | Social services involved? |
|---|---|-----------------------|----------------------|-----------------------|----------------------|---------------------------|
| Hash only   | Reduced usage   | Under 5               | Y                    | Participant & partner | N/A                  | N                         |
| Cannabis/alcohol mainly, - then Valium, then all drugs. Age first use 11. Cannabis reported as worst drug leading to MH issues.                 | 'Clean' 3 months but in and out of recovery for 5 years       | Under 5               | N                    | Ex-Partner            | Y                    | N                         |
| Party/street drugs, no drug of choice, whatever was available.  | 'Clean' 3 years   | 7-11                  | N                    | Ex-Partner            | Y                    | N                         |
| Cocaine Main drug (drink cocaine, gambling).  | 'Clean' 6 months, half-way house. Age 20 coming into recovery | 17-11                 | N                    | Ex-Partner            | Y                    | N                         |
| Heroin (previously alcohol/cocaine) age 1 <sup>st</sup> use 12. Residential 28 day addiction treatment aged 23, then heroin use, then homeless. | Now methadone only and in service for homeless                | 15-18                 | N                    | Ex-Partner            | Y                    | N                         |

Table 9: Female service users by type of drug, stage in recovery, and age range/living situation of children

| Substance Use History of Mothers      | Recovery Stage Status                             | Age Range of children | Lives with child (ren) Y/N   | Child Lives with   | Has access to child?                                | Social services involved?                                      |
|---------------------------------------|---|-----------------------|--|--|---|--|
| Cannabis, tablets<br>Bonsai           | Reduced usage                                     | Under 5               | Y  | Participant & partner  | N/A   | Y but child not removed from participant                       |
| Hash only                             | Reduced usage                                     | Under 5, 7-11         | Y  | Participant & new partner  | N/A   | No   |
| Cannabis use                          | Reduced usage                                     | 7-11                  | Y  | Participant  | N/A   | No   |
| Heroin – main drug                    | On methadone                                      | Under 5, 7-11         | Different arrangements for different children reflecting age of child and her stage in recovery. | 2 children with participants, 1 with grandmother, one with ex-partner.                     | Yes   | Y (VC Main care was family bar state care when not available.) |
| Class A drugs                         | 'Clean' Jan 2015- 2 relapses; Apr 2015 & May 2016 | ≤ 5, 12-18            | N  | The eldest with grandmother others with their father                                       | Limited   | Y (handed herself into social services for help)               |
| Heroin, crack, normal cocaine, benzos | Now on methadone programme.                       | ≤ 5, 7-11             | N  | 1 child with grandmother. 1 with dad since last year. Hates them being in different places | Yes, but she's in FT residential treatment          | Doing family care so SW don't have to be involved              |
| Alcohol—                              | In secondary treatment                            | 7-11, 15-18           | No- Participant in residential treatment   | Husband  | Ltd as in residential treatment but has full access | No but would have been only for husband                        |
| Cocaine, ecstasy, speed, Valium's,    | Sober   | 7-11, 15-18           | Lives with one child, other two  | 2 live with their dad, one living with participant.  | Y   | Yes, Social services became                                    |

|  |                            |             |  |                                |                               |  |
|--|----------------------------|-------------|--|--------------------------------|-------------------------------|--|
| Lyrca  |                            |             | lived with their dad. Social services were involved. Getting all children back soon. | All children coming home soon. |                               | involved when mother found unconscious from substance use but children in care of partner not social services. |
| Alcohol-and variety of other drugs. have taken drugs all life, | Recently turned to heroin. | 12-18       | N  | Grandmother                    |                               | 2 in care (with her mother – their nan) 27 lives own   |
| Alcohol and hash   | Reduced usage              | 7-11, 12-15 |  | 1 in care, one with partner    | Has supervised access to them | Y (one in care, others with partner)   |
| Alcohol only   | In secondary treatment     | Over 18     | Y but currently in residential treatment – children with dad                         |                                |                               | N because husband  |

### 5.3 Parents own lived experience

Before exploring these themes, it is important to note that when parents were asked about their lived experience of the risk and protective factors for children of parents who use substances, during this process, all parents firstly reflected on their own current drug use and how their pathway into addiction and out of addiction had been and continues to be, shaped by a myriad of factors. The different pathways into addiction included naivety with peers and partners and being uneducated about drugs, significant life events, mental health and witnessing drug use and other adverse life circumstances in their own family growing up. Significant life events growing up included exposure to parental domestic violence, parental mental health problems, growing up in care, parental substance misuse, parental suicides, sibling deaths etc. In other cases, exposure to significant adverse experiences occurred only in adult life, and in other cases, it was a combination of both. (see Table 10 below for a summary).

During this process parents also reported that their stage of addiction reflected different risk and protective factors for their children, and that the process of recovery was impacted also by their own access to or lack of social capital. Parents reported challenges to treatment including initial access to the service, readiness for change, alternative routes to addiction treatment, poor help-seeking behaviour, poor coping skills, the experience of the service itself once engaged, and dealing with life sober. Gender differences in the recovery process were stark, with women reporting a number of gender specific barriers including heightened stigma, and child-care issues.

Thus, for this study exploring the lived experiences of risk and protective factors of children of parents who use substances, themes were identified across the three phases of the addiction journey that emerged from the interviews-the active addiction phase, the road to recovery, and dealing with life sober. Findings revealed risk and protective factors being reported at a number of levels of the Bronfenbrenner ecosystem.

Table 10: Significant Life Events of Parents

| <b>Summary of significant life events for mother participants – from research notes</b>  |
|--|
| Children almost removed from participant. Partner drug dealer. Both are in recovery now. Children remained with them throughout. In care as a child from young age due to mother’s substance use. Residential care, fostered. Herself and her Siblings all separated during care process.  |
| Participant in process of getting assessed for bipolar. A lot of anxiety but no significant life events growing up or currently-a great family upbringing. Hash usage is believed to be because of untreated bipolar.  |
| Domestic violence, had to get barring order, happened after her partner had brain operation  |
| Reported a good upbringing and got into drugs from ‘being stupid and with wrong crowd’. Her partner laced hash with heroin. No methadone in area until 2010- didn’t gain access until 2013. Raised by grandmother as mother very young giving birth. Siblings raised by mum. Said when she got clean, she ended up homeless as her mum wouldn’t believe her. |
| None reported, but extremely traumatic abusive life with her partner.  |
| Mother died when participant was very young. No family support available when participant substance use was problematic. Sibling also experienced substance use issues. Children went to in-laws. Participant became homeless. Fraught Kinship care arrangement.   |
| In secondary treatment – children with husband which negated the need for children to be placed in state care. Mother is deceased, has no contact with her father due to his alcohol issues thus no family support available from parents.   |
| Split from her children’s father years previous due to domestic abuse. Her sister died when she was young. buried trauma in drugs. Social services involved after an accidental drug coma. Her son contacted his grandmother who contacted social services. That was her trigger for treatment.  |
| Abuse by extended family member growing up. Domestic violence with partner. Difficult relationship now with mother as she believes her son not safe with her and no one will believe her.  |
| Husband murdered when eldest was very young, and prior to that had a ‘stigmatising health condition’. Eldest went into care. 2 now with her ex-partner/sister  |
| No significant life events. Participant reported that drinking wine escalated. Depression and felt suicidal but wouldn’t do that to her children.  |
| <b>Summary of significant life events for father participants – from research notes</b>  |
| Reported no life traumas. Accessed drug service through youth club he was at, solely because he noticed he was starting to use hash more often and with two children was concerned about the cost  |

of the hash. Only uses at night when children in bed. Children live with him. Social services not involved.

Attended psychiatric services for mental health condition. Lives alone with mum, who is also a drug user. No family supports. Mother encourages drug use.

Participant exposed to domestic violence growing up. Father heavy drinker and left when he was very young. Sibling died young. Participant became a young parent, split from partner and currently homeless.

Participants mother had nervous breakdown when he was young. Him and his son have ADHD

Mum died by suicide when he was a young adult. He tried to take his own life shortly after. Attended alcohol treatment but felt that mental health needs were not addressed. Started heroin after this.

## 5.4 Themes identified in relation to parent interviews

The themes identified during the interviews with parents are summarised below. Five main superordinate themes were identified. Each of these themes consisted of subordinate themes.

**Theme 1: Secrets, suspicions, and solid disclosures-Unpacking the façade of non-use**

*Sub theme 1.1: I know your secret- unravelling the façade of non-use*

*Sub theme 1.2: What do my children need to know?*

*Subtheme 1.3: Silenced children – I need to talk but can't*

**Theme 2: Riding the ghost train- Children enduring isolation and the unknown**

*Sub theme 2.1: Physically present but emotionally absent parents*

*Subtheme 2.2: Shutting the world out: Isolation of the Child*

*Subtheme 2.3: Role reversal- Child become parent*

*Subtheme 2.4: Age of child during parental active addiction*

*Sub theme 2.5: Why is everyone leaving me?*

*Subtheme 2.6: Children torn between two sides- (impacted by age/position in family)*

*Subtheme 2.7: Dealing with false hope*

**Theme 3: What could help protect the children?**

*Subtheme 3.1: Someone to talk to for all the family*

*Subtheme 3.2: Services to suit family routine*

*Subtheme 3.3. Educate children about addiction*

*Subtheme 3.4: Different children communicate differently*

*Subtheme 3.5: Peer Support Groups and awareness raising of services*

*Subtheme 3.6: The role of sport as a protective factor for children and parents*

*Subtheme 3.7: Being a parent can act as a protective factor against consistent use*

**Theme 4: The Fragility of recovery**

*Subtheme 4.1: Supports weakest where they need to be strongest*

*Subtheme 4.2: Dealing with trauma sober – risk of relapse*

*Subtheme 4.3: Isolation*

*Subtheme 4.4: Lack of family support*

*Subtheme 4.5: Trust issues within family*

*Subtheme 4.6: Difficulty gaining employment*

**Theme 5: Protective factors in recovery for Parents**

*Subtheme 5.1: Peer support and groups*

*Subtheme 5.2: Support in general/one to one follow up support*

*Subtheme 5.3: Learning to breathe again –the world opening back up to you*

In relation to the thematic areas that emerged one can see the relevance of the Bronfenbrenner theoretical framework almost immediately. Themes 1 and 2 originate in the child's microsystem. Themes 3 relates to protective factors and as such reflects a combination of all levels of the Bronfenbrenner ecosystem. Themes, 4 and 5 originate mainly in the child's exosystem, but also certain subthemes relate to the macrosystem and chronosystem. However, all of these themes also relate to the mesosystem in terms of the impact of the interaction of these themes within that system.

Details of these themes are provided below.



## Theme 1: Secrets, suspicions, and solid disclosures – Unpacking the façade of non-use

All parents in these interviews were engaged in a recovery process, during which they had gained deep insight into what the experience was really like for the child, versus what they had believed at the time it was like for the child, during the active addiction phase. Complexities of non-disclosure as a perceived or desired protective factor for children of parental substance misuse arose, raising questions about the assumptions of effectiveness underlying such an approach. Different parents had different beliefs about how effective non-disclosure was in reality, versus the perceived benefits of adopting such an approach. The reality of non-disclosure ranged from parents believing they had shielded their children during their active addiction stage, only to realise retrospectively in recovery, that this hadn't been the case, with subsequent ramifications for the child and the parent. Parents felt guilt and shame in relation to these realisations. Other parents spoke of how tensions arose within families and couples about what children should be told, as certain parents believed that even if the children didn't know substance use was the issue, these children often sensed something was wrong and the non-disclosure and non-validation of their concerns caused anxiety fear and confusion in children anyway. Other parents believed they had successfully achieved the façade of non-use and advocated for this approach as the best way to protect the child. Parents reported overall a lack of consensus, clarity and guidance available on this issue, and this has clear implications for policy and practice. In all cases all parents had a primal yearning to be a good parent, a deep-seated want and appreciation of parental rearing and a battle to reclaim a parent right to fight to rear and protect their children

### *Subtheme 1.1. I know your secret – unravelling the façade of non-use*

Parents reflected sadly on the fact that in hindsight, their children were aware of the parents' substance use at the time, unbeknownst to the parent. That while the parent believed they had shielded the child from the addiction, that this wasn't the case. Rather, conversely, during those times when drug use was escalating children were more exposed to parental drug use, even though the parent had hoped to maintain a facade of non-use. It hadn't been possible to achieve the façade of non-use. Parents struggled with guilt, shame and sadness reflecting on these revelations.

“I know my daughter at the time at the height of my addiction, went to the social worker and said I can't get my mammy to eat her dinner. Not understanding like. Even though I've an OCD with the house, everything was always spotless, the drugs brought that on more, those were things that we're keeping me going was cleaning. And I'd always cook

big roasts, I love home cooking. I wasn't realising that the children were noticing that mammy wasn't eating. Even though they were having big dinners, so the kids have picked up on a lot that was going over my head because obviously I was drug fuelled. And she went to the social and said I can't get my mammy to eat her dinner and when they came back and told me that it broke my heart. That my little girl went to the social worker and asked can you please help me to get my mammy to eat her dinner. It destroyed me. Having that guilt like of her knowing. It was wicked hard." (8)

"I always thought, you know, I'm hiding it so well that they won't see it. But they are clever, they are so clever, they see things that you didn't even know they'd seen, and you have to face those demons too then. And I suppose all they want for you, is what you want for them, they want to see you do well and you want to see them doing well. And all things that you have in your head that you want for them they want the very same for you, which is a great thing because my kids are older like, like..." (1)

Even in cases where children were too young to grasp the concept of parental substance misuse, parents reported that they look back now and see that the child had sensed that something wasn't right and that their uneasiness and discomfort was as a result of the parental substance use, rather than other issues which the parent attributed the child's demeanour to at the time.

"I didn't see how it affected child X back then, until now, because when you think back on the situation you think how uneasy, and how you think ah maybe he was teething. Like all the times X was uneasy in the past had nothing to do with him being unwell, or teething or anything, it was because the Living situation that we were in. And I will never forget the day that he looked at me and even though he probably didn't understand, it was as though he was saying you don't look my mummy. And I was only after having a smoke of Bonsai, and he was looking at me as if to say you are not my mammy and I was thinking, omg he knows that I am after doing something. And then when I stopped and started reducing, I could see him being happier and then when I got off it completely, I could see some difference in him, he was like a new child. People think parent drug use doesn't affect the kid, but it does, big time." (9)

*Sub theme 1.2: What do my children need to know?*

Certain parents reported a fear that their children are being left in the dark, fuelled by a fear and confusion around the appropriateness of telling them what's going on, and that guidance is needed on this.

“Um, I found children were left in the dark, and, you know, a lot, on what's going on with me, and then I'm afraid to tell them, and, you know, things like that. Like what should we tell our children about our situation, everybody was agreeing, but there was like, ok, what do I tell them, or how do I tell them, what do they know, what's appropriate to tell them, you know. And you need to tell them that I'm ok, but I need to tell them why I'm not ok, you know, it's confusing because you're afraid then of the social services thinking that you were, oh you shouldn't say that like, and you're afraid then, to do something wrong, because you're trying to do so many things right.” (1)

Parents differed in their opinions on what is the best approach to this

“I hide everything from my children. They don't even know that I'm down at the Project.” (9)

This difference was evident even within couples.

“Because I know she's struggling at the moment, I FaceTime my children every single night and we see each other and talk, and I just know she is struggling. I text my husband afterwards to see if she was ok, and he's saying that she is very tired and very clingy towards him. They miss me very much. They were protected a lot from my addiction, my husband protected them a lot, so they can't understand why I have to be away for so long because my family won't talk about what's wrong with me, because of the stigma. So, my children are left thinking what's going on? The older two, my eldest does understand but you know, my husband can't and won't talk about it, so my children are left very confused and scared, thinking is Mummy every going to really come back. It is affecting her; I know it is. She needs somebody to talk to.” (6)

The instinct of many parents is to “protect” the child from reality of the situation and thus not tell the child that the parent is in treatment but to “soften” the blow with information such as “mammy is sick”. However, what we need to consider here, is if this approach, while well intentioned, is actually misguided, in that the child may be caused more unease by knowing that something is wrong but not being told exactly what is going on, leading to insecurity, fear, and self-blame. Some parents also reported that not telling the child what is happening can lead to heightened anxiety and fear for the child as the child picks up that something is wrong, but no one will tell the child what exactly it is.

Disclosure of information however did seem to vary depending on the birth order within the family, with older siblings mainly being told what was taking place, regardless of their age, and young children being “protected.”

“See I feel like definitely... my little fella, he has a heart of gold and he's 13, he took a lot of it like... he thought it was tablets, that's all I wanted him to know, and I said that to the social workers. He was only 11, going on 12. The eldest, the 15-year-old, he came to me, and I told him the truth and the social workers knew I sat him down and I told him that I had an addiction to amphetamines and diazepam.” (8)

### *Subtheme 1.3: Silenced children - I need to talk but can't*

Even in cases where parents were fully aware that the children knew about their substance use, many parents spoke of their children being locked into silence, that the children find it both difficult to talk to someone and are scared of disclosing family secrets or making the situation worse. Children understand or believe there is a need to maintain the family secret even though price for this can be socially isolating and a heavy emotional burden where parents do not openly acknowledge the fact of their drug use to the child, even whilst it was frequently a central organising feature of the household. The weight of silence can be seen to compound the trauma experienced by children in families with problems because they have no one to talk to about their feelings.

“I feel my children definitely feel like they are the only ones that had this addictive embarrassing mother, and they can't speak openly to me about it. They can't ask me questions that I know they'd like to ask me or they're angry. He is the type that would bottle it up. He's a lovely beautiful little child and he's embarrassed. He won't speak. He

won't ask mammy; how did you get on? How did this happen, or he won't tell me how angry he was? He bottles it all up. I think he does it out of shame and embarrassment that like mammy is the embarrassment. Or afraid Mammy is going to relapse. Those little fears that kids shouldn't have. I know because my own dad was an alcoholic, so I remember the social worker that I met at my addiction and she said we're trying to get you into (names a residential service) and I said yea, I know where it is. And she said how would you know where it is. It's a big white house out the country with a red door. She didn't realise and I said it's the only place I've seen my dad as a child." (8)

"And then they didn't want to get mammy in for trouble so they're trying to, they're hiding. They hide what's happening, because you're their mammy, no one wants to see their mammy, and no one wants to talk bad about their mammy and, you know that kind of thing, they are the protectors, and it's the unconditional love." (1)

Interviewer: "And what about your own children? Do you think they have any needs that aren't being met?"

"At the moment, I don't think there's anyone helping them to deal with what's happened. I know some of my children are struggling, especially my 10-year-old because she has no voice, and she needs somebody to help her. I don't know in what way, but I'm in Waterford and my children are in Dublin. I do get to see them, but they need help, they need support. I'm getting all the help I can possibly get, that's why I'm doing this. But I strongly believe they need someone they can talk to." (6)

## Theme 2: Riding the ghost train – children enduring isolation and the unknown

In theme 2, the parents reported children growing up in a home where the parent was physically present but emotionally absent, where basic needs were met but quality interactions were absent. Roles were reversed, and children's loyalties were torn. During recovery, children endured an emotional rollercoaster of the unknown and in some cases false hopes.

### *Subtheme 2.1: Physically present but emotionally absent parents- meeting basic needs*

When parents reflected on their active addiction stage, they spoke of being physically present but emotionally absent. That while they weren't physically isolating the child by asking the children to play in other rooms, or stay upstairs, that even when the children were in the same room as the parent, that the parents still weren't emotionally available for the child.

“Well, you see you'd be there, but you wouldn't be there, do you understand. You wouldn't be present really.” (5)

Some parents reported that during addiction that children miss out on quality interaction with the parent, but in the main, have their basic needs met.

“I supposed they missed out on the quality, they still got the quantity, but the quality of love wasn't there. They missed out on going to the parks, all the happy little things that you've done for so long, sit down and colouring a book, because sure you couldn't see the book, so how were you supposed to colour it. You always had their clothes done; you knew how to function. You'd be clever, you'd write, you could make the stew, you'd made what would last, you'd be wise you know, oh we'll have that today and we'll have that tomorrow, and I know I'll be after coming around by Sunday we could do the pizza day as we called it, so you knew, you weren't stupid. But you were, like you were in a haze.” (1)

A key risk point for some parents during the active addiction phase was weekend usage leading to child being unable to attend school on Monday as parent too paranoid to leave the house as coming down from weekend substance use.

“But you knew what you had to do. You had to have the clothes ready, so you were getting ready for the weekend, and it was Monday to Thursday is grand, but come Thursday, Friday, Saturday. And then obviously the kids start missing schools on Mondays, because you can't get up, or you have the paranoia and you can't, you can't face, you can't come out yourself, or you don't want the knock on the door. And the blinds are down, and the doors are locked, and GASP don't answer the door and things like that or.” (1)

### *Subtheme 2.2: Shutting the world out: Isolation of the Child*

Other parents reported that in conjunction with children missing out on quality time with parents due to addiction, that the children were often isolated within the house by being asked to stay in their rooms. These children had to live in a state of fear, worry and anxiety, not knowing what to expect next.

“But like I missed out on time with them. They were afraid to come down in case they'd find me dead. So, it did cause worry. It's something I can never give back to them. It's the most precious thing that you can give to anybody is your time. So, you know, I struggled with that.” (5)

“You do, you shut the world out, you go into your own world, and like you might say to the kids, will you play upstairs, you don't want them, like. That's the quality they missed out on, the hugs, the kisses, the togetherness, the sitting down watching telly, you know the little things that you take for granted.” (1)

“I know people who have addictions, and their kids would be kind of suffering like. Ya know like someone who smokes, like me brother smokes a lot of weed like, him and his partner and they don't go anywhere. They don't bring the child anywhere they are too paranoid like ... to leave the house really, you know that sort of thing, so the child is sorta isolated like ye know in a way.” (10)

### *Subtheme 2.3: Role reversals- child becomes parent*

Parents spoke of a role swap that occurs where children take on the role of parent, sometimes unnoticed by the parent, taking on so many worries. It was also recognised that birth order in the family impacts this role swap, with each elder sibling assuming responsibility for younger siblings.

“And like for a long time they become your parent and you don't even know that they, your children should be children, and they take on so many worries, and things like that, but thank God, or I wouldn't be where I am. I suppose for the 18-year-old, it's not nice having to help your mother is it, or it's like, they, like, then they become the parent and their minding the other ones and it was the 14-year-old actually, that was minding the 9-year-old.” (1)

### *Subtheme 2.4: Age of child during parental active addiction*

The age of the child during the different phases of addiction is also reported by parents as an important factor in terms of risk and protective factors for the children.

“Yeah, I think, like I’m so glad that my children weren’t in nappies and not able to function for themselves for daily lives. So that’s what maybe possibly made it easier for me to hide it for so long, I didn’t have this little toddler on the ground, that was so dependent, which is a scary thought, we, you know, all, all our children went through that like, but we were functional then, it’s when you’re not functional.” (1)

#### *Subtheme 2.5 Why is everyone leaving me?*

During the recovery phase, the children of the mothers in this study often experienced alternative care arrangements. Parents are acutely aware that their absence impacts the child in many ways. In the quote below the parent notes that not only are the children separated from their mother but that the children can also end up separated from each other. This pain that the parent experiences herself about being separated from her children is compounded by the fact that the children’s lives have also been disrupted. In conjunction with this, the relationship with her in-laws who are minding her children has deteriorated resulted in denial of access to the children, and name calling.

“Absolutely loved being a mum, it’s probably the best gift, the both of them are probably the best gift I ever could have been given. And like my kids are not gone long, its only coming up to a year, they are not gone that long, and we’ve all been separated, they've both been separated from each other now as well, so that kills me, you know. Because they were so used to being around each other, um, it’s hard, I mean really hard. Because the families, like this is voluntary, so um, instead of social work being involved, we have a voluntary thing, that, we'll do it amongst ourselves when we see them, but the families have stopped that, and kind of, they’re being nasty to me, they're ringing me, calling me all sorts, you now” (7)

#### *Subtheme 2.6: Children torn between two sides- (impacted by age/position in family)*

Parents spoke of their anguish of knowing that their children are caught in the middle and torn between two sides. In most instances, the impact of this is reported as being different for the children depending on their age and birth order in the family, in many instances with eldest children, regardless of their age, witnessing more, being told more, and younger siblings being “protected.”



“This boy then has no relationship with the father because he’s seen too much, and then, it’s hard to, I see how my mother went down because of all of you, all of this, and it’s easy to blame but it was, so like then, you pass, you think you’re not passing on your problems to your children but you are, you are like. Because you’re trying to shield them from, what was going on the whole time with mammy and daddy, but they’re stuck in the middle, and they shouldn’t be stuck in the middle, they have a right to be themselves and, not choose this one and not choose that one and, one might be fine saying well, its ok, and its grand, you know its ok, one is more understanding than the other person, but they get to see that, and they see that the hard way, which they shouldn’t have to. And they shouldn’t have to, so I can’t say anything about my mother now because this one will go mad and I can’t say anything about my father because this one will go mad, you know, because that’s not fair.” (1)

“My eldest boy he grew up between me and my mother, I live just around the corner and when I’d been too gone out of it she’d come up and take him, so um, and he’s very angry with me now, yeah, he’d be an angry boy, man, boy.” (11)

A number of parents spoke of how the younger siblings were “protected” from what was taking place by older siblings and parents.

Interviewer: “And what helped the nine-year-old?”

I suppose what helped her, she didn’t see it, because everybody hid if from her.” (1)

### *Subtheme 2.7: Dealing with false hope*

Children can be subjected to false hope in relation to their parent’s addiction, resulting in a rollercoaster of emotions and failed dreams.

“But what I’ve noticed, is he’s a loving boy, he’s brains to burn, very intelligent, he’s very charming, he’s very caring, and he’s funny. and, as he says to me, the whole time is, mam, I wait two more years now, I’m 14 and a half now this Christmas, and I’m going to wait until I’m 17, and please God then, you’ll be the two years clean and sober, and you’ll have a place got. And I’m going to live with you. And the courts and the social workers they say what they like, that’s happening, I can’t put up with what’s going on at

Nanny's house, so he's telling me little bits about what's going on, and I, um, heartbroken going around, is the only way I can describe it, he's been bullied since he went into the house.” (12)

### Theme 3: What could help protect the children?

Throughout the interviews, parents reported what they believe are key protective factors for children with a parent who uses drugs. In some instances, some of these protective factors were already in place, but the availability of these varied. These supports all centred on ensuring the family work together to heal and recover, that a voice and safe space is given to children to air any fears or worries they have, to be mindful that different children communicate differently, and the role of peer support for both adult and child. In all instances, across all interviews, the desire to recover was motivated strongly by their children and being a parent acted as a protective factor against on-going use.

#### *Subtheme 3.1: Someone to talk to for all the family*

Parents spoke of the value of family centred work as a protective factor for all family members. Central to this is someone for the child to be able to speak with, on a regular basis.

“First of all, what helps the kid is being able to speak with someone, on a regular basis, and that they can talk about their problems about what’s going on. Because that's the whole point of it, um, kids to be involved, to get to meet the workers. Its ok for me saying oh I need to go here, I need to go there, but my kids needed a lot of reassurance because, they were worried about mammy, they want mammy to be ok. So, to have like, for them to kind of come in and say, well this is this person this person helps me with this or, you know, so they know, well ok, I might trust you and they feel that their parent is safe going to these places. Because the children take on a lot of worry, and for them to build trust and it was all about they want to see, at the end of the day they want to see that their mom or their dad is doing ok, and, that the people that are with them are friendly towards them, and you know, that, like because they are protecting us, so they want to see things like that.” (1)

Service users repeatedly reported that additional supports for children were needed.

“Teach the kids that these things happen. That even if they’re having troubles at home, and they feel they can’t talk to someone, try and make them feel comfortable that they can go and talk to somebody. Explain that there’s this going on in their home, but they don’t want it to be said any further, they want it to be privately kept at first maybe, and then that person can work with that kid and explain, look you need to do this and do that if you want to fix this. They have someone to go to basically.” (13)

In conjunction with this is someone for the parent to be able to talk to and the partner to be able to talk to, to help them understand the addiction process that their partner is going through.

“The parents, the addict, they need to be able to talk about their usage, and what’s making them use, and what’s building up.” (13)

“Their partner needs to be able to listen to the problems and know what their partner is going through, what the addict is thinking, if they are educated, they won’t be inclined to give out about the addict’s behaviour for not being there. When I came out of 28-day detoxification program, my ex-girlfriend (my child’s mother), didn’t know about what I was going through. So, I think the partner needs to be educated, there’s no point constantly giving out to the parent, because they’re an addict. You need to work with them. There needs to be a counsellor, and they both need to go together, because it becomes a joint problem. The partner is a victim as well, they’re getting upset the whole time and hurting as well. So, they need to be educated, that piling on pressure and giving out the whole time, arguing and fighting back and forth is not helping. It leads the addict to use more and more. So, a service that would be there to work with the Addict and work with their partner, to educate their partner on what they’re going through. So, then that helps the addict become a better parent and a better partner. Me being thrown back into the three-shift jobs was too soon.” (13)

This family-based model would act as a protective factor for the child through facilitating someone to talk to, to the parents by addressing conflict caused by addiction and misunderstandings on the nature of the addiction, ultimately leading to a stable environment for the child. In the absence of this support and cross family understanding, the addiction can continue and escalate resulting in poorer quality of parenting for the child.

“When I was doing night’s, I remember I’d have to drive my young fella into school in the morning. I fell asleep one night at the traffic lights because I was so tired. My partner just didn’t understand that I was going through a drug problem, I was having to be in work, I was tired, then be around for my son, I wasn’t there enough, it just created more problems. I think all of that just piles up and they end up splitting from their partner, not seeing their child, they end up losing their jobs, they end up homeless. And it took all of that for me to end up getting into a hostel before I started to get linked in with the proper services. It’s not known in the workplace.” (13)

“And there's not enough family therapies, I was done my way, the children were done that way. We were a family when things went wrong, so we need to be a family when things go right.” (1)

#### *Subtheme 3.2: Services to suit family routine*

The importance of having services to suit family routine was also raised as a protective factor.

“Um, services to suit family routine, some do, and some don't, like some of us have children going to school, some of us have children going to creches, you know, if they could be more accommodation to our needs, rather than their needs.” (1)

#### *Subtheme 3.3: Educate children about addiction*

Education at the transition point between primary and secondary school was noted as a particularly important.

“It can be different for different kids and that, it’s different for everyone, but it starts in them secondary schools. The older kids deal to the younger’s kids, and they don’t realize, they’re only young themselves. That’s the way it works I think, one of the things would be to give information out in the Primary schools, for the young lads coming in. And I think there should be a drugs education class once a week in secondary school. Maybe a guard and an ex-addict, to go in and teach them, and talk about things every week and constantly educate kids about where drugs take people, how fun it is at the start, how you fit in with groups. But then people could go in and explain look what happened me, if they were to experience seeing someone, an ex-addict and a guard, letting them know, look you’re going to pick up charges, you’re going to end up in jail, teach the kids about what happens.” (13)

Our current national drugs strategy acknowledges the need for prevention and early intervention at this level in primary school settings (National Drugs Strategy, 2017- 2020).

*Subtheme 3.4: Different children communicate differently*

Parents noted that different children communicate differently and that services need to respond appropriately to the child's communication style. A good example of this is evident in the quote below where equine therapy worked well with one child who doesn't like talking, whereas the one to one talking worked well with the chattier children.

"I suppose they had to admit then, things about mammy that they didn't want to admit because my kids go to Barnardos. I find Barnardo's brilliant, I love that service, really really helps. And the equine therapy. Like I have, this one who will speak like this, no problem, whereas this one will not. He finds the one to one very hard, so it's the equine therapy, they colour and all of that, and I'd done that with him. His sister would talk you to death, she's well able to communicate that way, and it's just, different children communicate differently. And it's because you go oh yeah you come in here now and we're going to talk to this one and talk to that, not every child does that, two out of my children can sit down and do the talkie-talkie thing and everything is fine, but the other boy just (claps) clams up." (1)

*Subtheme 3.5: Peer Support Groups and awareness raising of services*

At the level of the child, peer support groups were suggested to complement existing individual therapy-based work with children. More awareness raising regarding what services, especially helplines, are available for children, keeping children informed at an appropriate level of the process, trauma informed interventions for children and family, and a comprehensive recovery-based action plan for the family once the immediate crisis has been stabilised.

"I always felt that the children felt embarrassed. They felt like they were the only kids with ye know ... an addictive mother. I think that really 100 percent from now from working with the service and watching my own children suffer, if you had like a group for addictive parent's children? They do a bit of it in service X, but they still feel like they're on their own. I know my kids are completely embarrassed because of mammy's addiction. They feel like they're the only kids." (8)

“At the moment, I don’t think there’s anyone helping them to deal with what’s happened. I know some of my children are struggling, especially my 10-year-old, because she has no voice, and she needs somebody to help her. I don’t know in what way, but I’m in Waterford and my children are in Dublin, I do get to see them, but they need help, they need support, I’m getting all the help I can possibly get, that’s why I’m doing this, but I strongly believe they need someone they can talk to. Someone who can answer their questions, because their Dad, although he is a fantastic Dad, he’s going through his own stuff, so I don’t think he is able to be there for them. I’ve thought about contacting schools to see if there is anything they can do, because I can’t be the first one to have gone through this. They need help, and don’t know if I will be able to do it while I’m in treatment but as soon as I’m finished, and I get myself back on track I will get them help.” (6)

*Subtheme 3.6: The role of sport as a protective factor for children and parents*

Sport was discussed by many parents as a protective factor for children and parents.

“I used to take him to sports when he was 3 or 4 you know what I mean. I love spending time with him, always did, I think it's got to do with his personality, he's 9 now and he's mad into sports. Hurling for the clubs, rugby, soccer, he's very good. I found that with me when I was younger, I was diagnosed with ADHD as well, so my father's way was to put me into every sport and burn his energy off. My son is the same as well so it's the same with him now.” (14)

“Parenting to me, is a joy. As I came from a broken home, I didn't want my children to have a broken home. But I haven't had much of an input in my 15-year old's life, he's in the care of the HSE and he's been there since he was 7, I always thought I'd get him back, but he's carved out a career in Soccer for himself and he's over in Ipswich at the moment. And he'll be signing for them next year. He's worked very hard, from not seeing me, he threw himself into the sport and I did the very same when I was younger without a mother, she was a chronic alcoholic, The shame and the stigma on the family you know, and I threw myself into athletics.” (12)

Interviewer: “So, what helped you stay off the drugs in your home? How are you managing to try and stay clean? Particularly when alcohol is included like that's a big step.”

Exercising. Training every day. Training 7 times a week. In the gym Monday to Friday, boxing Tuesday and Thursday, flat out like yea.” (10)

Interviewer: “What’s helping you reduce your weed usage?”

“The motivation with the kids and the motivation with the soccer as well. I play soccer three times a week. Just the two of them really like cause like as I said when I'm with the kids I don't smoke and obviously when I'm at training I don't smoke.” (15)

However, some parents reported that engaging children in sports can be very costly and that this can be a deterrent to the child being able to attend sports. A protective factor in addressing this relates back to schemes such as the CE employment scheme, supplemented childcare, and accessible residential services for parents.

#### *Subtheme 3.7: Being a parent can act as a protective factor against consistent use*

Whilst all the parents interviewed were parents who are currently accessing treatment for their substance use, their children act as significant motivation to reduce usage and recover.

Interviewer: “How do you find being a parent?”

“I think it's the best thing that ever happened me. For a good while then, I had the child at the weekend and then the weekends I wasn't using or drinking and then when I dropped her back, I was straight back - doing everything like ye know. But yea, I think it was a big help for me. Having that child really helped me like you know. Gave me a bit of responsibility like you know. Probably grounded me, I was wild like you know. Very wild.” (16)

Interviewer: “What about using a drug and having a child. How do you find that and what are the challenges, what's not there that could help?”

“I wouldn't do it around them, I wouldn't even go near them around them. I'd wait until they'd at least gone to bed or 'til they're not in the house.” (16)

Whilst parents reported that having the child in their care deterred them from using substances, thus acting as a protective factor against consistent usage, parents also reported that it can be stressful minding the child without the substance.

“The youngest, she starts whingeing like she knows it’s going to affect me. And I get down to try and talk to her, but she will slap and hit me and I’m like Oh God, but the minute I smoke a joint I’m like, I don’t give out, I’m so calm and everything. I know I am not ready to give it up because it is the only thing that is helping me to stay calm, especially with the kids (3)

“So, if I didn’t have it then when they’re there like it’s a bit stressful like. But they’re going to be kids at the end of the day, there’s nothing you can do, you just have to be there for them.” (15)

Interviewer: “You wait ‘til the kids are in bed?”

Yea or when they’re not there at home or at my girlfriend’s house so I’d do it then. But if they’re at my house in the daytime I wouldn’t bother. When I’m with the kids I don’t smoke and obviously when I’m at training I don’t smoke.” (15)

#### Theme 4: Fragility of recovery

Clients spoke of the challenge of dealing with life sober and the severe risk this creates for relapse. The challenge to this was twofold.

##### *Subtheme 4.1: Supports weakest where they need to be strongest*

Service users reported the fragility of recovery, and how supports are weakest where they need to be strongest.

“Support to reach sobriety is there if you seek it out, but the support to continue the journey of recovery is weakest where it needs to be strongest. The recovery inside, you have all the help getting off the stuff, but when you go back into the world, you will need all that help.” (13)

##### *Subtheme 4.2: Dealing with trauma sober – risk of relapse*

A key risk factor reported related to the issue of having to deal with life in a sober state of mind as being overwhelming and leading to relapse. Drug use can act as a numbing agent for many issues and the idea that achieving sobriety will lead to a natural state homeostasis is misguided.



The transition from sobriety to full recovery is a critical juncture that requires extensive support systems.

“For my court case to get my children back, I had to tell social worker everything that had happened to me over the past 17 years. I couldn't cope, I was crying, I was doing it drug free. I was feeling the pain, I was reliving the whole lot of it, and it was like emotions that never hit me in 17 years. So, on the way home, I stopped in an off license, bought a big bottle of vodka and I went home and locked myself in the house and I drank til I could just not think anymore.” (8)

“When you're clean then, you have so many problems, and you'd forget about the pain you went through coming out of the Heroin, and you'd think of the pain you're going through now with all of your issues, so you go back to using the drugs. You go back on the drugs then and you're in a vicious circle going around in a clock then. What broke it for me then I suppose it was a good thing, losing the house in O'Brien Street. Basically, if you've been using drugs since you were 12, you've never experienced what it's like to be sober and be able to deal with all of these problems, so now you're learning how to do it without drugs.” (13)

So, if you had a bad day on a Tuesday, ah look just a few lines, it became an everyday thing. If you had a bad day, turn to drugs. If you had a bad beating, turn to drugs. If it was before sex, turn to drugs. No matter if I was sitting there like black and blue from my head to my toes. Like I remember when he broke my nose in front of the children, that's when I relapsed last April. And I got a load of drugs, and I went away and took a load of drugs. It was the only way I knew to deal with it. So, it all continued like from the beatings to taking this and if you're sitting there black and blue from you head to your toe, one thing you're not doing on the drugs is looking in the mirror. So, you're just forgetting that. So even though its creating a hundred other problems around you, the one thing I needed at the time was to get my though what I was going through ... the only thing that was doing it was the drugs.” (8)

#### *Subtheme 4.3: Isolation*

Sustaining sobriety is impacted by the crippling isolation created when one achieves sobriety, as no longer able to socialise with old friends. Isolation results in the fact that many people who

use drugs have to stay away from friends who use, which in many cases were their entire network, often even including their family.

“If I’m starting to have a couple of days where I’m stuck in myself and stuck in house, leaving things build up, and I’ve nobody to talk to and I can’t go to friends that I had in the past because they use.” (13)

The last while I was using, I felt very isolated. I wouldn't leave the house or anything like that.” I have to stay away from people I used to be around like ye know to stay off drugs. Not even like staying away from them, it's just like kinda isolated now in a way like ye know. From one end of the day to the other, it's only the services and maybe me mother at night like. You get lonely like ye know, ye do. That's hard and boredom then can affect ye at the same time. Then when you're sitting at home then by yourself like or just overthinking things you know.” (10)

#### *Subtheme 4.4: Lack of family support*

This isolation can be particularly compounded if family support structures are not available

Interviewer: “In terms of support from your family, has that been important for you?”

“Well ... I don't have much family support. I’ve a bit of an odd family like ye know ... like me mother don't get on very well like. Starting to in the last while, but think my mother took me back to take drugs and drink more often than help me.” (10)

Interviewer: “And she's not involved in any of the therapy, it's just for yourself?”

“When I was in treatment and that, after we finished it, I was coming to my aftercare, and she had her own aftercare to go to as well like so ... I've finished that now and she's finished it so.” (10)

Interviewer: “Have you many brothers and sisters or is there just you and your mum at home?”

“I've one full brother and I've two half-brothers.” (10)

Interviewer: "Are they all living at home or just you?"

"No, just me. I'm the youngest." (10)

#### *Subtheme 4.5: Trust issues within family*

Other parents spoke of the issue of broken trust among family from the active addiction phase, which carries over to the sober phase. In the quote below, the parent reports that she only became homeless once she became sober, and this was because of a breakdown in trust between her and her mother. The family dynamic was infiltrated with mistrust, leading to accusations, which can lead to relapse – the feeling that I might as well use if being accused of it anyway. In this instance thankfully, despite becoming homeless, the protective factor of the need to be there for her children enabled this parent to sustain her sobriety.

"Being a parent the best thing ever, yeah, so I finally got on to the methadone programme in 2013 and um, yeah, just sort of went on from there, start getting better and better, um, but the funny thing was though I ended up homeless, when I was clean, from drugs. And I'd never been homeless when I was on drugs you know I always had somewhere to go, I just, couldn't wrap me head around that, um, so I was homeless for eight months." (4)

Interviewer: "How did that happen?"

"Uh, because I was living with me Mam at the time, and um, I was like a month clean, and I was thrilled with meself like, you know. Four weeks without touching anything, you know. But every time I came in, she was looking at me and was like, 'oh you're stoned out your face' and all this you know, when I wasn't, you know. And I was like, so I went, and I got my urines printed out and I brought em up and I said there you go there's my urines but em, yeah that sort of carried on. And it was upsetting me that I was being blamed for, you know when I was, doing so well myself you know instead of saying oh well done, this that and the other, you know. I was, just being put down and, you know then that started putting like oh sure I might as well go and use like when I'm being blamed for it, you know. But I said to meself, I'm not going to, I don't want to use, you know what I mean. I'm doing this for me and for my kids, you know, to get meself right. So, I left, and I didn't go back there because I knew it just wasn't a good place for

me to be in because it was upsetting me and you know, it was probably going to end up leading, to me going back (clears throat) on it.” (4)

#### *Subtheme 4.6: Difficulty gaining employment*

The issue of gaining employment can be a barrier people who use drugs. The reasons for this are multi-faceted and can mirror the stage of addiction the person is in, e.g., in active usage stage, the client may be unable to hold down a job. However, through the journey of recovery, accessing employment can be hindered by many factors. These can include a lack of self-belief that they are employable due to low self-esteem, a belief that a gap in a CV will prevent access to employment, and stigma (perceived or real) against drug users.

Interviewer: “And what about employment or options like that?”

“I've never worked, never had a job.” (10)

Interviewer: “But you did a CE scheme? Yea ...”

“I never got a job through cause all I was doing all through school was use. Out of school all I was doing was drinking. If I went to get a job now the reality is... if I ... CV, they're going to say like 'what were you doing the last 7 years like'. Do ye know what I mean, what have you been doing like?” (10)

Based on the quotes above, it is important to consider the need to have additional supports in place at point of sobriety and to be mindful of the challenges the process presents both for the parent and the child.

### Theme 5: Protective factors in recovery

#### *Subtheme 5.1: Peer and support groups*

Parents reported that peer support settings for socialising could act as a protective factor.

“If there was say a meeting, once a week, where addicts could go and say have cups of tea and a chat, and they met other addicts, and maybe over time, relationships would be built up, and people would be become friends or whatever. Maybe little day trips, or they can go off, so instead of them having nobody to talk to, and going in to town

and meeting old addicts, and using, if they had eh a place to go, once a week, to chat and go over there week and whoever is going through a few problems, they all help each other and have someone that's a professional that's there as well. Things like organizing a night to the cinema, everyone goes to together." (13)

Interviewer: "Is there anything that could be done in the community to help the recovery process?"

"Well, you have your AA groups. I think maybe some support groups in terms of just people meeting. Whether it's drugs or alcohol or gambling or whatever it is ..." (5)

Interviewer: "Other than an AA meeting or as well as ...?"

"Somewhere you don't have to go in and say I'm X, I'm an alcoholic, or I'm Mary and you know. You just go in and sit around and everybody just chats about their day, sort of thing. Not putting labels on people." (5)

A suggested protective factor to deal with the isolation is more groups.

Interviewer: "Is there anything that could help with the social isolation bit in recovery?"

"We need like groups, like ye know. Say if you're going to a group every week, maybe or had an activity or something that and then maybe you can mix with people that are in the group and do ye know, you might become friends with people then like." (10)

#### *Subtheme 5.2: Support in general/one to one follow up support*

Interviewer: "So you want to try give up alcohol, you want to try and give up drugs or ... what's needed to make sure that happens?"

"Just keep getting support ... Just say, even if it was just to meet someone once a week just to touch in with them like ye know ... just to see how you're getting on. What's working, what's not ..." (10)

Interviewer: "At the moment, if you want to touch in with someone you have to go to them. Is there anyone that comes out and checks on you?"

"No, no one checks ... that'd be another thing, I'd say that would be helpful as well yea, somebody to come out and check on me. A lot of people with addiction then wouldn't seek the help then ye know or wouldn't ask for it. People with addictions ... hold things in like ye know so if they're struggling like ye know they say 'ah no I'm grand, I'm doing well' like ye know even if they're not. Because I found that out for myself and a lot of other people that don't ask for the help even though they need it." (10)

*Subtheme 5.3: Learning to breathe again –the world opening back up to you*

Parents spoke of how the journey of recovery can breathe life back into you, how hard the battle is to get there but how it can be achieved.

"You just, you learn to relax, you learn to just see the bigger picture, and you find your own shade of grey, and that's what it's all about, find your shade of grey where you can cope and cope properly, and benefits your children and everything, you know, you find your little happy place. I left so much baggage behind, I forgave myself, I forgave my partner, or I call him my partner because obviously he's my partner in life for our children, but I can turn around and say something positive about him which I could never, do, never. And I just, I just left it behind. You just, you learn to stop living in the past, because that's where all of us are hurt, and I think that everyone that has, we are so sensitive, that we've just taken on so much, that you just have to learn to breathe again, and when you learn that you learn that the door is open to you, you're not stuck, and you're not just the addict, you're not stuck in your addiction, and there's so many other paths for you to go down and places to, just, you just, the world opens back up to you." (1)

Sobriety in home creates stability.

"Yeah, yeah, they still have their house, they still have their home, they still have their rooms, but they can see where you, it was, it's a happy home, it's a different home, there's not, there's no anxiety when they are coming to the door, going oh Jesus, who's inside, what's going on, that's all gone, and have that lifted off their shoulders, but you prove this over and over like, and when they can see that, things changed and its

positive change, and then you're positive change has such a domino effect for them for school, for, for everything, you know, they are not going into school with, oh my god is my mother alright at home and, who's up there in with her, and is she going into work, and not worrying about what homework they've done, but yeah, it's good." (1)

## 5.5 Conclusion

In this study, the lived experience in terms of risk and protective factors of all participating parents were similar despite variations in drug use, and exposure to significant life events. However, gender differences were strongly evident in relation to accessing treatment as a parent as a result of childcare needs, and a perceived gender specific heightened stigma for parents who are mothers. In addition to this, in this research study a stark difference in the childcare status was evident depending on whether it was the father, or the mother who was the parent who misused substances. In all cases for the father participants, their children remained living with their mother, fathers had access to the children, and no social services were involved. For the mothers in this study however, of the 11 mothers, only three lived with all of their children, and two others had one of their children living with them. The remaining six mothers did not live with their children but had varying degrees of access, some supervised, some less structured. In the absence of family support, or in the situation when capacity of family to care for child changed (e.g., grandparent became ill), direct state care resulted. Challenges with interfacing with child protection services were raised including reunification challenges, unrealistic goals, fuelled by a perceived lack of awareness of addiction recovery and a stigmatising approach to mothers who use substances.

Parents reported a range of ways in which they believe their children were impacted by the parents' substance misuse and highlighted how this was influenced by factors such as the birth order of the child, the stage of addiction the parent was in, the developmental stage the child was at during active addiction, and the access to resources the parent had. There was a palpable pain from many of the parents when they spoke of how it was often only when they were through the active addiction stage and in treatment that they could see retrospectively how their substance misuse was impacting the children in various way. They spoke of being present but absent, of meeting basic needs but not providing quality time, of children being shut out and isolated, children having no voice, feeling silenced. Parents also spoke of not knowing what to tell the children, not knowing whether it's better to hide the truth, of the children getting caught in the middle, and children dealing with false hope.

When parents were thinking through the lived experience during the interviews and how it impacted their children, comparisons to their own childhoods often surfaced, with many traumatic significant life events being reported. However, despite this high level of their own childhood adversity emerging, this knowledge provided little if any protection or context for the parent in terms of the immense guilt, shame and judgement they espoused in terms of their impact on their own children. The lens with which they viewed the lived experience of risk and protective factors for children of parental substance misuse, was overall a harsh judgemental lens where they as parents had failed.

In terms of what could protect the children, the parent interviews highlighted the need for the children to have someone to talk to, the importance of having family members who can help care for the children when needed, services to suit family routine, education for children around addiction, recognition by services that children communicate differently and the need to design interventions with this in mind. Parents also spoke of the importance of peer support groups and awareness raising of services, of the key role of sport as a protective factor, and how parents love for their children drives their motivation to get better, providing an additional protective factor.

In terms of hindering the protection of the children, parents highlighted factors that hinder the parents own recovery journey, reporting that currently systems are weakest where they need to be strongest, that dealing with trauma sober presents a risk for relapse, combined with isolation, lack of family support, trust issues within the family, and difficulty gaining employment. Protective factors suggested included peer support and groups, and overall general support and one to one follow up support.

Findings revealed risk and protective factors being reported at a number of levels of the Bronfenbrenner ecosystem. Parents reported risk and protective factors for both the parent and the children. The risks and protective factors were evident across three phases of addiction – the active addiction stage, the road to recovery and dealing with life sober. The implications of these findings will be discussed in later chapters.



## Chapter Six: Qualitative research findings from adult children's perspective

### 6.1 Introduction

Chapter 6 presents the qualitative findings of this research from adult children of parental substance misuse, further to the data analysis process as described in Chapter 3. The aim of these interviews was to explore the lived experience of risk and protective factors for children of parental substance misuse from the perspective of an adult child of a parent who used substances. The findings are arranged thematically. Eight subordinate themes were extracted within three superordinate themes. Each theme will be introduced and further illustrated below with participant extracts to represent and support each finding. Detailed discussion of, and recommendations from the findings will be outlined in Chapter 8. Below, a summary of the three superordinate themes and subordinate themes that were identified are provided.

#### Theme 1: The whole is greater than the sum of its parts

- 1.1. Different childhoods – The potency of cumulative factors
- 1.2. Down the rabbit hole – Risks and regrets transitioning from childhood

#### Theme 2: Weathering the storm – Protections growing up

- 2.1 One good adult- someone who cares
- 2.2. Sporting prowess-
- 2.3 Not all peers are created equal
- 2.4 A safe haven – The role of youth clubs

#### Theme 3: On the road to recovery – Succeeding yet scarred

- 3.1 Finding my way in the world but the scars remain
- 3.2 Show me the way- lead by example

In relation to the thematic areas that emerged one can see the relevance of the Bronfenbrenner framework. Theme 1 originates primarily in the family setting of the child's microsystem. This is particularly the case for subtheme 1.1 However within this child's microsystem, there were significant variations in risk factors between the parent child part of the microsystem, versus the family part of the microsystem, within and between participants. In addition to this, for subtheme 1.2, the role of neighbourhood environment and peers, in addition to the family environment was a potent combination of cumulative risks for one of the two participants, yet the role of neighbourhood setting and peers for the second participant had key cumulative protective qualities. Theme 2 and 3 addressed key protective factors growing up and in young adulthood, and with the exception of one good adult, these protective factors originated in the

community. The complex interaction between the risk and protective factors reported in these interviews, and their location at different levels of the ecosystem was evident. The findings highlight the dangers involved with examining risk and protective factors of parental substance misuse using a narrow lens of focusing solely on the parent child dyad and argue strongly for the consideration in future research for widening this lens to include all levels of the ecosystem, the bi-directional interactions inherent within these levels, and targeting the strengthening of the reported protective factors.

## 6.2 Profile of adult children: Family context- adult child and grandchildren

Five adult children volunteered to take part in this study. However, three of these adult children were unable to attend for interview on the day. These participants were contacted to see if they would like to reschedule, and they confirmed that they would. Interviews were rescheduled on a date that suited the participants. However, on the rescheduled date of interview, severe weather conditions prevented participants attending. The duration of the severe weather conditions also prevented a second planned rescheduling of interviews. Thus, due to the timeframe restrictions, a total of two adult children participated in the interviews.

The participants who volunteered to take part in this study were young Irish adults over the age of 18 (both participants were in their twenties), who had lived experience of growing up with parental substance misuse. Each adult child represented a separate family. Each participant was also attending treatment for their own substance use. Recruitment for adult children took place using the same gatekeeper and services that we had availed off to access the other participant cohorts. The participants were not related to other participant cohorts in the study.

We shall see throughout the themes, that while each participant had a shared experience, different additional inter-related risk and protective factors can mediate the impact. These variations included differing degrees of adversities within the family in conjunction with parental substance misuse, and different degrees of community adversity. In terms of homogeneity of sample, while both participants were male, in their twenties, both grew up with parental substance misuse, with alcohol being the dominant substance in both sets of parents and both participants currently now live in the same geographical regional urban location from which the pool were selected, one however of the participants grew up in a very different community setting and had moved to the current location in his late teens. This difference in childhood community setting was not possible to determine prior to the interviews.

Participant 1 (AC1) grew up in deprived urban area, a community area facing widespread poverty, and limited opportunity, the second eldest in a large family with very limited financial resources. The children had separate fathers. Both of his parents used substances, alcohol and cocaine. His father also suffered from mental health issues culminating in his father dying by suicide when participant one was under 10 years of age. Due to the death of his father, the reported unavailability of his mother to care for her children due to her substance misuse, and the absence of any other responsible adult living within the home at that time, from a young age onwards, AC1 reported having to assume the pressurised role of caring for his younger siblings in conjunction with trying to raise himself. Parentification, when the roles are reversed, and the child becomes the parent can be a cause of invisible childhood trauma.

During his childhood AC1 was exposed to 4 of the 10-family level Adverse Childhood experiences (ACEs), one of which was parental substance misuse. ACEs are potentially traumatic events that can have negative, lasting effects on health and well-being. In general, individuals who have faced more ACEs have been found to be at higher risk for impaired cognitive and social development, as well as for drug abuse, unintended pregnancy, depression, PTSD, and even higher rates of injury. However, not every person who has a challenging childhood grows up to be maladjusted. Some children are less susceptible to the negative effects of their surroundings and carry less stress with them into adulthood. Adverse childhood experiences can increase a person's risk for chronic stress and poor coping mechanisms.

In addition to this, more recent developments in this model also look at the interconnectedness of the family level ACEs in conjunction with **Adverse Community Experiences** (the community environment – the soil in which some children are rooted. This soil that can be steeped in systemic inequities and dysfunction, robbing it of nutrients necessary to support a thriving community. Adverse Community Experiences, such as lack of opportunity, limited economic mobility, fear of discrimination, and the associated effects of poverty and joblessness contribute to – and compound – the adversities experienced by individuals and families. When childhood adversity occurs in the context of an adverse community environment, these stressors can become toxic to a child's development and long-term health.

Participant two (AC2), grew up in a non-deprived regional area, and is the eldest of four children. He was exposed to 3 ACES growing up but was not required to assume any caregiving role to younger siblings. One of his parents used substances- his mother (alcohol and Valium), and she

has co-occurring mental health issues requiring intermittent psychiatric services involvement. Currently his mother continues to use substances. His father never used drugs or alcohol. The parents are still married but live apart. AC2 reports himself as being the black sheep of the family.

Both participants were also now parents themselves. Social services were involved with participant one's child, but the children were never taken from him and his wife. The children of participant one is living with him and his wife. For participant two, the children live full time with their mother and participant two has full access and sees them regularly but does not live with them. There was no social services involvement with the children of participant two. Both participants were at various stages in their recovery. Details are provided in the tables below.

*Table 11: An overview profile of family structure and environment growing up*

| ID                             | AC1  | AC2   |
|--------------------------------|--|---|
| <b>Gender</b>                  | M  | M   |
| <b>Age</b>                     | Deleted to ensure anonymity  | Deleted to ensure anonymity   |
| <b>PSMU (Mother)</b>           | Alcohol and cocaine but mostly alcohol. Would drink from minute she woke up.   | Alcohol. Self-medicates with alcohol and Valium. Frequently found her passed out from drinking when he returned home.   |
| <b>Recovery (Mother)</b>       | Sober 7 years  | Still using   |
| <b>PSMU (Father)</b>           | Cocaine, alcohol   | No substance use issues   |
| <b>Recovery (Father)</b>       | Deceased- died by suicide.   | N/A but Father had limited role in his life.  |
| <b>Mental Health (Mother)</b>  | No diagnosis or engagement with services reported  | Mother in and out of psychiatric services over the years.   |
| <b>Mental Health (Father)</b>  | Mental health problems, died by suicide. AC1 was under 10 years of age   | No mental health issues   |
| <b>Family Structure</b>        | x siblings (number removed to protect anonymity). 2 <sup>nd</sup> eldest. different fathers. Step father abusive to mother.  | x siblings. Eldest child. Parents still married but no longer live together.  |
| <b>Environment</b>             | Exposed to 4 ACES<br>Deprived Urban area   | Exposed to 3/10 ACES.<br>Non deprived area.   |
| <b>Significant Life Events</b> | Mothers substance use-emotional and physical neglect. Mental health - Father deceased by suicide. Role of carer for siblings, own substance use, gangland involvement, attempted suicide age x, diagnosed mental health age x, prison time, rehab, self-harming. | Mothers substance use- some emotional neglect. Own drug use. Prison. Emotional Isolation from siblings because of substance use. Currently homeless.  |
| <b>Protective factors</b>      | One good adult(s): Yes   | One good adult: Yes   |
|                                |  | Peers   |
|                                | Sports: <ul style="list-style-type: none"> <li>- Kept in school because of sporting ability.</li> <li>- Focus, structure, team building, self-worth</li> </ul>   | Sports. <ul style="list-style-type: none"> <li>- Stayed in school because of sporting ability.</li> <li>- Focus, structure, team building, self-worth</li> <li>- Cost of sport risk factor</li> </ul> |
|                                | Youth Clubs  | Youth clubs   |
|                                | Drug treatment service- helped with recovery, someone to go, provides structure and support.   | Drug Treatment service which includes the CES Scheme providing focus structure, support, and employment.  |

|                                |  |   |
|--------------------------------|--|---|
|                                | Social services: non-judgemental supportive approach.  | N/A   |
|                                | Cannabis- prescription   |   |
| <b>Own Substance Use</b>       | Heroin use from age x until child was born age x. Drug dealing from young age. Cannabis use from age <12   | Drinking, tablets, cannabis, Bosnai (synthetic form of cannabis)  |
| <b>Recovery status</b>         | Weed only.   | Cannabis only   |
| <b>Mental Health</b>           | Attempted suicide age x. Self-harming. In and out of rehab and prison. Currently self-isolating as coping mechanism. Unable to eat. Current unresolved emotional issues. | Has undertaken significant personal development within treatment service. Some emotional issues remaining unresolved. |
| <b>Own Family Structure</b>    | 1 child aged x, wife pregnant with second child.   | 2 children aged x & x   |
| <b>Living situation</b>        | Lives in own house with child and wife. Becoming a parent turning point in addressing addiction.   | Homeless, couch surfing. Still with partner but doesn't live with her. Children live with partner full time           |
| <b>Social services</b>         | Were involved with children but never taken from AC1. Positive experience with Social services. Provide support for daughter who has Autism                              | No social services involvement.   |
| <b>Employed</b>                | Yes, works for brother   | Engaged with Community Employment Scheme through drug treatment service   |
| <b>Prison</b>                  | Been in prison over the years.   | In prison for x months. Turning point for him.  |
| <b>Significant Life Events</b> | Coping by self- isolating. Significant unresolved emotional trauma.  | Prison. Isolated from siblings because of substance use. Currently homeless.  |

### 6.3 Themes identified by Adult Children interviews

Three superordinate themes emerged from the coding process during the data analysis process described in Chapter 3. The superordinate themes consisted of a total of eight subordinate sub themes.

#### Theme 1: The whole is greater than the sum of its parts.

Throughout the interviews, the participants reported risk and protective factors that they experienced growing up in a house with parental substance misuse. However, there was also additional risks reported by participant 1 as a result of the combination of the parental substance misuse and other additional adverse factors. Experience of parental substance misuse and risk and protective factors varied within these two participants depending on inter-related factors such as the, the number of parents with addiction, the degree and outcome of mental health issues, the degree of exposure to different types of adverse childhood circumstances, including the level of neglect experienced, the requirement to assume additional roles, the community area they grew up in, and the support structures and protective factors in place to mediate the impact.

#### *Subtheme 1.1: Different childhoods- The potency of cumulative factors*

A spectrum of risk and protective factors were reported by the adult children. These risk and protective factors merged and varied across the different levels of individual, family, service,

and community. As noted in the profile of the participants, while both participants grew up with parental substance misuse, their childhood experiences had similarities and differences in conjunction with the parental substance misuse, including context.

Participant 1 (AC1) was the second eldest of X number of children, both his parents used substances, alcohol and cocaine. Both parents also suffered from mental health issues. For participant one this culminated in his father dying by suicide when participant one was under 10.

“Me mother and father both used substances. Me father he, he passed when I was only a child. It was suicide. He had mental problems, drug problems, cocaine and alcohol. Me mother was an alcoholic and in the mix cocaine but mostly an alcoholic all her life. She would get up in the morning and drink.” (AC1)

Participant two was the eldest of X, only one parent used substances (his mother- alcohol and Valium), and his mother also suffered from mental health issues and frequently attends psychiatric services. Currently his mother continues to use both substances. His father never used drugs or alcohol. The parents are still married but live apart. AC2 currently occasionally lives with his mother.

“Alcohol and tablets. Me mother. She has been in psychiatric services ya know. Ya know the usual run of the mill. She has been put into psychiatric services and all ya know. Me da was about but he wasn't so much if ya know what I mean. It might only be six cans every night, but it's still six cans every night. and then there is Valium as well like every night like I still live on and off with me mother. Me father though, no drinking or drugs or with me da as far as I remember” (AC2)

While answering the question about the substances his parents used, AC2 remarked that his grandfather on his mother side was also a heavy drinker and all his aunts and uncles on her side were also heavy drinkers, querying the role of intergenerational substance misuse.

“Me grandfather was a heavy drinker as well, me mams da. and me ma's sisters are drinkers as well like. I don't know if they are as into it as me mam is, because I don't be seeing them all the time, ya know behind closed doors.” (AC2)

When asked what it was like growing up, AC1 reported that it was horrible for him. He expanded on this by stating that he grew up in a deprived urban area, that he had three fathers, and that his mother was an alcoholic all her life. He continued to recount his upbringing, noting that his eldest brother was a protective factor for him, who reared him and was like a father figure for him, the only father figure he had. He added that the brother did this because his mother wasn't available to do it as she "just drank all her life". From the lived experience of AC1, his mother's drinking rendered her incapable of looking after him in any capacity. However, up until this point, his eldest brother, the eldest in the family, took on the responsibility of looking after his younger brother acting as a protective factor to mediate the impact of the unmet need as a result of the mothers substance misuse.

"It was horrible for me, I lived in X (disadvantaged urban area) you know, and I have an elderly brother that lived in X, he was from one father and there's me and my other brother from another father and then X number of other siblings are from another father. My eldest brother, his part was, he lived in X, he reared me and my brother, coz my mother was an alcoholic, and she just drank all her life." (AC1)

A significant change in family life however culminated in the death by suicide of his father, in conjunction with his eldest brother having to leave the family home when AC1 was young. During this transition, in conjunction with dealing with the loss of his father by suicide, and his brother who provided a protective rearing role moving out of the house, AC1 had to assume a role of caring for his younger siblings even though he himself was under 10.

"And I remember when I was young (under the age of 10) I started looking after the X number of young siblings then because my brother moved out coz he couldn't hack her no more, no man around, my father passed, and them kids... My mother and stepfather, they were always fighting, they were very abusive. My two brothers and sisters' father, they were younger than me, I had to look after them. I lived with my mother all my life. I was on the dole." (AC1)

There are multiple risk factors for AC1 here. He lost his father to suicide, he lost the only secure stable influence in his life from the home setting when his brother also left, his mother and step father were constantly fighting and were abusive, and in addition to this he had to assume a

care role for his younger siblings and himself as there was no one else there to look after him or his siblings due to his mother's incapacity to fulfil the role as a consequence of her substance misuse. What is of additional note here is that his stepfather performed no parenting role in relation to either AC1, or his own children. Up until the age of 7, AC1 had his older brother looking after him providing him with security and stability amongst the chaos. However, once his brother left the home, and his father passed, there was no one living in the house who was looking after him or the younger siblings. A key risk factor here for the AC1 in conjunction with the parental substance use, was his older sibling leaving the family home given the protective role the brother had played in his life. This was despite the fact that he said he knew his brother was always there for him and only a phone call away.

The risk factor of living with parental substance misuse is now compounded as the nurturing and protective role of the brother within the house is gone, the father is deceased, the step father performs no parenting function, and there is an additional burden of now having to look after both himself and his siblings. Parentification, when the roles are reversed, and the child becomes the parent can be a cause of invisible childhood trauma.

From the age of 7, AC1 felt abandoned and neglected by his mother's substance use, compounded by having no alternative positive role model or parenting person within the family setting, left to grow up in a house with no role model, no one to teach him right from wrong, a house within which even the most basic of the hierarchy of needs were not being met combined with a burden of responsibility for his younger siblings – the weight of the world on his young shoulders.

For participant 2, when asked what it was like growing up, he reported that while his mother drank every day and took Valium, that she raised him well, that his mother did everything for him into his twenties. And that she has continued this with his children – her grandchildren. AC2 was protective of his mother and cautious about how he portrayed her substance misuse and how he experienced it.

“It might only be six cans every night, but it's still six cans every night. And then there is Valium as well like every night like and its nothing against me mother like you know, she raised me well. I never had to clean, I never had to change my bed, fold my clothes, clean me room like ya know. I never had to do a thing. My mother done everything



single thing for me. (laughs). And she is very good to my two kids - buys them clothes, buys them everything.” (AC2)

When asked what it was like for him growing up, his protection of his mother continued, stating that he didn't want to state what happened on the tape. The researcher offered to turn the tape off which the participant accepted. During the off-tape time, he disclosed some of his experiences. He then said he was happy for the tape to be switched back on. From this point forward, the interviewee began recounting his lived experience in more depth, comfortable to disclose what the experience was really like. Trust issues are a significant impact of children who grow up with parental substance misuse and the capacity to open up to people requires a feeling of safety.

Following this interaction, AC2 began to speak about recurring episodes when his mother would be passed out when he would come home with a bottle of pills beside her, and her drink spilt. And that he had become so used to it that he would just step over her.

“When I would come home sometimes my ma would be passed out when I came home sometimes my ma would be on the floor right with bottle of pills beside her, and the can split and I'd be like, that's the norm like, so I would step over her.” (AC2)

As he recalls the events, his responses become more agitated with his mother's behaviour.

“I literally would go like this (shows stepping over someone) and step over her, fucking asshole and pick up the can on the floor and empty it into the sink so as when she did wake up, she wouldn't be able to drink that can ya know. That was an ongoing thing.” (AC2)

This agitation culminated for him in a guilt-ridden experience where out of exasperation with his mother he reached out to an extended family member to disclose the state his mother was in. An issue arose which cannot be disclosed in this thesis due to confidentiality request by the participant as he stated during the interview that he hadn't disclosed this issue to anyone else. The important point here is that this again reflects the conflicting emotions in relation to his mother's substance misuse, including a sense of betrayal for discussing it.

Participant 2 concluded this section of the interview by stating that he is able to deal with his mother, that he has now become used to it to the extent that if she didn't drink alcohol, he would think there was something wrong with her. This again demonstrates an over-riding desire to protect his mother.

“I can deal with me mother; I am used to it. If me ma came home tomorrow and didn't drink, I would think there was something wrong with her like. Is there something wrong with you or something I would be thinking.” (AC2)

From the findings above we can see that while each participant experienced parental substance misuse, the spectrum of neglect reported varied as there were additional factors contributing to the intensity of that experience on their childhoods. In addition to this, while participant one openly recognised and articulated the extent of, and the perceived impact his mother's substance use had on him, from the outset of the interview, participant two was more cautious in disclosing initially what the experience was like. AC1 reported being completely abandoned and neglected physically and emotionally within the home. AC2 however stated that despite the fact that his mother drank, he was raised well and always had everything done for him. However, he also then proceeded to recount episodes where his mother would be passed out and recall how frustrated he was with these situations culminating with an attempt at help seeking that resulted in feelings of guilt. It is also worth noting that while AC2 said he was reared well despite his mother's drinking as he never had to do anything, the degree to which his emotional needs were met by his mother are not articulated. And as we will see throughout the following themes, AC2 wrestles within himself on what role, if any, exposure to his mother's parental substance misuse had on him and his subsequent life trajectory.

#### *Subtheme 1.2: Down the rabbit hole – Risks and regrets transitioning from childhood*

Despite differing exposure to degrees of neglect and other additional contributory factors intensifying the lived experience of parental substance misuse, from the teenage years onwards both participants reported similarities in their life trajectories. Both participants used drugs, both participants were in prison, both participants are parents, neither participant went to college. However, as before, the intensity of these experiences varied.

For participant 1, prior to the age of 13 he was drinking and smoking weed, By the age of xx, he was using heroin, by the age of xx, he was drug dealing, at the age of xx he was involved with

the gangland underworld. He reported that all his friends were dead, and many of his cousins were in prison.

“... I have cousins that are locked up, none of them are over 25 and they are all locked up for X, it’s all the gangland war stuff, I got out of there, me brother X got me out of there ..... Drug dealers taking advantage of you ya know, once they get you wrapped, your wrapped ya know what I mean.” (AC1)

He attributes this life-path to a potent combination of risk factors consisting of his mother’s substance misuse, and the subsequent neglect, no alternative positive role model in the house, the deprived area he grew up in where exposure to criminal gangland activity was on the doorstep. No-one at home was minding him, no-one was looking after him. He had no role model, no-one showing him right from wrong. His only exposure to his mother was witnessing her constantly under the influence of alcohol and as such unable to meet his needs.

In conjunction with this he said that his family had a bad reputation and that he hung around with the wrong people. He described persistent feelings of unworthiness, low self-esteem, and not being good enough. A key protective factor for him throughout this was a feeling of worthiness brought about by making money from drug dealing.

“I didn’t feel I was good person because I was in with the wrong people and my family come from a bad reputation and the only thing that made me feel good about myself was handing over a bag of drugs and getting the money in my hand and counting it at the end of the week. The only thing that made me feel good was selling drugs like.” (AC1)

With hindsight however, he believes that the reason he needed drug dealing and the money from it to feel good about himself was that there was no other option for him. That for him it was literally sink or swim. This absence of structure, purpose, and options was repeatedly reported throughout all the previous cohort interviews as a key risk factor for instigating, maintaining and relapsing during substance use.

“...but the way I look at it now is because it was the only thing that was there for me, I had no one else or nothing else to occupy my mind or distract me or show me any

different way of life, I was just thrown into a disaster basically a disaster. Basically, sink or swim.” (AC1)

However, despite his persistent exposure to cumulative adverse life experiences, the neglect and abandonment he was exposed to, he still found the strength within himself to look after his younger siblings, making sure they got something to eat and that they got to school.

“No one was minding me. That's the thing like. You know that love hate program\*, that's exactly what it's like up there. I was just getting up seeing me ma drunk so just going smoking weed and making sure me brothers got something to eat and got them to school. and then going out taking drugs and robbing and just doing all bad stuff but it was all down to looking at me mother drunk, I never had a parent there to tell me no, you can't do this or do that, this is the right way to grow up, this is the right way to be reared. Only sometimes did I get a meal.” (AC1)

*\*Love/Hate was a TV series in Ireland depicting the criminal underworld life in a deprived urban region*

In the case of AC1, he recounts that the responsibility of full care of his younger siblings, culminated in him trying to take his own life while minding his younger siblings. AC1 is unable to remember what age he was when this happened but said he was younger than 16.

“I can remember being in the house and me mother left and me trying to get me brothers and sisters to school, and he was just misbehaving, and I went to the back garden trying to hang myself and they went out and called the neighbour, so I just ran off up the cornfields and he chased me up there and ever since then I have just been linked in with doctors and all. I think it was because the neighbours rang an ambulance.” (AC1)

This began a lifetime of engaging with mental health services including treatment to try and “wipe his past”

“In and out of mental institutions all me life like. I got X done and all, I was diagnosed with Y when I was 16 or 17. I got X done to try and wipe me past, I just remember all bad ya know.” (AC1)

AC1 first experience of engaging with mental health services during this crisis was that he remembers being too young for the service so they couldn't keep him in, and he had to attend alternative services in different regional locations. The capacity of mental health services to respond to mental health needs of older teenagers is a pervasive issue across Ireland (Dooley & Fitzgerald 2012).

“It was a man's hospital anyhow, they had to take me out of there because I was too young to be in there, they brought me up for a day and then took me out. Yeah, they couldn't keep me there with people with mental illnesses that were ya know, so it wasn't safe to keep me there, since then I've been in mental health services in X and Y locations (regions outside of his living area).” (AC1)

For participant 1, upon discharge from the mental health service, he did not return home. This began a journey of recovery which will be discussed within the next and final theme.

For participant 2, like Participant 1 above, he reported ending up going “down the wrong route”. This wrong route included using substances, cannabis, alcohol, tablets, and stealing his mother's tablets, culminating in a one-year prison sentence last year.

He initially attributes his own substance use to having been exposed to substance use in his home- a risk factor for his own behaviour.

“But I just went down the wrong route ya know. Part of the environment like, monkey see monkey do like, drinking and tablets and robbing me ma's tablets. Then I ended up doing cannabis and bosnai and I ended up in prison last year for year” (AC2)

In addition to this, he also states that he lacked an older person who he could look up to who wasn't a drug user, a role model, one good adult. For AC2 this role model needed to be someone outside of the family, someone who would steer you away from temptation with peers.

“Maybe if I had of had an older person who I could look up to who wasn't a drug user. A role model. Ya know someone to give a bit of guidance to ya. Your father is not always the one to be there like ya know. Your father is your father like. He is not the one who is going to be offering you a joint of weed like. He is not going to be there when you are around the gang or the group or the lads. I probably still would have smoked dope though ya know. I'm not trying to put that on me ma like ya know.” (AC2)

At the end of the statement, however, AC2 demonstrates the same conflicting emotions in relation to the role his mother's substance misuse played in his subsequent life trajectory, making it clear that he was not blaming his mother for his substance use, that he believed he would have taken drugs regardless. And that he actually enjoyed it and liked it. For him it was his time in prison that acted as a catalyst for change.

“I probably still would have smoked dope though ya know. I'm not trying to put that on me ma like ya know. I do love it like. and there were times now when I used to get up every morning and want to smoke a joint first thing, want to go chase it, want to get a 50 bag, an ounce, but I don't do that anymore because with eight months in prison you have a lot of time to think about what you want in your life.” (AC2)

This is an important point in relation to taking a substance because you like it. This is a topic that is not discussed much, rather taboo, that consumption of substances takes place because people like how the drugs make them feel.

To add to the conflicting emotions in relation to what if any role his mother's substance use had on his own substance use, AC2 noted that none of his other siblings take drugs. That he is the “black sheep” of the family. There is an intrinsic sense of shame, confusion, self-blame and guilt.

“My siblings are all anti-drugs. They always be calling me names, you're only a scumbag, go away and smoke your weed. They are anti-drugs like. That's why I found it better to smoke the synthetic stuff because then I could smoke it in the room without them knowing it was being smoked because there is no smell of it...I'm the black sheep of the family.” (AC2)

During the parent cohort interviews, many parents expressed concern that their own children would follow in their footsteps and misuse substances. They attributed this to both the fact that children saw their parents doing it, a learned behaviour, and also a coping strategy as a result of exposure to parental substance misuse growing up, in conjunction with a possible genetic pre-disposition for substance misuse. This unprompted discussion in the parent interviews involved discussions about the role of nature and nurture and this discussion was made more difficult to decipher when only certain children followed in their parents' footsteps, despite all children being exposed to the same parental environment and socio-economic environment. Bronfenbrenner's bio-ecological development theory stipulates that context is of critical importance, but that other factors are at play, a pivotal factor being the role of proximal processes in child development. Proximal processes involve the bi-directional interaction between child and environment, including child and parent, and is influenced by the child's own characteristics including demand characteristics, resource characteristics, and force characteristics.

For AC2, this "wrong route" culminated in a prison sentence last year. During this stay in prison AC2 reflected that whilst Heroin was rife, he never succumbed to it. When asked how he had the strength to resist the temptation during prison sentence, his answer stated that it was down to his own self-control and a lack of motivation to use the drug due to its known negative impacts.

"Oh, its people who have no hope, maybe, everyone has temptations, whether it is lust or whether it is, ya know, but we don't always act on it ya know. We don't always act on our temptations or our impulses ya know. Restraint, I had the restraint and the common sense like ya know. I never did heroin once and I am so glad like. Because even the life, people doing life sentences will tell ya, don't do that you know, it's a life sentence." (AC2)

For participant two, his time within prison was a key turning point in his life and culminated in his desire to change. For participant one, becoming a parent was a pivotal turning point, in conjunction with a change in his living circumstances. Prior to exploring the third and final theme, theme three, which explores their road to recovery, participants reported what for them were key protective factors during their childhoods growing up in home with parental substance misuse.

## Theme 2: Weathering the storm -Protections growing up

The second superordinate theme relates to what the participants describe as protective factors for them during their childhoods while growing up with parental substance misuse, how certain factors helped them weather the storm.

### *Subtheme 2.1: One good adult – some who cares*

For participant one, growing up, the over-riding protective factor for him in his life was in the form of his eldest brother, a role which his eldest brother continues to date. The reason that the brother for him was viewed as a protective factor was that his brother provided with a consistent unconditional love, and a sense of security. That his brother was always here for him, had never touched drugs, only occasionally drank, had never let him down and had always been his support, the only father figure he had in his life growing up.

“Yeah, me eldest brother X, that lives in X, he has his own business and all. He never touched drugs; he only had the odd drink at the weekend. He always worked hard, and he has always been there throughout me life, even when I have done the worst of the worst, he has always been there for me, he has never let me down, he’s always been my support, I see him as my father, that’s the only father figure I had in my life growing up. He tried to stay around for me and me other brother X and the others, but he couldn’t put up with me mother, ya know it was too much ya know. I can’t imagine what he went through from when I went through.” (AC1)

He viewed his brother as a critical protective factor growing up both while he lived in the house and even after he had to leave the house.

“He was only a phone call away, I was doing me own thing, I was only a child running around like, before I knew it I was kicking a football and then before I knew it I was in a robbed car, robbing shops, robbing houses, taking drugs and all ya know, that was my life up til three years ago when I had my child and just taking drugs after drugs after drugs, going into rehab and having mental health issues and all. None of that helps.” (AC1)

AC1 furthermore demonstrates compassion understanding about why his brother left, stating that he didn’t have a choice in it. His eldest brother also protected his younger brother and his



wider family from death threats by providing money to protect his younger brother and by always being there for him no matter what situation he was in.

“He's a very strong man (his eldest brother). He's been through a lot. This family we have put him through a lot, ringing him up telling him we owe a lot of money, we are going to be killed and he has to pay it but the hurt he had to go through, he won't even talk about it, I can't understand what he is going through, I can understand but not enough because he won't tell me. I remember him always being at the mental home for me, be at the police station, the hospital.” (AC1)

He also ensured that his younger brother was moved out of the deprived urban area that he was living in after his involvement in the criminal gangland world culminated in him being shot. This intervention was a critical protective factor as AC1's life was in danger.

“Me brother X got me out of there when I was shot, I was a only a teenager when I was shot. Drug dealers taking advantage of you ya know, once they get you wrapped, your wrapped ya know what I mean.” (AC2)

His eldest brother currently employs AC1 also, providing him with a sense of purpose, structure, a means to support his own family. The protective role of this “one good adult” brother is transferring down to the next generation of children.

Participant two also stated that growing up his grandfather was a protective factor for him; however, he did not expand in the interview on what it was about this relationship in particular that he found protective for him. However, a second good adult in his life was his PE teacher. In this case, AC2 describes how a PE teacher acted as a protective factor in participating in sport when he persisted in following up with AC2 to attend games even when AC2 was hungover and unmotivated. In the excerpt below you can see the example he provided to explain how a teacher who believed in him had gone to extreme lengths to ensure that that AC2 lived up to his potential as much as possible. AC2 recalled in admiration the effort the teacher had put in to ensuring he attended the game, how in the absence of this support he would not have attended and won the title. This memory was recalled fondly, and tenderly.

“My PE teacher used to be my trainer. And one day I was hungover, and I left my boots in school on the weekend and the teacher called to my house. I woke up like and the teacher standing over me, what are you doing, we have a match out there in the park, the lads are on the pitch. So, he brought me out hungover, belching smelling of drink of me. Next thing I know I was standing on the pitch, put me boots on me and then we went on to win the title. We won the regional title. The teacher said that he was looking for my house and couldn't find it anywhere, and he was parked about twenty minutes away, brought me up the road and then I'm on the pitch!! I was hungover and I wasn't going to turn up. But I'm good when I play. I would have a level of play that the other lads just wouldn't have.” (AC2)

The role of sport in the lives of both participants was reported as a protective factor growing up. The next subordinate theme explores this.

#### *Subtheme 2.2: Sporting prowess*

Sport was reported as a protective factor available outside of the home for both participants, and in both cases, both participants stated that it was their capacity to play sports that enabled them to stay on in school. While school was not a positive experience for AC1 as he had dyslexia and said he was playing up in school, and was distracted by the area he grew up in.

“I did go into school but I'm dyslexic and I was acting up, the area I was from like. I started drinking at a very early age and smoking cannabis and all. No, the school was no help at all, I don't think I even made my confirmation. I was kicked out in fourth class. And then I went to 5th and 6th class and then went to secondary school for six months and then left there and went to Fast and did me junior cert I think.” (AC1)

He continued to say that the school only kept him on because he was good at sports.

“The team I play for, the school wanted me to play, that's the only reason they kept me on at school was to play sports.” (AC1)

Sport also acted as a protective factor for participant two, both within and out of school. Within school, AC2 credits his sporting ability as the reason he remained in school and achieved his leaving certificate.

“Yeah, did the leaving and all and the only reason I got that was because I was on the soccer team, Gaelic team, hurling team, rugby team. I was always on the school teams. I was more out of school than in school.” (AC2)

Whilst it is encouraging to see the role that sports play in the lives of children in relation to their schooling, caution is also needed here to ensure that children who do not have sporting prowess receive the same encouragement and motivation from the school to progress within the school setting.

Both in school and out of school, AC2 reported that sport had a huge protective factor in his life.

“Ah Gaelic football and sports really helped me growing up. God yeah, if I hadn't of had that I would have been lost ya know.” (AC2)

Sport provided structure, motivation, physical and mental health benefits, including the comradeships of a team and the confidence building nature of being a key player within a local team. However, participant two also flagged that a risk for participation in sport is the cost that can be associated with it. In his case, for certain sports, he couldn't afford the sports gear.

“Like you see the lads who play rugby and all their fathers' own businesses and all, massive chains of businesses and like they had all the padding and all but I was going playing rugby I had nothing, nothing.” (AC2)

Important issues are raised in the themes above, issues which previous research literature has mirrored. Sporting prowess has been reported as a protective factor for young people in the literature. This was also the case within the parent cohort interviews, where the capacity to successfully participate in sports were repeatedly listed as a key protective factor both in their own childhoods growing up, and still to date it protected some of them who were still able to play sports. It was a protective factor for their own children indirectly through it keeping parents in recovery, and directly by it being a source of structure engagement and cohesion for their own children who played sport themselves. However, just as the adult children reported here, parents also reported that capacity to participate in sports can be hindered by unaffordable associated costs. For some parents the issue of cost of their children participating in playing sports was an issue that prohibited participation. This was viewed as a risk factor. Also, of

importance above, is that while sports can be a protective factor for children, and enhanced their school experience, for young people that cannot play sport, this could be a potential risk factor.

*Subtheme 2.3: The role of peers: not all peers are created equal*

The role of peers was reported as a protective factor for participant two but a risk factor for participant one. Participant two recalled his friends as being a source of support for him growing up. For him, having his friends around him provided a buffer to some of the experiences he was going through at home.

“My friends were really important to me growing up. I would hang out with them, play sport with them, meet them at youth club. They were a great support network for me.”  
(AC2)

Participant one however, viewed his family and friends as negative influence in his life as his family were from “a bad reputation” and he hung around with the “wrong people”. Participant one described entrenched persistent feelings of unworthiness, low self-esteem, and not being good enough, feeling which, he attributes to being born into a bad family, and hanging out with the wrong people.

*“I didn’t feel I was good person because I was in with the wrong people and my family come from a bad reputation.” (AC1)*

All his friends are deceased, and his cousins are incarcerated.

“When we were growing up in X, it wasn't nice ya know, all me mates are dead up there like ya know what I mean, I have cousins that are locked up, none of them are over 25 its all the gangland war stuff.” (AC1)

In conjunction with exposure to adverse circumstances behind closed doors within the family home, AC1 describes how his family’s reputation irrespective of him, predetermined how people perceived him and responded to him outside of the home. In addition to this, he notes that a number of his cousins are locked up for murder and all his friends are dead. There are significant traumatic events mentioned above here, including the fact that he himself was shot when he was a teenager, and was living in fear of his life. The degree to which the role that his

parent's substance use in isolation, had on his life experiences are not possible to determine in light of the other inter-related family level and contextual level factors at play. And while it is not the aim of this research to do so, it is important to remain vigilant to the interconnectedness of a myriad of factors when discussing risk and protective factors for children of parental substance misuse. From the outset of the interview with participant one, he spoke about how all the factors contributed to his life experience growing up. Of course, his parent's substance use was a critical risk factor and had a critical role in his life. This is not being disputed. But he also describes numerous inter-related risk factors.

*Subtheme 2.4: A safe haven – the role of youth clubs.*

At the level of the community, both participants described an extremely positive and critical protective role for them was the availability of youth clubs to them- youth clubs played a critical protective role in their lives growing up. For participant one, he described how the youth club provided the option of somewhere to go after school, somewhere where all level of needs were being addressed from the basics of food and shelter, to acting as a key support for him while he navigated the adverse circumstances, he was living in.

“There were the youth clubs, I remember you would finish school at 4 and go to them from 5-7 and you could have something to eat and do PE or play football or something, That was the only type of thing, apart from X, do you know of him? drop ins from different services and then you can get into this youth club and that youth club and that's how I was getting through.” (AC1)

Participant two also reported the key protective role that youth clubs had for him. It was a safe haven, somewhere to go where basic needs and emotional needs were being met. A place with good people, a place with structure. A place where you were made feel welcome, safe, a place where you were made feel good about yourself, a place where people responded positively to you. This was reported also by parents in the parent interviews.

“When I was a young fella, I used to go to the youth club as a young fella, like a youth drop in and I found that was great. It's a thing they have around the counties - a youth drop in where all the youth go to keep them off the streets and all like. And when I was like 14 15 16, we were going there playing pool and all and we used to go on the hop from school there and I know that's a bad thing ya know. It was a place where I could

go and there was good people there like ya know. They were all nice people. Putting up me with at that stage like and me running around wild like...” (AC2)

However, a gap in terms of protective factors, from AC2s experience, is somewhere similar for young people aged 17-24 to spend time, a place opened at night. Something to replicate the function of youth clubs but that caters to an older age range. A safe haven providing structure, and support.

“A young adult between like 17 and 24 - what I reckon would help would be somewhere at night where they could go and congregate with people, places like this but opened at night-time. Like youth clubs are opening in the evening, they are but like there's nothing for adults anymore. But the youth clubs would be open, I used to go to all of them when I was young fella. I used to go to Dublin to play soccer, all the youth clubs come together from everywhere around Ireland, I met the Shamrock Rovers manager there at the time, went to this big complex in Dublin with like 40 astro turf pitches and all. Things like that.” (AC2)

As can be seen from theme two above, both participants reported the same protective factors. These were one good adult, participation in sport, and the essential role that youth clubs played in supporting them as they navigated their childhoods. The question in relation to protective factors was a very open-ended question with no prompts – it simply asked young people what helped and protected them growing up. The protective factors listed all reside outside of the home, with the exception of the role the eldest brother played in the life of participant one in the earlier years whilst living in the house. In addition to this, while participant two reported the role of peers as a protective factor, participant one reported his peers as the opposite, a risk factor given the nature of his upbringing and community environment.

### *Theme 3: On the road to recovery – Succeeding yet scarred*

The final theme looks at the journey on road to recovery engaged in by both participants. Both participants had different factors contributing to their ongoing journey of recovery. Both journeys involved similar experiences and ongoing challenges to resolve emotional needs.

#### *Subtheme 3.1: Finding my way in the world but the scars remain*

At the end of theme one, we discovered that participant one had to engage with mental health services in his late teenage years and upon discharge from the mental health service, he did not

return home. This was an important event in his life, and he described that this was made possible by the presence of two key protective factors. The protective factors were that when he left the mental health services, he had turned 17, and was entitled to disability allowance, and in conjunction with that, he had another good adult in his life, a solidier who provided him with a deposit to get his own house.

“I didn’t move back in with me mother when I got out. I got disability when I was 17 and then I got from X, the solider a deposit and I got me own please and I’ve lived in me own place and lived on me own ever since I knew how to look after meself.” (AC1)

These factors helped AC1 to begin to build his own life away from the adverse family circumstances. Since the age of 17 AC1 has shown incredible resilience by maintaining his own place and surviving on his own. He attributes part of this to knowing how to look after himself after all the years surviving in his home. In conjunction with this, his eldest brother remained a consistent steady stabilising force in his life. The pivotal turning point for him however was becoming a father. Research literature has shown that children can be a motivating factor in recovery for many parents and acts as a protective factor against relapse.

“I feel a lot better now that I am a dad. A lot better. That’s what has gotten me somewhat right ya know what I mean. Last time I was in court, I told the judge, look, I am sick and tired of coming in and out of jail and back on the streets and back on the drugs, when I come in I get off it and when I go back out I’m just thrown out into a new environment and I don’t know what to do with meself, and so I just stayed in there for a while, and then just slowly weaned myself out.” (AC1)

In the parent interviews, the drive to repair relationships with children and to resume the parental role was a key motivating factor in their roads to recovery also. Currently AC1 is off all drugs except weed, is working, is married and expecting a baby. However, while at the time of interview he was off all substances except weed, in terms of recovery, sobriety is not the end goal but a steppingstone. The scars of his childhood remain, and his coping skill is to self-isolate, only leaving the house to bring his child to and from school and attend his drug treatment service. He perceives this isolation as a way to protect himself, yet also acknowledges that he does so as he is does not know how to involve himself with or interact with other people as he still has extensive unresolved emotional needs and issues.

“I don’t cross the hall door, I bring me daughter from school, collect her, come to xxxx and that’s it. I don’t go out; I don’t cross the front door otherwise. I’m isolating meself, and I’m more emotional at home and all like then, after a life time of drugs, I would go through a half ounce of heroin in 2 or 3 days injecting ya know what I mean, done that all my life, and then in three years just coming off drugs, I still kind of smoke weed like but its em, it’s all the heavy stuff out of the way, but the emotions are still there and I said to meself, I don’t know how to involve myself with people or interact. The only thing that it is getting me through the day is wakening up and hearing the child.” (AC1)

There are multiple factors at play here, for both the current adult child but also for the next generation, his children. These factors mirror the parent interviews, the fragility of recovery, how recovery involves so much more than just reducing drug use or coming off all substances, that the road to recovery can be harrowingly isolating, and re-traumatizing, critically, that processing trauma sober or with reduced substance use is a significant risk factor for relapse and ongoing self-growth and healing, requiring extensive ongoing emotional support.

One additional support that AC1 believes helps him deal with the emotional pain is smoking cannabis. His psychologist, GP and probation officer agree that the substance is playing an important role in managing his emotions, and as a result of this, they are all trying to get it on prescription for him.

“My probation officer, my GP and my psychologist and all want to get it prescribed to me because they know it helps me.” (AC1)

Despite the progress and the protective factors that were in place growing up and currently, AC1 self-harms as a coping method to deal with the emotional pain. The protective factor of his eldest brother, his soldier friend, the youth clubs, sports, all helped him, but still there was significant unaddressed emotional needs, which persist today.

“I’m all scarred to bits from cutting meself... Yeah.” (AC1)



For participant two, a pivotal turning point for him was his time spent in prison. During this prison sentence he said he had a lot of time to think and review his life and left prison determined to change his life.

“There were times now when I used to get up every morning and want to smoke a joint first thing, want to go chase it, want to get a 50 bag, an ounce, but I don't do that anymore because with X months in prison you have a lot of time to think about what you want in your life.” (AC2)

As the participants became older and began to seek help to address their own addiction issues, another protective factor for both participants was in relation to the drug treatment service they were attending. This drug treatment service also consists of a community employment scheme, which supported AC2s recovery in addition to up-skilling him, increasing his chance of employment outside of treatment, and providing meaning, structure, and purpose.

“Yeah, come in a chat to someone, and then there is facilities over there where you can make like t-shirts and print t-shirts and cups and put anything on them. I am doing cooking over there in the kitchen actually at the moment.” (AC2)

Access to the scheme is not automatic, clients have to earn their place on the scheme by building trust, by showing personal development and growth, by demonstrating self-growth.

“I'm on the community employment scheme now, took me a good while trying to get on it like ya know. You have to show trust like ya know, they can't just say alright no bother you are on, and then next thing one obstacle thrown in your way, and you blow up like, ya know what I mean. Ya have to be able to, what I think is anyhow, you have to be able to see that you are changing. Sure, I was here bullying the man in here for years, why I am not on the scheme, but I was going about it the wrong way, but I didn't see, I thought everyone else had the problem with me, but it was me who had the problem. I swear.” (AC2)

AC2 reflected on the progress he made during treatment to turn his life around. Physically he was perfect but mentally he was broken.

“I used to be paranoid. I don't know how the lad stuck me. Physically I was 100% but, nothing wrong with him, but mentally I was broken, mentally I wasn't right. And to look back now I can see that, I was in a bad place in mind, bad state of mind, but back then I didn't know, looking back. I was 21, 22, 23.” (AC2)

A key protective factor within the drug treatment service was the non-judgemental accepting attitude of the workers who see the growth and development that AC2 has taken part in.

“Engaging with her here has helped me and helped me for court. Not many people think that I am ya know, at least in here I am getting people's minds changed, perceptions changed about me, thinking different about me. I find this is a good place like ya know. It really is, it really is a good place. I love coming down here like ya know. When I am down here, I don't smoke dope like or anything. Other than that, I would be, I wouldn't be a chronic user like or anything, that doesn't take over my life like or anything.” (AC2)

Similarly, AC1 described the positive impact that a non-judgemental supportive experience with social work services had for him. This echoes some positive experiences reported in both the parent interviews and the grandparent interviews in relation to the role that social work can provide. The protective factor for AC1 involved the non-judgemental approach of social work, their willingness to “give them a chance”, the willingness to recognise the progress he has made. This was critical for AC1 after a lifetime of being judged and labelled.

“Like even with me wife when she got pregnant after being on methadone and thought social workers would get involved, but they got involved in the start, we seen them once and they never came near us again because they knew me wife's background and what family she came from, and how much of an effort I tried and showed and having not been proven guilty, it feels nice like knowing, after experiencing what I experienced and after being labelled for so long, that's a big thing ya know what I mean, for someone to give us a chance. It's not like they are going to take the child away, if the social worker calls its because of the autism ya know what I mean, for us to report back on how she's getting on with the doctor, and how we think she should get this that and all. But she just says you contact us because we have priorities you know what I mean, our daughter has 5 or 6 appointments a month ya know what I mean OT and everything.” (AC1)

### *Subtheme 3.2: Show me the way- lead by example*

When asked what would help other young people or what would have helped you growing up, the key issue for AC1 was structure and people who will look out for them, love them, and show them the right way to live.

“They need structure, they need something in their lives, they can’t be sitting around doing nothing. Alcoholics, drug addicts, normal people, animals, everyone needs structure, if there is no structure there, if bad things happen, there is no way of getting through it.” (AC1)

Becoming a father has provided a reason for living to AC1, a structure to his life, a motivation to stay off hard drugs and a burning desire to break the intergenerational cycle of dysfunctional adverse childhood experiences. His main aim is to provide his daughter with everything he never had growing up. This includes providing a love that he never experienced.

“They need to stick with family and good people who will look out for them, not people who will send them down the wrong road or put them in danger, not people who will ask them to do something that they are not comfortable doing, ya know what I mean. Basically, what I am trying to do for my child, I'd hug her as many times as I can in a day because I don't know what that feels like, my wife knows what that feels like.” (AC2)

This painful issue was reported in the parent interviews also, a challenge for many parents being that they don’t know how to parent and show love as they themselves never received love or proper parenting. This intergenerational issue was a key fear for parents and many parents wanted this dysfunctional pattern to cease with their own children. AC1 demonstrates this further when he describes how he is also repairing his relationship with his own mother so that his child can have the love of her grandmother also. His mother is currently 7 years sober.

“I am starting to speak to my mother now again for her to have a relationship with my child but still I wouldn't take a hug from her.” (AC1)

“That’s the only reason why I'm letting my mother back in me life, me mother was in X treatment out there a few years ago and she stayed sober and has been in sober for 6 or 7 year now and for her to make up to me, I'm letting her slowly prove herself to the

child like ya know. Because the child has been born and she is 3 now like, and she has autism, she hasn't been there, she just walked away, it's terrible ya know what I mean, there's me wife and me child, and look at me skin is tattooed from needle marks, all me veins are gone, they look like veins, but you won't get blood out of them, all me arms are destroyed, everywhere is destroyed." (AC1)

Despite having endured a very traumatic childhood, void of love, consumed with emotional and physical neglect, and a subsequent traumatic life trajectory, including prison, being shot, mental health illness, at the age of 17 AC1 had managed to secure and sustain his own house, by the age of 21 was married, in his twenties had weaned himself off all drugs with the exception of weed (which is now being considered as a necessary prescription to help him manage his emotional pain), is a father to a young child, with another child on the way and is facilitating reconciliation with his mother to ensure his daughter never endures a life without love like he did. This is despite the fact that he still struggles to deal with all the trauma he suffered and copes by self-isolating, with his whole reason for living circling around his immense love for his child and his desire to give her a better life than he had. Key protective factors for him were his eldest brother who was and still is there for him and provided the only father role he ever had, providing consistent emotional support and protecting him from external threats to his life and welfare, his friend who provided him with the deposit for his house, the youth clubs that provided a safe haven for him, the drug service he currently attends and the fact that he could play sports. A myriad of interrelated risk factors were reported and included exposure to 4 out of 10 ACEs, (neglect- physical and emotional), household dysfunction (mental illness, death of parent substance abuse), challenges at school, growing up in a deprived urban area, exposure and involvement in criminal gangland underworld. A key risk factor is the absence of structure, guidance, boundary setting, nurturing and love.

Participant two has also demonstrated in his journey from childhood to adulthood significant resilience, self-development, growth and self-awareness. Key protective factors for him were one good adult, his friends, sport, youth clubs and the drug service he attends. Risk factors reported were in relation to the possible role his mother's substance misuse had in his own subsequent life choices, resulting in ongoing inner conflict fluctuating to acknowledging that his childhood exposure may have been a risk factor for his own current drug use, to reverting back to self-blame, and guilt. Guilt over his interpretation of how his mother's substance use may have impacted him, and guilt about his own life trajectory.

## 6.4 Conclusion

In conclusion, as you will see from the findings above, each participant while having some similar life experiences growing up, also had divergences in their lived experience of parental substance use, and their own life trajectory. The aim of this research is not to determine or measure the degree to which parental substance misuse impacted the child's development and subsequent outcomes, but rather to understand from their lived experience of growing up with parental substance misuse, what they perceived as the being the risk and protective factors for them in this situation.

What emerged from the findings was that while both participants shared an experience of growing up in a home with parental substance misuse, and both reported some similar risks and protective factors, there were also other risk and protective factors reported to be at play in conjunction with the parental substance misuse, that contributed to variations in their lived experience of the perceived risk and protective factors of growing up with parental substance misuse. The risks for children of parental substance misuse can be compounded in the presence of additional adverse circumstances and compounded further in the absence of protective factors to mediate the impact.

These divergences incorporated different exposure as children to the degree of parental substance misuse (AC1 had two parents who misused substances), different outcomes of having a parent with mental health issues (AC1 father died by suicide when he was 7), different exposure to additional adverse childhood experiences (ACEs) in conjunction with the parental substance misuse, different pressures and responsibilities within the home as a result of the combination of ACEs and parental substance misuse, and different socio-economic environments. These additional factors are important to consider when exploring the risk and protective factors for children of parental substance misuse. Research has shown that the intensity of exposure can result in different types of stress and experiences, and in conjunction with this, the presence of protective factors can mediate the potential impact of parental substance misuse. Ultimately, e.g., while having a parent who misuses substances can be a risk for a child, having both parents misusing substances can compound this risk. And this is particularly pertinent if there is also a lack of alternative protective factors.

Furthermore, Bronfenbrenner's bio-ecological development theory stipulates that while context is of critical importance, that other factors are at play, a pivotal factor being the role of proximal processes in child development. Proximal processes involve the bi-directional interaction between child and environment, including child and parent, and is influenced by the child's own characteristics including demand characteristics, resource characteristics, and force characteristics.

The intergenerational nature of the cycle of substance misuse, and impact on future generations was also emerged from this research in so far as both children who took part in this interview, reported experiencing their own addiction issues, and both are now also parents. One participant in particular spoke of the remaining unhealed scars and the possible ramifications of this, yet still possessed a burning desire to break the intergenerational cycle of dysfunctional adverse childhood experiences. The desire to provide a better life for his own child was clearly evident and reported as his main motivation for living and recovering.

In terms of key protective factors, the adult children reported both protective factors growing up, and protective factors in their adolescent life and current life. Despite the diversity in circumstances additional to parental substance misuse growing up, both participants articulated almost identical protective factors.

These protective factors included One good adult, sport, the safe haven of youth clubs and access to community level drug treatment services and the community employment scheme. In terms of the one good adult, in both cases this was predominantly a family member (older sibling, grandparent). Sport was reported as a protective factor available outside of the home for both participants, and in both cases, both participants stated that it was their capacity to play sports that enabled them to stay on in school. At the level of the community, both participants described an extremely positive and critical protective role for them was the availability of youth clubs to them- youth clubs played a critical protective role in their lives growing up. In terms of the protective role of peers however, the participants diverged here. While one participant reported the key role of peers as a protective factor growing up, the other reported the detrimental impact that a negative peer group had.

The key protective role of community level drug treatment services and the community employment scheme were also reported by both adult child participants as being a critical

protective factor in their adolescent and later adult childhood in relation to their own subsequent substance misuse. These services were reported as providing a non-stigmatised supportive environment, which provided a safe space for upskilling, emotional support, employment, meaning, structure and hope.

In summary, the findings here highlight the extensive complexity involved with exploring the issue of risk and protective factors for children of parental substance misuse. Risk and protective factors were reported at multiple levels of the ecosystem, and a complex interaction between these different factors and their location at different levels of the ecosystem was blatantly evident. The findings above highlight the dangers involved with examining risk and protective factors of parental substance misuse using a narrow lens of focusing solely on the parent child dyad and argue strongly for the consideration in future research for widening this lens to include all levels of the ecosystem, the bi-directional interactions inherent within these levels, and targeting the strengthening of the reported protective factors.

## Chapter Seven: Qualitative research findings – grandparents’ perspective

### 7.1 Introduction

Chapter 7 presents the qualitative findings of this research from the perspective of grandparents who have an adult child attending drug treatment services and their adult child is also a parent or guardian. The aim of these interviews was to explore the lived experience of grandparents with an adult child who attended treatment for substance misuse, in terms of the risk and protective factors that the grandparents felt existed for grandchildren of parental substance misuse. The grandparents were one of the three family level perspectives and one of the five overall perspectives examined during the research. The family perspectives were from parents who misused substances, adult children of parents who misused substances, and grandparents with an adult child who misused substances, who was a parent. Service provider perspectives were gathered from both child and family services and drug and alcohol services, and their finding will be presented in chapter 8.

The findings from the grandparents are arranged thematically. Five main themes were identified for the purpose of this thesis. Detailed discussion of, and recommendations from the findings will be outlined in Chapter 8. The following are the five superordinate themes that were identified for the purpose of this thesis. Each superordinate theme has a number of subordinate themes which are presented in detail in this chapter.

#### Theme 1: Families struggling to cope

- 1.1 Impact on mental health and well-being
- 1.2 Destruction of family relationships
- 1.3 Flying solo-Other family members not there for the grandchildren (aunts, uncles)
- 1.4 Fragility of recovery
- 1.5 Learning to cope

#### Theme 2: Shifting priorities and role reversals

- 2.1 Role switch- Prioritising grandchild needs over parent needs
- 2.2. Agonising choices- Grandchild needs versus adult child
- 2.3 Shielding their parent from harm-Grandchild becomes parent

#### Theme 3: Living in a house of cards

- 3.1 Living on a knife edge
- 3.2 Lack of psychological/emotional support



- 3.3 Blurred lines- living in a parallel universe
- 3.4 Spectrum of abuse
- 3.5 Abandonment
- 3.6 What's in it for me? -Surviving through manipulation

#### Theme 4: Shaky Scaffolding – service response

- 4.1 Strained social work system
- 4.2 Impact of high turnover on staff and child development
- 4.3 No background check- We could've been monsters
- 4.4 No voice in relation to duration of monitoring
- 4.5 Battle to secure right to care for child
- 4.6 Experience with school system

#### Theme 5: The need for comprehensive integrated services

- 5.1 Early age awareness raising
- 5.2 Challenging energies into activities
- 5.3 Comprehensive recovery-based family focused action plan
- 5.4 Aftercare

In relation to the thematic areas that emerged one can see the relevance of the Bronfenbrenner theoretical framework almost immediately. Themes 1, 2, and 3 originate in the micro system of the individual young people and their parents. However, all of these themes also relate to the mesosystem in terms of the impact of the interaction of these themes within that system. Theme 4 relates to the mesosystem and the exosystem and how those interactions are fragmented and not as effective as they could be. Some of what occurs in relation to theme 4 in the mesosystem is created by what occurs in the exosystem and macrosystems, and the influence this has on integrating services and approaches to people who misuse substances, and their children. Samples of quotes are listed under each theme. The following section provides a profile of grandparent participants.

#### **7.2 Profile of grandparents: Family context- adult child and grandchildren.**

A total of 12 grandparent family members self-selected to attend to take part in the focus groups. The participants who volunteered to take part in this study were all grandparents resident in Ireland who were currently providing, or previously provided care for their grandchildren as a result of the grandchild's parents' misuse of substances. Table 12 and Table

13 below provide a summary profile of grandparents, adult children, grandchildren, current living status and care status.

Two separate focus groups took place consisting of 5 grandparents and 7 grandparents respectively. Ten of the grandparents were Irish, two of the grandparents were originally from the United Kingdom. All the grandparents were Caucasian. Each grandparent represented a separate family. The grandparents were not as far as we are aware related to other participants in the study.

All grandparents currently provided, or previously provided, care for their grandchildren as a result of the parents' use of substances. Care arrangements can have both formal and informal elements and lie along a continuum. For the grandparents in this research, duration and type of caring responsibility varied across a continuum of informal to formal care roles by grandparents, encompassing a range of levels of state child welfare system involvement and custody arrangements, from no state involvement (privately arranged agreements within family), to informal arrangements between state and family, to full state child welfare involvement and full grandparent custody and fostering arrangements. These care arrangements adapted to suit presenting needs and capacity to respond.

Four sets of the grandparents currently had their grandchildren living with them full time, five of the sets of grandchildren currently lived with their own mothers, who were at various stages in their recovery, and three of the sets of grandchildren currently lived with their own mothers with no social services involvement as it was the fathers who had problem substance misuse issues. Care roles varied from fostering the grandchildren, monitoring the grandchildren, to formal and informal minding of the children during key crisis points.

For the focus groups, there was a total of 11 female grandparents and 1 male grandparent. Eight of the parents with substance use were female and four were male. The ages of the parents who used substances ranged from 33 to 44 years. Primary substance varied from licit (alcohol) to illicit substances. Poly drug use was reported. For five of the parents', the main problem substance was heroin, three had alcohol as the main problem substance, and four were reported as poly drug users. The parents who used substances were at varying stages of recovery.

Table 12: Profile of Grandparents' adult children, grandchildren, current living status and care status: Focus Group 1

| ID | Parent Relationship to Grandparent | Parent Main Problem Substance | Parent Recovery status                       | No./Age range of Children | Living status of grandchildren                             | Grandparent Care Role   |
|----|------------------------------------|-------------------------------|--|---------------------------|--|---|
| G1 | Daughter                           | Heroin                        | Methadone last 9 yrs. Weed                   | 2 (15-17, +18)            | Living with their own mum                                  | Children lived with G1 FT for 3 months while daughter accessed Tx. 1 yr monitoring - later stage. Youngest child had difficulties at school-bullying & being aggressive.  |
| G2 | Daughter                           | Heroin                        | Subutex age 28. Alcohol bingeing destructive | 1 (7-12)                  | Living with their own mum. Ex-partner has them once a week | Child was taken off daughter by hospital age 1, undernourished, dirty nappy. G2 took daughter and child in for two months, until daughter went back to partner. Had to leave him as gambling and stealing. Social work asked G2 to monitor Monitored for 1yr. Never had to take the child-always on good behaviour. |
| G3 | Daughter                           | Weed D10s                     | Still using                                  |                           | Living with own mum  | Grandchildren living with their own mum. Grandparents provide emotional support to them.  |
| G4 | Son                                | Poly drug use                 | Clean now                                    | 5                         | 5 grandchildren living G4                                  | Grandchildren living with their grandparents  |
| G5 | Son                                | Alcohol                       | Death from alcohol                           |                           | Living with own mum – no history of smu                    | Grandchildren live with their own mother who has no history substance use issues.   |
| G6 | Daughter                           | Alcohol                       | Still using                                  |                           | Living with G6   | Grandchildren living with their grandparents  |
| G7 | Son                                | Poly drug use                 | Still using                                  | 2 (7-12)                  | Living with own mum – no history of smu.                   | Grandchildren live with their own mother who has no history substance use issues.   |

Table 13: Profile of Grandparents' adult children, grandchildren, current living status and care status: Focus Group 2

| ID  | Parents Relationship Grandparent | Parent Main Problem Substance                                  | Parent Recovery status                                | No./Age range of Children    | Living status of grandchildren                | Grandparent Care Role  |
|-----|----------------------------------|--|---|------------------------------|---|--|
| G8  | Daughter                         | Heroin   | Methadone   | 3 (1- 12)                    | Grandchildren and their mother living with G8 | Fostered his 3 grandchildren on his own for 3 yrs. Had to fight the courts to get them back from care system as originally the daughter said they couldn't go to her father. G8 allowed gradual contact with mother. New social worker told mother she could have them back FT without consulting G8. Didn't work. All now living with G8.   |
| G9  | Daughter                         | Heroin in 40s Alcohol mainly but other drugs also has bi-polar | Heroin use started in 40s, poly drug use and alcohol. | 3 (Teenagers)                | Youngest 2 living with G9 last 10 years.      | Live FT with G9 for last 10 years- the 2 youngest. Teenagers now, under 5 when she got them. Daughter handed her own children over to social services as worried about their safety. They were taken in to care on a voluntary order. G9 had to go to court to get them. They were in 3 different foster homes before that, and G9 would go for access once a month, then found out there were being put into long term care and the people they were with were applying for them. G9 fought for custody and won. Bitter battle. |
| G10 | Daughter                         | Heroin   | Off methadone 1 Yr.                                   | 4 (not provided)             | Living with mum                               | Minds children occasionally. No formal care role.  |
| G11 | Daughter                         | Alcohol  | Still drinking alcohol                                | 5 (3 adults, & 2 teenagers). | Live with mum (2 youngest)                    | G11 reported her own adult child to social services as was worried about her grandchildren being impacted by parents drinking – not getting hit but not a normal childhood. Social services-asked grandmother to monitor grandchild for six months   |
| G12 | Son                              | Poly-drug use  | Still using drugs                                     | 1 daughter (7-11)            | Living with their own mum                     | G12 has no formal care role as children's mother does not use substances. Child is used as bargaining tool if G12 expresses any concern.   |

### 7.3 Themes identified by grandparent interviews

The grandparent interviews address the grandparent component of objective two:

- Identify and explore intergenerational lived experiences of the risk and protective factors of children of parental substance misuse from a triad of, parents who use drugs, adult children of parental drug misuse, and grandparents.

Five superordinate themes emerged from the coding process during the data analysis process described in Chapter 3. Each superordinate theme consists of subordinate sub themes. The details of these findings are presented below.

#### Theme 1: Families struggling to cope

The first superordinate theme represents the impact on the immediate and extended family infrastructure that having a child who is a parent who uses substances, can have. Grandparents reported their initial extensive and heart wrenching grappling to come to terms with their new reality, and its consequent ripple effect on the entire family structure and functioning. They reported the experience as a living hell with significant impact on their own mental health and that of family members. Family dynamics were damaged significantly by the adult child's substance use. Within the immediate family, grandparents reported living in a constant state of fear, fear for their safety, their adult child's safety, their family's safety and the wider insidious fear of relapse, borne from their experience of the fragility of their child's recovery. The grandparents learned that in order to cope with the situation, that over time, through engagement with external supports, they must engage in their own process of recovery by developing their own coping skills, to accept that they will not be able to cure their child of their addiction, and to operate within their own locus of control. Ensuring their own recovery was critical as grandparent focus within the family moved from the adult child to the grandchild, forcing a switch in priorities from child to grandchild. These changes in family dynamics resulted in new roles for family members, including the grandchildren.

#### *Subtheme 1.1: Impact on mental health and well-being*

Grandparents reported a gamut of negative emotions they experience directly as a result of having a child who misuses substances, tantamount to a living hell. These included anguish, turmoil, trauma, heartbreak, shock, despair, and helplessness. Given that grandparents in these interviews have to care for their grandchildren, the state of mind of the grandparents is an important factor to consider in terms of risk and protective factors for the grandchildren.

“The words I'd use to describe how I felt through the years are anguish, turmoil, trauma, heartbreak, shock and despair. I could go on and on. All of the family have been affected, sisters, brothers, stepfathers. They've all experienced the effects of heroin. We've argued, wept and hoped together. We felt the heartache after watching her go through so much only to relapse...You must learn to look after yourself, your mental, physical and emotional health because if you don't, you'll get ill as I did. And at one point, the heroin will have gotten you too.” (G10)

“In a word – having a child who misuses substances is hell. It's like you wake up one day and it's a stranger. It's not your daughter or your son anymore, it's a stranger.... Frustration, anger, you go through the whole gamut of emotions. You seek help from everywhere; doctors, priests, policemen - all around you.” (G8)

Grandparents reported living in constant fear for their own safety, their family, and their child's safety, nightmares, mental health issues, and always living on the edge.

“Some days were total hell, hell wouldn't even describe the days. Or nights where you'd be creeping into their bedrooms to hear they're still alive. Or waiting for the police to come knocking on the door or visiting them in prison.” (G8)

### *Subtheme 1.2: Destruction of family relationships*

This fraught relationship is not limited to the parent child dynamic however, it also extends into the sibling relationships, creating additional pressures on the wider family unit. In the quote below the grandmother is having nightmares about her son breaking into her house and the chaos this will cause within the family.

“And it affects you mentally as well ... It's a nightmare. The other night I woke up and I was dreaming that he was holding me down on the bed and saying, 'mam it's ok, you wouldn't answer the front door, so I had to break in the back door' and he said 'it's ok I'm going to fix the door' and the next thing I heard his brother coming in the front door and I thought oh God there's going to be murder because his brother hates him. And I actually woke up.” (G12)

In the quote above you can see that not only is the dynamic causing the grandparent to have nightmares for their own safety, but they also report that the substance use has created broken relationships between the siblings.

The grandparents spoke of how addiction impacts all of the family, of families and friendships being torn apart by it. The destruction of family relations is infested with toxic feelings of bitterness around parent providing ongoing support to the person who uses substances, which is perceived as enabling the child with substance misuse, rather than helping them overcome it.

“Yea, he's the youngest of four and there's only ... I had four in the space of 6 years and he's the youngest and the oldest is 38, I think. And it just splits them all up. It really does you know. His older brother just hates him. With a vengeance. To see what he's doing. I think to see what he's doing to me, you know, because you can't make the minute or the hour he's going to be at your door. It could be at half two in the morning and he's in a mess and he's verbally abusive and you fear for your life. You know it happened in the last two weeks I had to put him out and he's now in the hostel.” (G12)

This support can be perceived as being at the expense of other family members, leaving them feeling neglected. The dynamic can foster hatred between siblings, between siblings and parents, and can cause husbands and wives to split up. Also, friendships can be destroyed by it.

“Everyone suffers from a family member being an addict, bitterness between other family members because of the addict, people getting neglected. Its breaks up families, creates hatred between siblings and splits up husbands and wives. Family members don't know what to say. Friends don't know what to say. I've lost many 'friends' over it.” (G9)

“Other family members can get very bitter; it breaks up families.” (G12)

“It splits up husbands and wives.” (G11)

The pain and helplessness of the situation for grandparents is explicit in the quotes above. This exposure has led many grandparents to a resignation that the child would be better off dead as both they and the grandparents are the walking dead anyhow. This pain is penetrated with

guilt, guilt at not being able to “fix” the child, and guilt at being of no use to anyone else in the family from the sheer exhaustion of trying to support your child. There is a feeling of complete helplessness, that they themselves have become the walking dead. Grandparents spoke of giving up on their children completely.

“A person went into the group and said her daughter she was threatening suicide and after 2 or 3 weeks they come back to the group and say 'do you know what she's still doing it and I couldn't give a fk if she did, ... And I don't get shocked anymore. Of course, I can understand.” (G8)

“We've all said it. This is hell. They'd be better off dead. We've all said it, haven't we? We don't actually ... but the pain is so bad they're like the walking dead anyway. And you feel like you're dead because you're affecting everybody around you, the whole family. Others are getting neglected and they're in your head all the time and it's very, very painful.” (G11)

### *Subtheme 1.3: Flying Solo: Other family members not there for the grandchildren (aunts uncles)*

These damaged family relationships seep down to the level of the grandchild, with grandparents reporting that other family members offer no help with the grandchildren. The grandchildren's aunts and uncles were sick of what they perceived as the consistent enabling by the grandparent of the adult child with substance use issues, to the extent that they were unwilling, or unable to help the grandparent in caring for the grandchildren.

“No one in family would help anymore. Sometimes there is no point trying anymore.” (G11)

“There are members of the family who don't actually know what to do for you because they kinda get embarrassed and shy, but others just have enough of you as well ... they are sick of listening to same ole fk shite, ... throw them out, do this, do that, but if it was their son or daughter what would they do?” (G8)

“But where the grandchildren are concerned, even your very close family, like your daughter, your other family, sometimes they're not interested, you know, like a brother



or a sister, the child's aunts and uncles, you might think oh surely, they'll take them for the day - the grandchild - you know.

but that doesn't happen." (G10)

"You took it on for yourself, so you deal with it". (G9)

"They've reared their children and for God's sake if everyone carried on like that, no one would help anyone." (G11)

#### *Subtheme 1.4: Fragility of recovery*

Grandparents all warned that in conjunction with the fraught family dynamics and its insidious impact across the immediate and extended family, that an explicit risk for all family members and especially the grandchildren, is that of the excruciating fragility of recovery. How "getting clean" is only the beginning of the recovery process, not the end of it.

"Addiction is one thing, but recovery is another journey completely. I want people to know how scary, how fragile and how fearful recovery is. It's awful. You need to be aware of the absolute fragility of recovery. All parents need to be aware of - relapse. The first chance she went to rehab I thought it was all over. For most, it's the start of many relapses. The addict is desperate to recover. She tried and tried but the monster heroin is just too much for her to fight. This doesn't mean that people don't recover because they do. One piece of advice for parents, never give up on your child." (G10)

"Three days the physical cravings would be gone [6:24], but the mental want would be there constantly... recovery is fragile. An alcoholic or type of drug addict will never recover. You're constantly having that battle every day to stay clean." (G8)

Grandchildren are immersed in a rollercoaster of emotions mirroring the parent's journey through addiction and recovery. If the parent is cannot be there for themselves, how can they be there for the child?

"You know the effects that it has on children, I think, is devastating. I really think it's devastating, the effects that it has on children.... if they're not there for themselves, how can they be there for the children?" (G1)

“And you know when they're in recovery, you're still living on the edge. I take it every day but in the blink of an eye ... my daughter came about two months ago and said 'mum, I'm really struggling. I'm struggling mum. I'm having very dark thoughts and heroin is everywhere. So, I said 'look I'm glad you told me'. So, we got her to see a counsellor but it's only one counsellor that can help her, you know, and the meetings are very short. But she goes to NA as well. But what I'm trying to say is ... it's a struggle to get through every day. Addiction is one thing, but recovery is another journey.” (G10).

#### *Subtheme 1.5: Learning to cope*

The grandparents reported that they also have to engage in a process of recovery and develop their own coping skills to survive the process, to accept that they will not be able to cure their child of their addiction and to accept the fragility of recovery. The coping process mirrors that of the parent in recovery where they grow to accept the fragility of recovery and begin by taking one day at a time. Grandparents also grew to accept that they must operate within their own locus of control. It was through engagement with external family support services that the grandparents developed these coping skills. These coping skills became even more essential when the grandparents cared for their grandchildren.

“Through family support, I learned to cope. I learned that I would not be able to cure my daughter or my sons so it's just learning to cope yourself. If they were to recover from heroin or alcohol, it'd be a day at a time and for us to cope with their addiction, it'd be a day at a time as well. The drug just takes them over and you try to fix them and then you realise you can't fix them. You learn they can only fix themselves.” (G8)

#### *Theme 2: Shifting priorities and role reversals*

The second superordinate theme relates to the shifting of priorities and role reversals within the family and the consequent risk and protective factors. Role reversals for grandparents consisted of prioritising the grandchild needs over their own adult child's needs. Conversely, the grandchildren often assumed the role of parent for their own parent. These changes in family dynamics have an impact on the three generations within the family – the child, the parent and the grandparent.

#### *Subtheme 2.1: Role switch - Prioritising grandchild needs over parent needs*

After a lifetime of always prioritising their own child, the dynamic within the family changes as a result of the situation, and the grandparent now has to prioritise the grandchild. The

relationship between the grandparent and their adult child has changed, but so also has the relationship between the grandparent and the grandchild. The new dynamic now requires that the grandparent switches to the role of parent for the grandchild.

“Then when we had the social worker, they said would I monitor and if I was in any way worried, would I take the baby. So, I said yes, and I felt I could do it because I thought the safety of my granddaughter is more important than my daughter. My daughter is an adult. I felt I could do it, but it was very stressful and strained.” (G2)

In some instances, grandparents had become so exhausted from supporting their adult child that the decision to switch roles to focusing solely on the grandchild was a more welcome transition

“I'm at the stage now where I don't want to be part of her recovery. I've done all I can do for her and now I'm concentrating on her children.” (G9)

#### *Subtheme 2.2: Agonising choices: Grandchild needs versus adult child*

A number of grandparents spoke of the horror of agonising choices brought about by their adult child's substance use, in relation to the safety and well-being of the grandchildren. Grandparents found themselves in the difficult situation of having to make the excruciating decision of reporting their own adult child to social services for substance misuse, as they feared for safety of their grandchildren.

“I had concerns because of her drinking, and I went down to Social Work because they seem to take forever, and it did take a while. When I first did it, I wondered did I do the right thing. Yes, I did do the right thing. I have to think of the grandchildren. At the moment, I'm thinking of going back down there because nothing is getting better. The two younger ones are with her, and I had to go down and report my own daughter because I felt the kids were going to be harmed.” (G11)

Another grandparent discussed that despite how difficult it might be, you have to be the parent to the grandchild, not their best friend, and do what's in their best interest.

“And they want to be their best friends. I'm rearing my two grandchildren, they're 14 and 15. I have them ten years. I don't want to be their best friend. I'm their protector,

I'm their saviour, I'm their warrior. I do everything for them. They're my daughter's children. But all their friends, their mums and dads, they want to be their best friends. So, I'm constantly battling 'well X is allowed to do this,' and 'X is allowed to do that' and I said that's ok, and their mam and dad is making that decision. I'm not your mam and dad. I'm your Nan. I'd love to be just your nan but unfortunately, I'm not. I have to do it all. So, I'm constantly ... it's a battle, constant." (G9)

And sometimes this can mean making the difficult decision that the grandchild should not see their own parent(s).

"And I would say, again, a bit of access with their parents, with their mum, that's the biggest hindrance for them. She's in prison for 3 years and that was the best time of their lives. And mine." (G9)

The grandparent making the decision for the grandchild that it is in their best interest that they do not see their own parent is a difficult decision to make and can have ramifications for the family. The child no longer has access to their parent, the parent no longer has access to their child.

### *Subtheme 2.3: Shielding their parent from harm: grandchild becomes parent*

The dynamic between the parent and the grandchild can also change at this juncture, with the child assuming the role of parent for their parent. These changes in family dynamics have an impact on the three generations within the family – the grandchild, the parent and the grandparent. Grandparents reported witnessing the strong desire of the grandchild to protect their parent by adopting the carer role and by trying to hide the reality of the situation from social services.

"They were looking after their mother, but the 14-year-old wanted to hide everything. Make it look like there's roses growing everywhere and the social worker does call. But my opinion' now is the social worker right ... 'well I'm calling Wednesday at 4 o'clock' and of course everything is done. The house is spotless, there's no alcohol around, the fires alight. But call there any other time and knock on the door and you'll see a difference. Because I've gone out there a few times, myself over there." (G11)

### Theme 3: Living in a house of cards:

As the interview progressed, grandparents began to elaborate more on the risk and protective factors of parental substance misuse on their grandchildren. These factors could vary depending on the stage of addiction, the number of parents with addiction, the number of relapses, and the support structures in place. Across the interviews, grandparents reported grandchildren feeling a gamut of negative emotions, an emotional hunger, abandonment, fear, nervousness, and that these feelings often transferred to external situations including the school environment. Grandchildren are immersed in a rollercoaster of emotions mirroring the parent's journey through addiction. The exquisite fragility of recovery penetrating the grandchildren's psyche as they grapple with the ever-changing landscape. Grandparents reported how they began to notice their grandchildren learning to adapt to their environment, with some children developing manipulation as a survival skill, different children being impacted differently, and ultimately all children living in a parallel universe, where guidelines on right and wrong were often either absent or inconsistent.

#### *Subtheme 3.1: Living on a knife edge*

Grandparents believe that exposure to parental substance misuse can create an endless sense of heightened tension, agitation, fear and nervousness for grandchildren, and these feelings can become overwhelming for a child and manifest in many different ways. Grandparents reported the pain of hearing from the grandchildren from their heart what they felt about their parent's substance use. The grandchild is sad, crying and feels helpless in the situation, helpless because they don't know how to fix the situation. This is a difficult situation for both the grandchild and the grandparent.

"They were sad because their mum was sad, was always crying and they couldn't help her and they weren't even thinking of themselves, they were thinking of their mum. That was the hardest thing, sitting there, was hearing from their heart what they felt. But they did put in it, 'but then we know we have my nanny and she'll take care of us.'"  
(G11)

The situation of witnessing the parent in addiction, and the subsequent emotions brought about by the situation are a risk factor for the child. However, the fact that the child has the grandparent to look after them and is aware of that, and sees that as a comfort to them, acts as a protective factor. The sadness and helplessness brought about by the situation for the

grandchild, is alleviated to some degree by their awareness of the support from the grandparent.

In the example below, all five children were living with their grandparents. The grandchildren's father had previously had substance use issues, although at the time of interview, the grandparents reported that their son was now "clean" of all drugs. However, despite this, his children all still lived with their grandparents. These grandparents reported instability, lots of fear and not enough emotional support as being risk factors for the grandchildren as a result of their fathers' substance misuse.

"I'm looking after 5 of my grandchildren. In terms of the effects, I'm seeing from their parent's substance misuse, they would be 'no stability, lots of fear and don't get enough emotional support'." (G4)

In the second example below, the grandchildren also live with their grandparents and it's their mother that had a problem with substance use – mainly alcohol. Grandparents reported that the grandchildren's exposure to the parental substance use had led the children to feeling abandoned, disappointed, no longer wanting to know their mother, scared of being left alone and nervous. The eldest child is in trouble in school. The issue of abandonment is discussed in a separate subordinate theme- abandonment.

"My daughter has addiction. I think it's mostly alcohol but it's everything and anything. So, the children are actually living with us, their grandparents and they feel abandoned by their mother, and she disappointed them by not turning up. She had supervised access visits and every time she wouldn't turn up, so they'd be very disappointed. Now they don't want to know her. They won't come to the phone to talk to her, and they say she hasn't been very nice to them and there's fear and upset. They're frightened by her behaviour. They don't like to be left alone; they get nervous. The eldest boy is trouble in school and at home he's worried, restless and agitated. He's about 10 and it's really affecting him." (G6)

In the instance below, grandchildren were living with their own mother, but their father had problems with substance use. The grandparents reported these children as being nervous and frightened of their father when he was drunk and shouting.

“The grandchildren are living with their mother and the father had addictions. And the kids were badly affected. They were frightened of their father when he was drunk and shouting. They didn't want to visit him. They were nervous, they were frightened even of strangers shouting or drinking or any loud noises. The older child used to visit his father. He had difficulties at school but he's fine. He's now 25, gone off to XXX for a new life. The younger ones didn't want to visit - afraid of what their dad might be like. And then the father did die from alcoholism, so it was very tragic and traumatic, all that. Father was homeless before he died, living on the streets in Dublin.” (G5)

However, this fear was not limited to exposure to their father. It transferred to the children becoming nervous and frightened even of strangers shouting, or drinking, or any loud noises. As like the previous case example, in this instance also, the exposure culminated in the children no longer wanting to visit or see their parent. Also, similar to the case above, the eldest son had difficulties at school.

Tragically, in the current quote above it can be seen that the father died from alcoholism and was homeless at his time of death. These children lost their father through addiction before he passed away, and now as a result of addiction their father is gone forever. With the passage of time, the children will have to come to terms with not only the parental addiction and how it may have affected them, but also having to deal with grief and potentially never having had the chance to say good bye to their father. For the younger children, they also have to deal with not having seen their father while he was still alive.

Similarly, in the example below, the children are frightened of their father. The grandparents report that the eldest child has been impacted by exposure to having a parent with substance misuse issues and is consequently a nervous child. The grandchild has been exposed to a lot of traumatic experiences e.g., the police coming to the house to arrest the father. The youngest child is reported as being scared of the father, yet also being fine. The grandparent attributes the difference in responses to the situation, to the developmental age of the child at the time of exposure.

“The children are living with the mother and the father has addiction. So, my son had addictions. They're frightened of him now. He (the father) is acting strangely, especially

the 11-year-old. The 2-year-old seems fine, he's a bit too young. The 11-year-old is frightened of her father. She is nervous and she has had (28:49) a lot of traumatic experiences like the police coming to the house and all that. The little 11-year-old is nervous. Because her father was arrested and whatever else. Yea, he was arrested a few times." (G7)

### *Subtheme 3.2: Lack of psychological/emotional support*

A number of grandparents reported that a significant gap for the grandchildren is emotional and psychological support. This issue is compounded for the grandparents below by the fact that they are not guardians for the child, thus while the mother is responsible for approving activities such as the child going swimming, she does not fulfil this role, thus the grandchildren miss out. In this example, the grandchildren are living with their grandparents as their mother left them two years ago. In this instance, the grandparent reported that in the two years since their mother left. they haven't had anyone call to see how the children are.

The grandparents are not legal guardians, they didn't apply for it as they hoped the mother (their daughter) would get better. However, their son is considering being a foster parent to his sister's children. In the meantime, the grandparents feel the grandchildren's needs are going unmet as they lack psychological support and building up problems for later.

"So, we are just looking after the children. We were hoping their mother would get better, but our son is considering being a foster parent - that would be to his sister's children so that's all going nowhere. In the meantime, they can't go and have swimming or outings. We feel the children need some psychological support, they're building up problems now and it's two years since she (their mother) finally left, and it was chaos before that. They haven't had anyone come to the house to talk to the children, see how they are." (G6)

Grandparents reported themselves as often feeling like 'bystanders' to this gap, even when they had a formal care role or formal monitoring position. This unmet need for children is often exacerbated by the grandparent having no voice with services in relation to the child. This will be reported on further in theme 4 – Shaky Scaffolding- response from services.



“The biggest need for the children is the emotional support. It's a bit like, Frances Fitzgerald came out the other day with the domestic abuse thing. The bystanders. So, we're kind of like the bystanders looking in.” (G1)

Another key risk factor for grandchildren from the lived experience of grandparents, is that where emotional support interventions, are available, that the grandparent has to fight constantly to avail of and maintain them.

Interviewer: “With regards to the grandchildren, was there any psychological interventions provided for any of the children to explain what was happening or anything?”

“Oh yea, there is. I mean my grandchildren have done their life story. They've done everything. But only because I push everything. You have to fight for everything, your rights, your grandchild's rights, your adult child's rights.” (G9)

“Yes, but you have to fight for it, for everything.” (G8)

Grandparents also ran the risk of the grandchild being used as a bargaining tool and denied access to the grandchild if they tried to intervene when they were concerned about the grandchildren.

“Constant bickering with the parents of the child. It's my son that's the addict and his girlfriend ... they're not living together but they could use the child as a bargaining tool. Things are good I'm allowed to see the child but if I open my mouth, I'll not see that child anymore.” (G12)

### *Subtheme 3.3: Blurred lines- living in a parallel universe*

Grandparents reported that many children are “living in a parallel universe”, removed from the real world by virtue of the risks they were being exposed to at home. In conjunction with living a life removed from the real world, children can be exposed to multiple risks including a dirty home, and neglect.

“My daughter is on drugs and when I am looking at my grandchildren I see 'weed overload and D10s equal dirty houses, neglected children and removal from the real

world. The lines of what is right and what is wrong are mixed up because they live in a parallel universe.” (G3)

For these grandchildren the lines between what is right and what is wrong are blurred, and the children have no frame of reference for a “normal” home.

“The addict, the parent don’t trust people, so they don’t have a constant, and if they the parent don’t trust people, the child of an addict obviously don't trust people and they haven't a constant so what's the norm? What's the norm?” (G8)

The ramifications of these trust issues area discussed in the subordinate theme, abandonment. Creating a stable home with consistent boundaries can be difficult for the parent during addiction. This can be confusing and destabilising for a child.

“I'd say that's my daughter - borderline neglect. Because when she's drinking, she's in a bad mood. And when she's hungover, she's in a bad mood. But she's treating ... she'd be giving her treats; she'd be remorseful to the child. Most of the time she's disciplined. She can only have chocolate on Friday but that goes out the window with the hangover. Chocolate will keep her quiet. Being consistent.” (G2)

Other grandparents described the grandchildren experiencing an emotional disconnect from the parent side, resulting in an emotional hunger in the children. In conjunction with this, basic needs sometimes also go unaddressed, children going hungry, no food on the table, no clothes, dirty nappies.

“Three times a day I had to go down and make sure everything was alright. Thankfully I never had to take them. Now they would come and stay with me alright. I suppose being older you would notice more where the emotional disconnect would be. They'd be hungry or they'd be wanting this or that. But sure, it's emotional hunger that would be there.” (G1)

“For my daughter, she was a bit unstable when she had the baby first, but I don't think she was on heroin. But I don't know what, but she didn't give up everything else. After two or three months she was trying to live with the partner and they were just terrible

together, but they tried it for a little while and I don't know, things went wrong so the child was taken into hospital as an emergency ... undernourished and dirty nappy and things like that and they took the baby in and kept the baby” (G2)

#### *Subtheme 3.4: Spectrum of abuse*

Grandparents reported that there can be a spectrum of abuse from verbal, emotional, physical and neglect. With each level having an effect on the grandchildren but with different levels of abuse being viewed differently.

When grandparent 11 made the decision to report her own daughter to social work, she did so as she became concerned for the children’s safety. When she told her daughter, her daughter explained that she had never hit the children, but the grandmother explained that not all abuse is physical, and that emotional abuse was taking place, depriving the children of a normal childhood.

“I had concerns because of her drinking, and I went down to Social Work because they seem to take forever, and it did take a while and when I first did I it I thought did I do the right thing? Yes, I did do the right thing. I have to think of the children. At the moment, I'm thinking of going back down there because nothing is getting better. The two younger ones are with her, and I had to go down and report my own daughter because I felt the kids were going to be harmed. Well, she said to me 'well I never hit my children' - I actually told her I went. This is the thing; the help is there you know. And she said, 'I've never hit my children' and ...and I said I'm not saying you hit your children but what you're doing to them is here [points to head] and depriving them of a normal childhood.” (G11)

Concerns were also voiced by some grandparents about the role alcohol can play in relation to neglect and abuse.

“I think alcohol can make some people very violent. Well, I wouldn't say my daughter ever slapped any of her children to tell you the truth. In all the years through ... definitely wasn't abusive in that way but it would have been verbal abuse and I was verbally abusive as well. And when you talk about abuse you've got all sorts of abuse; emotional abuse, mental abuse, physical abuse, verbal abuse, drug abuse so.” (G1)

“And then neglect. You can have neglect before it's abuse.” (G2)

“Deprivation. All kinds.” (G1)

“I'd say that's my daughter - borderline neglect. Because when she's drinking, she's in a bad mood. And when she's hungover, she's in a bad mood. But she's treating ... she'd be giving her treats; she'd be remorseful to the child. Most of the time she's disciplined. She can only have chocolate on Friday but that goes out the window with the hangover. Chocolate will keep her quiet. Being consistent.” (G2)

However, grandparents did report that during recovery, significant improvements can take place. In the example below the adult child stabilised on methadone, and clear improvements were evident. Whereas previously when the adult child was on heroin, the family allowance would be gone the same day, now the basic needs of the children are being met. There is food on the table and clothes for the child.

“Because one time when the family allowance money came in, it was gone the same day. There was nothing for food in the house. There'd be no clothes and that would be the general run when they're on heroin. Methadone normalises their life. Her life is definitely more normalised but there's still is a disconnect from the whole family. It's like they do stay having their curtains pulled, it's like that's the old stuff that went on when there was heroin use, the curtains would be pulled all day. It's like the old patterns ... like there is glimpses.” (G1)

However, the emotional disconnect of the parent continues to prevail, old patterns still in place, despite no longer being on the substance.

“Now I have seen functioning ... and I'm sure you all know functioning addicts. They get up and they clean the house and I'm not staying, even though my daughter ... there was glimpses of recovery with the methadone. She would go to school whereas before she wouldn't have gone to school. She's getting more ...what's that word ... self-worth, self-esteem, than what she learnt here in this project I suppose.” (GA) (G1)

### *Subtheme 3.5: Abandonment*

The theme of abandonment was reported by grandparents. Feelings of abandonment is one of the key emotions that grandparents perceive exposure to parental substance misuse manifests in the grandchildren.

In the quote below, the grandparent reports that to access help, her daughter had to move out of her hometown for three months to avail of methadone treatment which was not available locally. During this period, her two children moved in with their grandmother.

“So then help came and she had to go and stay in Dublin for 3 months to access methadone treatment and I had to have her children then, she had 2 children at the time. She stayed with her partner's parents, they kept her there.” (G1)

It is important to note in this instance, that key protective factors were in place in the form of social supports for the mother who used substances, in that the child's grandmother was able to take both of the mothers' children while the mother availed of treatment. And in conjunction with this, her partners' parents were able to facilitate the daughter living with them while she availed of treatment. The presence of these protective factors enabled the mother to access treatment and prevented the child from having to be put into care during her mother's treatment phase. During the parent interviews, capacity to access treatment was often hindered by lack of suitable alternative care for the children, and/or resulted in children being placed in care. Whilst kinship care has been reported to have its own complications internally within the family, kinship care arrangements are still the preferred option for many.

However, despite these protective factors which facilitated access to treatment, and enabled the grandchild to remain within the family structure during this period, the grandmother reflected that her grandchild had told her that she “had no mummy and no daddy “. In this instance, *both* parents were active heroin users, and the mother was away from the home accessing treatment - in the grandchild's eyes, this was tantamount to being a child with no parents. In the grandparents eyes the child was feeling abandoned. In the literature, having both parents using substance is a pertinent risk factor for a child.

Interviewer: “So how were the children coping at the time?”

“But sure, her father ... the little girl, her father is a heroin addict, and my daughter was as well. So, when she was going 'sure nanny, I have no mammy and I have no daddy'. But sure, the child feels abandoned.” (G1)

The theme of abandonment was explicitly reported by other grandparents also. Feelings of abandonment is one of the key emotions that grandparents perceive exposure to parental substance misuse manifests in a child.

“Our daughter has addiction. it's mostly alcohol but it's everything and anything. So, the grandchildren are actually living with us, and they feel abandoned by their mother, and she disappointed them by not turning up. She had supervised access visits and every time she wouldn't turn up then, so they'd be very disappointed. Now they don't want to know her. They won't come to the phone to talk to her, and they say she hasn't been very nice to them and there's fear and upset. They're frightened by her behaviour. They don't like to be left alone; they get nervous. The eldest boy is trouble in school and at home he's worried, restless and agitated. He's about 10 and it's really affecting him.” (G6)

In this instance, according to the grandparents, the feeling of abandonment in the grandchildren was fostered by their mothers repeated absence during supervised visits, causing the children to accumulatively feel disappointed, escalating into a desire to no longer want to know their mother or speak to her. The mother's behaviour frightened and upset them. The eldest boy began getting into trouble in school and at home became worried, agitated and restless. The eldest boy was 10 years of age.

As parents wade their way through their own journey of addiction and hopefully recovery, children are trailed along with the parent, constantly hoping for the desired outcome. The ups and downs of recovery are experienced by children parallel to the parent's journey.

Abandonment fears can impair a person's ability to trust others. They may make it harder for a person to feel worthy or be intimate. These fears could make a person prone to anxiety, depression, co-dependence, or other issues. Abandonment issues are also linked to attachment anxiety.

Other grandparents spoke of attachment disorder manifesting in children as a result of their exposure to parental substance misuse, and its consequent trust and abandonment issues. Compounding this issue, grandparents believe, is the impact on the child of high service staff turnover in child services- including mental health services and social services. The role of service response in relation to grandchildren is reported in more detail in theme 4.

“Every time we go now, we go to CAMHS, my friend's son, he's the oldest of the two and he has severe, I say attachment disorder because everybody that ever loved left him. And I bring him to CAMHS and it's a joke. Every time we go out there, it's somebody different. There is no continuity. They ask you the questions and they have a stack, a file, this high in front of him and they ask me the questions.” (G9)

“It's probably getting back to the same thing she was saying ... the addict, the parent don't trust people, so they don't have a constant, and if they the parent don't trust people, the child of an addict obviously don't trust people and they haven't a constant so what's the norm? What's the norm? If that child's going to be shuffled around the system into a different office, into a lady here or a ... my granddaughter is 14 now, she's very very intelligent.” (G8)

The parent would also often be absent due to prison sentences.

“What would help him is a treatment centre. If and when he's ever ready. He's been in and out of jail since probably he was about 18. He's been up on big, big charges only because he owed it to money lenders. And they dropped him off at certain places to armed robberies [24:37] and I think he done about eight in the space of a couple of weeks. And he ended up doing time. And he was great, as we think, when he was in prison, they look great and all that and all the promises about when he will be coming out, he's out about 14 months I think it is. And in the last while he's just a mess coming around.” (G12)

“Their mother was involved in a murder; she was sent to jail for it.” (G9)

However, in some instances, grandparents believe that parent's absence, although hard on the child initially, can end up being the best thing for the child.

“And I would say, again, a bit of access with their parents, with their mum and that's the biggest hindrance for them. She's in prison for three years and that was the best time of their lives. And mine. (G9)

*Subtheme 3.6: What's in it for me? – surviving through manipulation*

Manipulation was reported as another manifestation of exposure to parental substance misuse, where a child learns to adapt to the situation by manipulating it to their own advantage. In the quote below you can see that from as early an age as 6, the grandparent noticed a distinct change in how her granddaughter was responding to the parental substance use in order to gain a positive for her, from the situation. The grandparent noticed the grandchild becoming aware that sometimes when her mum drinks, that everything can go wrong. But that this has led to manipulative behaviour because the child also learned that while things can go wrong, if she responds in a certain manner, she can manipulate the situation for her own gain.

This has led to the grandchild, from as young an age as six, of no longer reporting to her grandmother what is really going on at home.

“But for myself, my daughter didn't have her child while she was on heroin. So, it's only now with a bit of the alcohol and the little binges that I find the daughter ... the effect on the girl, the little one who's 6, is ... she's become very aware of sometimes her mummy drinks and sometimes when she drinks everything goes wrong. And she might miss school. Or her mum might get angry and take away her iPad and also, it's made her a bit manipulative. Because she knows when they go to the shop to buy the wine, she goes 'can I have something too' but my daughter would not normally be buying her treats but because she's buying her bottles of wine the little kid gets some things ... and I see her noticing [23:45] and there's this little slight element creeping in now of covering up. Whereas when she was a little bit younger, she'd say 'guess what nana, me and mammy fell asleep on the settee, and we forgot to go to bed, and we were asleep on the settee all night 'til the morning. And then we forgot it was a school day'.” (G2)

Manipulation developed as a coping skill was reported as a learned skill, mirrored on the parent's behaviour. A skill developed to by the grandchild to help them survive and gain from an adverse situation.



“Like you were saying, the manipulation ... I see it with my 17-year-old granddaughter ... would have been 8 when her mother ... I would see the manipulation in her, how she manipulates. She's been taught how to manipulate. They learn the manipulation. They see the manipulation, so they learn the manipulation.” (G1)

However, this learned behaviour of manipulation was viewed as both a protective and a risk factor. – protective in that it could be viewed as a learned survival skill, necessary to adapt to the environment in the present, but concerns were raised as to what impact this will have at a later stage in the child’s life and how it will manifest for the next generation.

“When they have children ... the next generation goes on.” (G2)

“I don't think we'll be waiting that long to look after them because there's a lot at the minute coming in with it, isn't there really?” (G1)

#### Theme 4: Shaky scaffolding – service response

Throughout the grandparents’ journey to help the grandchildren, there is an obvious engagement with services required. Grandparents reported experiencing both protective and risk factors for the grandchild during this journey.

##### *Subtheme 4.1: Strained social work system*

One of the key services grandparents engaged with was social services. Grandparents reported both positive and negative experiences with this service. A number of grandparents recognised and acknowledged the extreme pressure that child social services were operating under, under-resourced and unequipped to deal with the extensive issue of children’s unmet needs in relation to parental substance misuse.

“There's not enough Social Workers in the country to deal with what's coming down the line. I don't believe there is. I don't know who'd believe that.” (G1)

Grandparents also recognised that in conjunction with social services being under-resourced and working under extreme workload pressure, that despite this, when the service was in a position to assist, it acted as a protective factor for the grandchild in that social services facilitated the parent in addiction accessing treatment, where the parents were taught about their triggers, and about the children.

“Now we did have an instance with the Social Workers. It was very positive. It got them in here. They got them, you know when they were really, when they came back from location X, they got them in here to work in the X project, so they were gone every day and that was good and it was the best 3 years, those 3 years when they were involved here. The parents were involved here because they were being taught about what we're talking about ... about their triggers and stuff like that and about the children and stuff like that.” (GA)

Some grandparents also reported the crucial role that social worker intervention had in changing the parents behaviour in that prior to social work involvement, there was no fear of the children being taken away, but with social work involvement, the parent wanted to change to ensure they got their children back. Nothing the grandparents had said to the parents prior to this had initiated the required change. But once social worker placed the grandparent in a monitoring role, the parent's behaviour changed for fear of losing her children.

“But my daughter did say 'if anyone ever came tapping on my door I'd stop'. And I thought we've been tapping on your door for the last fecking, I don't know how many years, and you didn't stop! But I think the social workers were the best thing that ever happened to us.” (G1)

#### *Subtheme 4.2: Impact of high turnover of staff on child attachment*

However, the impact on the child of high child service staff turnover, especially its consequent possible impact on the attachment development of the children, especially given the already damaged trust issues that children of a parent of substance misuse can have and the quality of service available was reported.

“Every time we go now, we go to CAMHS, my friend's son, he's the oldest of the two and he has severe, I say attachment disorder because everybody that ever loved left him. And I bring him to CAMHS and it's a joke. Every time we go out there, it's somebody different. They ask you the questions and they have a stack, a file, this high in front of him and they ask me the questions.” (G9)

“It's probably getting back to the same- the child of an addict obviously don't trust people and they haven't a constant so what's the norm? What's the norm? If that child's going to be shuffled around the system into a different office, into a lady here or there.” (G9)

“It's probably getting back to the same thing G9 was saying ... the addict, the parent don't trust people, so they don't have a constant, and if they, the child of an addict obviously don't trust people and they haven't a constant so what's the norm? What's the norm? If that child's going to be shuffled around the system into a different office, into a lady here or a ... my granddaughter is 14 now, she's very very intelligent. When she was 6, she was down with the child psychologist, and he asked her what anger was And she had a match and a firecracker and she said, 'anger is ok' but she brought the match to the firecracker and said 'that's what anger is then.’” (G8)

#### *Subtheme 4.3: No background check – we could've been monsters*

However, a key risk factor for grandchildren that grandparents reported, was that in their experience, in the case where they were asked to monitor their adult child and grandchild following an incident which initiated the original social work involvement, no background check was carried out on the grandparents.

“The only thing that I found that was really strange, they didn't do a background check on us. Now, I got a phone call to say would I monitor the situation and I said no problem. 'But if they're off their head you've got to take the children out, and this is probably a little bit of a thing with me now that I never followed up on ... they never came to our house. They never done a background check. We could have been monsters taking those children. They never came to our house to see if we had enough places to put them, so I was a little disappointed with that. Then when I think about ... and what we're listening to every week and they're talking about their children and their grandchildren, and you think there's not enough Social Workers in the country.’” (G1)

Interviewer: “Can I just check the thing you said about the social worker - so the social worker asked both of you to monitor but there's no background check done on either of you?”

“Yes, we were both asked to monitor our grandchildren, at completely different times.”  
(G2)

“But there’s no background check done, nothing. It’s mad like. My husband could have been a sexual abuser. I could have been a robber. There was no background check done.” (G1)

“And she never rang.” (G2)

This is in contrast to grandparents who wish to foster their grandchildren. In this instance, a stringent background check is carried out.

“When you want to foster your own grandchildren, you're treated the same as if you were a stranger. They have to go through the whole police vetting and [50:35] back through your family history.” (G8)

#### *Subtheme 4.4: No voice in relation to duration of monitoring*

In conjunction with this, Grandparents reported having no guidance or voice in relation to the duration of the monitoring. Initial consultations did take place with grandparents to instigate the monitoring, but in of the cases reported during these interviews, the cessation of the monitoring was either a decision made in isolation by the grandparent in the absence of guidance from the social workers, or a decision made between the social worker and the parent, excluding the grandparent.

“She (the social worker) never rang me up. I rang her up say after a month or two because she didn't say how long I was to do it for and I thought am I going to do this forever so I said, 'there hasn't been any feedback, you haven't asked me how my daughter is and how things are going' and she just said 'how's it going anyway?' and I said 'it's going well and I don't mind doing it. How long more should I do it? '. 'Well, what do you think? Do it for another month'? But I don't know.” (G2)

Interviewer: “And then what?”

"I don't know. I couldn't really ... I couldn't understand the whole thing. I just felt ... and then my daughter said kept saying that if I didn't do it, they might consider ... imagine being in a foster home in Wexford? It'd be just awful." (G2)

Interviewer: "So when did that process stop? When did you stop having to monitor?"

"I just stopped myself then." (G2)

Interviewer: "Nobody from the social worker department said time's up?"

"No. it seemed a bit up to me and then they did ring my daughter and say we're closing your file, but I think if anything else happens, I don't think the file is permanently closed." (G2)

In the second instance below, the grandmother found out from her daughter that the grandmother would no longer be needed to monitor, that the daughter had been "signed off.

"No, they didn't come back to me either, but they told my daughter which I thought ... why didn't they tell me? Now I didn't follow up ... I thought the lady was great and she had promised all sorts. but one day my daughter said, 'mam I've been signed off today'. I asked her When was that? she said, 'I got signed off today and I'm really thrilled I got signed off'. "That's great now wouldn't it have been great now if they had said it to me. But then I thought afterwards I should have rung her and said 'why wouldn't you tell me that I was finished' you know. But I was so delighted then." (G1)

Other grandparents spoke of the negative impact on the grandchildren when they were not consulted about the parent's role in relation to access to the grandchildren. In the example below, Grandparent 8 had fostered the grandchildren full time on his own for three years. Following this period, his daughter began to show improvements, and he allowed gradual one-hour access visits to the mother to her children, in consultation with social services. This then developed into the children being able to stay one week with their mother and one week with their grandfather. This was significant progress. However, when a new social worker came on board, without consulting with the grandparent, she suggested to the mother that if she was fit to do every other week with them. then she would be fit to care for them full time. This

discussion took place without the presence of the grandparent. The grandparent was told ad hoc and was unwilling to shatter the children's excitement at moving back in with their mother despite his concerns. His concerns were warranted and 12 months later both the grandchildren and the mother are now living back with the grandfather full time.

"So, after that I said week on, week off. Same things happen, working well. The kids were a lot happier as well ... So anyway, this new social worker came on and she told my daughter 'sure if you can manage him for a week, why can't you manage him for the whole time?'. She didn't take into consideration that my daughter was getting extra money and she has the backup help from me as well - getting them to school and helping her when she was down, because she was still sick at this stage. So, all of a sudden over the weekend they plunged her ... she was of course 'yea I'll manage, I'll be great', she suffered then with her nerves... I went to a care plan meeting two days after that and he said to me at the table 'and how are you with this?'. I said are you fucking joking me ... so you expect me to say something now. So, you're after telling the kids they're going home and what am I supposed to do? Say no she's not ready, so I said just leave it and see how it goes. I gave it 12 months and that's it, she's back with me. Because she's on methadone, she's with the methadone clinic. As far as I know, that's all she's on." (G8)

#### *Subtheme 4.5: Battle to secure right to care for child*

Grandparents reported the battle to secure the right to care for their grandchildren as a risk factor for grandchildren. The process was often traumatic for the grandparents and the grandchildren. In the cases below where engagement with courts was a necessity, both sets of grandchildren endured long terms of external care. The process was a laboured process, and an expensive process as it required lengthy court battles.

Interviewer: "And you had the children with you as well, you still have?"

"I had to go to Court to get my grandchildren. Prior to me getting them, they were in a different part of the country. My daughter had actually went and handed them in to social services for their own safety and for her safety at the time in a different part of the country, so they were taken into care then on a voluntary order. They're 14 and 15 now. They were 4 and 5 when they came to live with me. But they were in three different foster homes in the X region, and I used to go for access with them. I used to drive wherever they told me, I'd go once a month for access with them. And like that

we were invited to a care plan meeting in the health board in X and the result of that was that was that they were put into long term care and the people that they were with, at the time, were applying for them and I said, “over my dead body, if they're going into it on a long-term order, they'll come to me”. And they didn't want to give them back to me and I fought everybody along the way. I got a solicitor and I demanded that I wanted to go before the judge and if the judge said give them to those other people, I'd go along with the judge said - give them to that woman.” (G9)

In this second example the mother had handed her own children into social service for their own safety, and at the time she was in such a bad place, she was unwilling to allow the grandfather to have them. This resulted in a three-year battle to fight to get the grandchildren back out of care.

“In my situation the kids were taken into care. At the time my daughter was in such a bad place, she wouldn't have allowed me to have them. So, I had to fight to get them back out of care ... For Three years.” (G8)

#### *Subtheme 4.6: Experience with Schools – grandparents having no voice in relation to grandchild*

Another key service which grandparents interacted with in relation to their grandchildren was schools. Experience with schools was both positive and negative. The key issue for the majority of grandparents with schools was similar to the issue with social services- that of having no voice in relation to the welfare of the grandchildren in the school setting.

In the example below the grandchildren were living with their grandparents since their mother, who had problems with alcohol, left them over two years ago. Yet despite this arrangement, which the school were aware of, the mother was still the person assigned the right to sign consent for her children in the school setting, the children's guardian. However, the mother in her present condition didn't ever fulfil her role and sign the consent forms or send them back, so the children were constantly missing out on key activities like school trips, swimming events, day trips, any activity outside of the school building.

“We can't understand that the mother still asks to sign consent forms from the school - say permission to go swimming. She doesn't care about them in her present condition and doesn't sign the forms or send them back and we as the grandparents could do

nothing when the school asks for permission for an outing ... we as grandparents can't give permission for that." (G6)

Other issues related to not having a voice as a concerned grandparent in the school setting. Schools e.g., are not allowed to divulge any information in relation to the child to family members who are not guardians of the child, only the parent- concerned family members have no voice. In the example below, the grandchildren do not live with the grandparents, but the grandparents are concerned about the well-being of the grandchildren.

"The school, they've contacted me. X wasn't in school but then when I phoned them to see if she was, they couldn't answer me- no 'we're not allowed to divulge that information- But I'm her grandmother and I'm concerned here. I know for a fact that that child in the last two weeks has only done two days at school over her and her drinking and not getting up in the mornings." (G11)

Interviewer: "So you are aware that your grandchild is missing school because of the parents drinking but the school aren't in a position to disclose any information to you about your grandchild because this type of information can only be disclosed to the child's parent?"

"Yes, that's right, but I think, if you're going to be the nanny my phone number's there why not ring me." (G11)

Whilst it is understandable that schools cannot divulge personal information about grandchildren to people other than the child's parent, in a different example below, the grandparent reported finding the headmistress in the schools a key protective factor for her grandchildren's welfare. In this instance, the grandparent did not have the grandchildren living with her, but despite this, the headmistress was willing to sign forms for the grandchildren to allow them to attend outings.

"And getting back to that thing again - I found the schools ... now you were saying who helped me ... I found the headmistress in the school was the best person I ever spoke to. And I have grandchildren there. I was not one bit afraid because I thought I'm going to go and talk to her and I'm going to tell her what's going on in our family. Because I



knew the daughter wouldn't tell and anytime it ever came up with permission or anything like that, I told her who I was. Now she knew I wasn't a guardian; I was looking out. I was able to sign forms if they wanted to go on a day trip or anything like that. Honestly, I felt that was the best thing, it was the best thing and not only that she was aware of the other children and how they were." (G1)

"She was willing to bend the rules a bit." (G2)

"She was ... and watch out for them and if they were a little bit out ... she'd let me know how they were. She would." (G1)

Grandparents also felt that school staff would benefit from being upskilled in relation to the impact of parental substance misuse on children.

"It would be good if teachers were a bit more aware of drug and alcohol problems." (G2)

"It could be absolutely brilliant if they have an open meeting about the effects, you know the effects that it has on children, I think, is devastating. I really think it's devastating, the effects that it has on children. That's for the people who are, now say the polydrug use you know that's you know ... if they're not there for themselves how can they be there for the children? So I'd say what we're going to see coming down the road is." (G1)

#### Theme 5: The need for comprehensive integrated services

Grandparents reported that in addition to the issues reported thus far, that in order to protect their grandchildren, comprehensive collaborative interagency supports need to be in place for both the child and the parent. The key changes needed to achieve this are more collaborative interagency work, comprehensive recovery-based family focused plans, better aftercare supports, out of hours services, and early age awareness raising in schools.

##### *Subtheme 5.1: Early age awareness raising*

That early age awareness raising critical for young people in schools, especially at the transition into big schools, and for young parents also.

“We need people educated as young as possible, at as early an age as possible, with young children and young parents, in schools, particularly at the transition from primary to secondary school, in GP centres, shops, barracks, prisons everywhere to inform and encourage help seeking.” (G8)

#### *Subtheme 5.2: Challenging energies into activities*

Grandparents spoke of the importance of channelling the grand-child’s energies into activities that will guide them in the right direction.

“Channel your children's energies into sports, reading and gardening, anything other than hanging around street corners. I realise some kids don't stand a chance. God love them.” (G9)

#### *Subtheme 5.3: Comprehensive Recovery based family focused action plan*

The need for a family focused comprehensive recovery-based action plan was reported.

“You need to be informed and have a shared plan - find out what kind of program they’re on, what they will be like coming out, how you should react? How can you support them when they get out?” But aftercare should be tempered with the whole family. Any member of the family that wants to be involved. Because what happens is they go into rehab sometimes or into prison and you want to be involved, you want to help them, you're not allowed. You're not allowed to interact, find out what kind of programme they're on, what's it going to be like when they come out. What have they been doing? What should we react to? You get some after being on a 6-month treatment programme.” (G8)

#### *Subtheme 5.4: Aftercare*

Aftercare was reported as a big gap in service provision by all grandparents, particularly when a parent is exiting prison. The need for a family focused comprehensive recovery-based action plan was reported.

“Getting off drugs or getting out of prison is just the beginning of the recovery process, not the end of it. When they come out of prison or they come out of rehab and they're clean, aftercare is so important. But we're only a small country and surely, they could get up something.” (G10)

## 7.4 Conclusion

In conclusion, throughout the grandparent interviews, very little was reported in relation to existing protective factors for children. The grandparent responses throughout the interviews were predominantly deficit and risk focused, despite questions being asked about what helped protect the grandchildren. When protective factors were discussed the answers focused on the risks the parents behaviour was presenting for the children, and that in the absence of full recovery, the main protective factor for children was removal from their parents, and future developments required to address the gaps in services reported in this chapter, with particular attention being paid on the meeting the unmet emotional needs in the grandchild, and grandparents having their voice heard in social services and schools. Grandparents who took part in these interviews were exhausted from the process their adult child's substance use had subjected them and their family to and were using all their remaining resources to ensuring that grandchildren were as protected as possible. Many grandparents had given up on their adult children. There was a palpable heart wrenching sadness through these interviews from the pain the grandparents had gone through on this journey. It was clear that the grandchildren provided a light at the end of the tunnel for many. A switch of energies from the adult child to the grandchild. The merging and diverging of grandparents lived experience of risk factors for grandchildren with the parents, adult children and services will be discussed in the discussion Chapter.

## **Chapter Eight: Qualitative research findings – service providers' perspective**

### **8.1 Introduction**

Chapter 8 presents the qualitative findings of this research from the service providers, further to the data analysis process as described in Chapter 3. The aim of these interviews was to explore the lived experience of risk and protective factors for children of parental substance misuse from the perspective of service providers. The findings are arranged thematically.

Three superordinate themes were extracted, with a total of 13 subordinate themes. Each theme will be introduced and further illustrated below with participant extracts to represent and support each finding. Detailed discussion of, and recommendations from the findings will be outlined in Chapter 9. The following are the three superordinate themes and subordinate themes that were identified for the purpose of this thesis.

#### **Theme 1: Risks to children and impact- living in a house of cards**

1.1 Risks to children in the home

1.2 Impact on children

#### **Theme 2: Sweeping statements- an unfair narrative when void of context?**

2.1 Sticks and stones may break my bones, but words will never hurt me...

2.2 Drug type and degree of exposure

2.3 Parenting capacity – life skills and substance misuse

2.4. Parents own adverse childhood experience- unresolved trauma

2.5 Protective factors within the family- a moveable feast?

2.6 Community level resources- barriers to accessing services

2.7 Turning a blind eye – sure its only alcohol

#### **Theme 3: When worlds collide: Merging silos of expertise**

3.1 Identification, assessment, referral challenges and use of data

3.2 Show me the way, how do we meet the needs of children

3.3. Merging siloes of practice

3.4 Making the new way work

In relation to the thematic areas that emerged one can see the relevance of the Bronfenbrenner theoretical framework almost immediately. The service providers taking part in this research

worked in either child/family services or drug treatment services. Throughout the themes, the service providers report a myriad of risk and protective factors at varying levels of the Bronfenbrenner's ecosystem, articulating the importance of multiple systems including those beyond the immediate micro level system in the initiation, maintenance, treatment and recovery from substance misuse, and its subsequent risks for children, recognising the bi-directional influence between parental substance misuse and the multiple nested systems. Service providers also highlight that the degree of risk and or protection provided by these factors can fluctuate, lessening or increasing the impact of these factors on the child. Critical to these are risk and protective factors that operate within the parents' mesosystem (e.g., drug treatment service), where the parents participation can have an impact on the child, despite the fact that the child themselves may have no direct involvement with that system. In these instances, the parent's mesosystem can present risks in the child's exosystem. In cases where the child does have a direct relationship with a service within the parent's mesosystem, e.g. child involved directly with the parent's treatment service; this then becomes part of the child's mesosystem also. In conjunction with this, the service providers reported themes operating within the macrosystem which exerts an overarching influence on the environment of an individual and consists of factors such as societal beliefs and culture. Finally, throughout the interviews, service providers reported risk and protective factors operating at the level of the chronosystem- which focuses on aspects of individuals and their environment that remain constant or change over time. Overall, across the service provider interviews there was recognition of how different relationships and environmental factors interact to influence individuals and families.

Theme 1 originates in the in the micro system of the individual young people and their parents. Theme 2 intersects across all levels of the ecosystem. Theme 3 originates in the mesosystem of the parent and if the children become involved with the service, this theme manifests in the child's mesosystem. These themes illustrate the impact of the interaction of these themes within the ecological system. Theme 3 demonstrates how interactions are fragmented and not as effective as they could be. Some of what occurs in relation to the themes is created by what occurs in the exosystem and macrosystems, and the influence this has on integrating services and approaches to substance misusers and their children. Samples of quotes are listed under each theme. The following section provides a profile of participants in the context of their role as a service provider who has lived experience of parental substance misuse.

## 8.2 Profile of service providers

Service providers who were steering committee members were invited to take part in the interviews. All 10 of the service providers agreed to participate. However, a total of 7 of the 10 service providers took part. Two of the participating service providers worked in child and family services, and the remaining five service providers worked in drug services, representing both statutory services and community-based services. For the remaining three service providers, of which two were from child and family services, due to high pressured workload were unable to attend for interview. Attempts were made to reschedule interviews but due to workload of service providers, alternative dates were not secured. The perspective of risk and protective factors for children of parental substance misuse from these different services is important as primarily, in drug and alcohol services, the focus is on the person using the substance, whereas in child and family services, the focus is on that of the child.

## 8.3 The themes

In this chapter we explore the experience of risk and protective factors for children of parental substance misuse from the viewpoint of service providers from both child and family services, and drug and alcohol services. All service providers reported that parental substance misuse can present a myriad of risks for the child within the home, which can have significant impacts on children both within the home and in external settings. Many of these impacts may not manifest until the child is older and trying to assimilate into the world as an adult. However, throughout these interviews, service providers responses focused predominantly in exploring the role that systems external to the family also play in contributing to what the child is exposed to, and what supports are there for the child. The nature of these contributory factors varied in some cases across the two different types of service providers. The themes elicited from the interviews challenge us to question further the possibility that prevailing narratives may contain sweeping statements that negate context regarding parental substance misuse, that are damaging to both the parent and the child. That there are risk and protective both factors at community level, and service level that mediate or exasperate these risks. Central to these is the role of service provision. Protective factors, when reported, were predominantly reported as being at the service provision level. However, the presence of these protective factors at this service level were reported as being aspirational in most cases. A trauma informed, non- judgemental, holistic response to addiction is imperative for both the parent and the child. Policy and practice changes are beginning to take steps to address this. However, this type of response involves

significant systemic change, as it must be provided across multiple sectors and agencies and requires significant interagency work across both drug service provision and child and family services, services which prior to this have had opposing focuses- that of the child and that of the adult. Achieving change of this magnitude involves significant implementation challenges including but not limited to, sufficient resources and support. The following themes explore these issues.

### Theme 1: Risks to children and impact- living in a house of cards

Service providers reported that many and varied risks within the home can occur as a result of children's exposure to parental substance misuse. These risks can have a significant impact on the child across all areas of development. These risks can be particularly potent for children who are in need but not known to services, and for children where family issues are entrenched.

#### *Subtheme 1.1: Risks to children in the home*

Within the home, parental substance misuse can present a myriad of risks for children, and this can lead to numerous negative consequences for children. These can manifest both within the family home, and in external environments such as the school setting, which can include children struggling in school with peers, and an increased risk of substance misusing themselves as a coping strategy.

Children's needs may not be met, children may be living in poverty, children may experience neglect and abuse.

“The risks are many and varied! Where to begin ... I suppose just their needs not being met. I suppose there would be an increased risk of abuse, struggles at home, increased risk of poverty. Really, God, all and everything I've seen you know.” (1)

Parents may be unable to be there for their children, or care for their children, because of their substance misuse. This may not be intentional but balancing parenting with active use or recovery can be challenging for parents. Children can be at risk during all stages of addiction.

“There would be a risk of neglect. Maybe that wouldn't be intentional on part of the parent but if they have a substance misuse problem then they may not be able to care for their children in the way that they should be. So, neglect would be one thing.” (2)

“I speak to a lot of people in recovery or active users and for them it's a balance trying to maintain their own recovery and all that goes with that plus childminding. It sounds like everything comes down to 'how do my kids fit into my recovery?' in terms of childminding, making appointments but also just in terms of having access to their children.” (3)

These risks for children can be compounded if the issue remains hidden. Parental engagement with drug treatment may increase the chances that the needs of the child are at a minimum identified, and ideally, subsequently addressed, but this is not in any way guaranteed. When parents engage with treatment, the needs of the child can remain unseen or secondary to those of the adult. Challenges with identification and intervening to meet the child's needs are explored in Theme 3.

“But the risks for them I suppose for me coming at it from a slightly different angle, the chief risk is that they're not identified, and their needs aren't assessed. So, I suppose my fear is that the risks are unknown. That's what I'd love to get to so for me the risks are ... that we don't know the risks, we know them generally, but we don't ask specifically.” (4)

“There's such hidden harms with it that we're probably not getting to meet enough children who are being affected.” (1)

However, whatever chance the children of parental substance misuse have of getting their needs met where needs exist, this window of opportunity is extremely limited if not obsolete in cases where the parents' substance misuse, or a child being at risk as a result of parental substance misuse, has not come to the attention of services. In rural areas where services are no services, the extent of hidden issues can be exasperated.

“We have large areas of rural Wexford where there wouldn't be services so ... I'd say there's a lot of hidden issues for families in those areas. Sometimes it's a bit more obvious maybe in the town areas. So, I don't know, like it's such a huge issue I don't know where you'd start.” (2)



Within this group of children, a sub-group believed to potentially be at particular risk are those aged between 1 years of age and 5 years of age. This cohort were reported as potentially being “invisible.”

“The age group that is actually of most concern is the age 1-5 years. From 0-1 years you have some level of input in terms of developmental checks, checks for the mother after the birth. From 5 years you go to school, and you get kicked into that system and people can recognise things that are happening. Between 1-5 years, you’ve got four years there where that kid is invisible. Absolutely invisible. If there was going to be a priority area for those parents coming in anywhere, if they were in substance misuse services. I mean the data we collect is largely demographic, it doesn’t take much to change it into risk assessment. You could use the same stuff; do you have children – that’s demographic information. How old are they? Well now, that’s not a question on the form. If that were on the form that now could be a risk assessment. Because if they are between 1-5 years, you know they’re invisible to the rest of the world. Potentially. And that’s the group we would like to investigate that a little bit more.” (4)

This issue of challenges with identification is reported as a critical risk throughout the interviews across all service providers and will be explored in greater detail in Theme 3.

#### *Subtheme 1.2: Impact on children*

Exposure to these risks can have numerous negative consequences for children, and may manifest in many ways, both within the home setting and in external settings. Children’s development may be impaired or impacted in many ways, attachment issues may arise as a result of an emotional unavailability of parents. Children may struggle in the school setting and with peers. Parents emotional unavailability may not be intentional, but in many cases can develop as they struggle with their substance misuse.

“The whole attachment thing as well might be an issue, parents can’t be there emotionally maybe for their children even though they may wish to, and they love their children, but substance misuse can take over your life really can’t it. Then I suppose, it’s very broad. It can affect their education, their ability to concentrate, their diet; it’s very broad really.” (2)

There can be a significant developmental risk for children in terms of care and attention that can affect brain function and development. Attachment can become a major issue, and this in part may be attributable to the child becoming subsumed by the narrative of the parent's addiction and recovery journey, with children's identity and choices being limited to those of the parent. This may lead the child to start their lives from a negative perspective. The parent's substance use can be the 'central organizing principle' of the family, with all the family members operating around it, and in relation to it.

"I think there's a huge developmental risk in terms of care and attention which would affect brain function and development. I think that attachment is a huge issue and I think that part of it is that the parent's story becomes the child's story. So, they don't get an opportunity for their own story, so they become affected very early on by the parent's story. The narrative comes about their parent's recovery and life as opposed to their own. So, they have a tendency to start off their life from a negative perspective or what's worse, an isolated perspective which may be subtle but could have a large effect." (3)

Children can be affected by the cyclical and relapsing nature of their parents' substance use and problems. Children can be impacted by each stage of the parent's addiction and recovery as parents may struggle to negotiate the parenting role throughout. Relapse of parent can have a terrible impact on child in terms of trust and progression linked to parents' journey. The focus may constantly be on the parent's recovery rather than the child's needs.

"Relapse has a terrible effect on kids as well especially in terms of trust building and again, in terms of that focus ever being on the kids. Because sometimes with the children, it's like their progression is linked to the choices and issues that the parent may have which is like the roles are reversed. I think the caring and nurturing - the roles can be reversed. So developmentally, they become parents before they've had time to go through their own developmental stages as well." (3)

Children may also have to take on the role of parent themselves within the family. Developmentally this can impact children as they are required to take on a parenting role before, they themselves has reached their own developmental milestones. The responsibility can "hijack" childhood and place adult burdens on children's shoulders.

A key developmental risk for children of parental substance misuse reported was that children may also themselves begin to misuse substances as a method of coping.

“We certainly seeing a lot of teenagers engaging ... that are affecting the home but often they’re mirroring a lot of behaviours, certainly increased risk of maybe similar behaviours themselves ... certainly as they begin to hit the teenage years, substance misusing themselves as a coping strategy.” (1)

Service providers reported that the misuse of substances by children may not manifest until the child’s twenties, as the child begins to try and navigate their own place in the world and struggle to assimilate their childhood experiences as an adult.

“I remember speaking to one mother, for her there was this sense of helplessness that she was in addiction, and she was trying to get recovery and next thing all her kids, once they hit into their twenties, all of a sudden, they're all in active addiction as well - self-harming extensively. And I think that's a trend that I'm noticing in terms of its later in maturation when the kids develop the substance misuse issues is because they have to assimilate their childhood experiences as an adult and their lives are complex and their stories have sometimes been complicated by other people's narrative.” (3)

“We get a lot of referrals because again, young people who are substance misusing, and again, that’s not strictly a Social Work issue you know what I mean, you’ve got a parent there who’s trying to help the child and the child is maybe a bit out of control but they’re not at risk because of the parents. But you go in then and you’re talking to the parents and a lot of that is learned behaviour from the stuff, you know, so you have to deal with that legacy and also deal with a young person who is substance misusing.” (1)

Compounding this issue is that some parents can contort narratives and memories. Parents can rebuke the child’s memory, telling the child that their experience wasn’t as they remembered. This can cause great confusion as the child’s memories don’t match their feelings.

“Ah no, no your father wasn't like that ... no, no, that didn't happen to you, no, no, I never put you in danger ... I never had you in a room with other people when they were

using. So sometimes these narratives can become hazy by the very people that were there to protect them. And if you have that effect, then you have a whole story that you have feelings that you can't match. So that lead to confusion so what you're left with is the feeling that something happened. Or what's worse is your left with the effect of it without the memory which is even more". (3)

This theme consisted of service providers experiences of risks to the child within the home from parental substance misuse, and the potential impact this can have on children. However, whilst reporting and acknowledging these risks and impacts, service providers also reported that there are many factors that mediate these risks (protective factors), or exasperate these risks, factors which can originate both from within family setting and external to the family setting. These contextual factors are discussed in the next theme.

#### Theme 2: Sweeping statements- an unfair narrative when void of context?

In this second theme, service providers reported that while children of parental substance misuse may be exposed to many and varied risks, and this exposure can manifest in many different ways for children, it is important to also contextualise this issue and acknowledge the nuances in relation to risk and protective factors for children of parental substance misuse and potential subsequent harms to children. Factors within the home include but are not limited to, the type of drug being used, degree of exposure to parental substance misuse and behaviour of parents while using substances, parenting capacity, the presence of additional co-occurring adverse experiences including co-morbidities, the unresolved complex trauma of parents from their own exposure to adverse childhood experiences, resulting in intergenerational legacies. whether or not the parent is engaged with treatment, whether or not services are even aware that an issue exists for the child.

Community and society level factors were also reported and included barriers to accessing services, varying degrees of acceptance for different types of drug use and a prevailing sweeping statement collective negative narrative about parental substance misuse, and its impact on children, which can have detrimental impacts on both the parent and the child. These issues are all reported on within this second theme. An additional critical factor reported on was that of the role of service response. This service level issue is discussed separately in the third and final theme, Theme 3.

*Subtheme 2.1: Sticks and stones may break my bones, but words will never hurt me*

Whilst acknowledging that children of parental substance misuse may be exposed to many and varied risks, and that this exposure can manifest in many different ways for children, service providers reported that it is important to also contextualise this issue and acknowledge the nuances in relation to parental substance misuse and potential subsequent harms to children.

It is important to be mindful of sweeping statements in relation to parental substance misuse. It is important to ensure that a blanket negative narrative in relation to children of parents who misuse substances is monitored and challenged where necessary, as parental substance misuse and its impact on children within the home is not a black and white issue. Discourses, including media and political discourses often tend to pathologise parents who misuse substances inferring direct one directional causal links between the parents' substance misuse and negative outcomes for children, rather than contextualising the role that other additional systems also play, in facilitating these outcomes. Steering the focus to shine as brightly on role that systems external to the individual play, is one way to counteract stigmatising views and narratives.

“Some peoples' substance misuse problems don't have as detrimental an impact on people as people or maybe the public would perceive. That would be my view.” (5)

Prevailing narratives can be challenged by ensuring that when reporting on parental substance misuse that one does so in context. There are many factors at all levels of the child's ecosystem that can mediate the degree of risk a child is exposed to.

*Subtheme 2.2: Drug type and degrees of exposure*

Factors that can mediate or exasperate risks to the child within the home setting are reported by service providers as including but not being limited to the following issues. These factors can include the type of drug being taken with different drugs presenting different types of risks. Drugs that require IV administration for example can place the child and parent at risk of blood borne diseases. Drugs which have resulted in drug debts can result in the child being exposed to intimidation and threats within the family home.

“I suppose talking from experience; it would probably be a little bit different than what it could be ... so obviously if someone is an IV user then there could be risks around blood borne viruses, where there's intimidation going on around drug debts or stuff like

that then if the house is targeted or stuff like that then they're going to be exposed to that." (6)

Different substances will highlight different risks. For people misusing alcohol, while intoxicated, the degree of risk can be elevated if the parent is simultaneously trying to carry out activities like cooking for the child or driving the child to school.

"We would ask clients when they are initially assessed or as a continued assessment without a form per se, if they are an alcohol or drug user. Depending on the substance that they are using, that will highlight different risks. So, if someone is using alcohol, they are potentially putting their children at high risk of because they are intoxicated, you know, even basic things like cooking. Did they turn the gas on/off, driving the car ... sometimes we have mothers who tell us that they drive their children to school, and they start drinking before they drive them to school? So, it's assessing, are you drinking before school, before the drive/after the drive, so it's breaking down all the questions." (5)

Different drugs have different types of dependency and different treatment options and subsequent recovery success levels as a result of that. Relapse of the parent can be extremely traumatic for the child, particularly in cases where the child is removed from the home.

"Some clients are not physically dependent on something and the only things that people are physically dependent on are alcohol, opiates and drugs called benzodiazepines. But you have people who come in with methamphetamines, cannabis, they're things that can't be medicated so they sometimes take a little bit longer to work with and sometimes people relapse, don't engage for very long, go away and come back, go away and come back. And then they have their children, and they go away and come back. So, they're well known to Social Services and Social Services have plans in place that children can be removed and then they come back and it's very traumatic." (5)

Service providers also reported that extended exposure can have an accumulative effect where damage can build up over the years. This type of exposure can present additional risks for the child and require a more intensive intervention from services, a holistic family approach as opposed to the dominant individual behaviour changed based models provided across some

sectors. The role of service provision in addressing the risk and protective factors for children of parental substance misuse is explored in Theme 3.

“But I’d say a lot of children and young people ... like the damage ... if it’s an ongoing issue ... the damage building up over the years ... they would probably need more intense support. In terms of maybe one-to-one support but then working with the child in isolation isn’t going to help either so it has to be a whole family approach. So maybe some kind of programme that looks at the needs of the children and then maybe the needs of the parent and maybe a holistic family approach. It has to be a whole family approach. So maybe some kind of programme that looks at the needs of the children and then maybe the needs of the parent and maybe a holistic family approach.” (2)

#### *Subtheme 2.3: Parenting capacity – life skills and substance use*

Caution on isolating parents’ substance use as sole source of compromised parenting. Isolating the parent’s substance misuse as the sole source of potential compromised parenting may can be a dangerous narrative as parenting ability may be limited due to poor life skills and parenting skills, irrespective of the substance use. Parenting ability may be an issue more than substance misuse in isolation as can be the case for parents who don’t use substances.

“I think there are some clients - the same as mainstream people who don’t have substance misuse problems – is that their parenting ability is more of an issue as opposed to just substance misuse in isolation. It’s that sometimes the people who have the substance misuse problem, maybe their life skills are very limited as well. But some peoples aren’t. some peoples’ substance misuse problems don’t have as detrimental an impact on people as people or maybe the public would perceive. That would be my view.” (5)

In many instances, the parent’s life skills may be limited as a result of their own childhood where they themselves never were exposed to effective parenting or taught life skills. Services providers reported that in their experience, in almost every instance, people who end up misusing substances have reasons stemming from childhood.

*Subtheme 2.4: Parents own adverse childhood experiences – unresolved trauma, learned behaviour and legacy issues.*

Parents who now are misusing substances may often be doing so as a result of their own childhood experiences.

“We get a lot of referrals because again, young people who are substance misusing, and again, that’s not strictly a Social Work issue you know what I mean, you’ve got a parent there who’s trying to help the child and the child is maybe a bit out of control but they’re not at risk because of the parents. But you go in then and you’re talking to the parents and a lot of that is learned behaviour from the stuff, you know, so you have to deal with that legacy and also deal with a young person who is substance misusing.” (1)

The unresolved complex trauma of parents can be passed onto the child, who in turn can then pass it on to their own children, and the cycle continues. These intergenerational traumas can manifest from exposure to issues other than parental substance misuse and can include other factors such as exposure to parental mental health issues, where children can take on a lot of guilt from trying to fix the parent, internalising this process, and subsequently entering into difficult relations themselves.

“Complex trauma. I see complex trauma. Most of the people that I see ... the service users in the projects ... you can see that they suffer with anxiety from trauma related incidences. And you can see that they're complex, some of them are based on their own complex relationships with their parents. It can be parental substance misuse, it can be mental health - dealing with depression, dealing with these issues, where those kids themselves ... I mean I've spoken to a number of service users who would say that as a result of either their parent's depression or anxiety that they took on an awful lot of guilt over that because they were trying to fix their parents. So, they internalise this process for themselves and then they're using or entering into difficult relations themselves” (3).

Other legacy issues can include abuse, and family break-ups.

“In my experience, I would see the substance misuse as a symptom of something else and that can be different for different people.... There can be trauma from childhood where families have broken up. Where there's been substance misuse in the parents



when they were growing up. It can be a lot of different things. And mental health would be a big ... we can't get away from ... a lot of people are presenting with mental health issues. Now whether those mental health issues are environmental again so things like dealing with anxiety and things like that. (6)"

Children may also have been caught in the crossfire between parents. Children may have been caught in the middle of a parent who wanted to hide their issues from their partner. In cases like this, the child is scapegoated to deflect from the issue at hand to avoid exposure. This type of childhood experience can manifest in destructive development for the adult child.

"That's an example one service user that I spoke to, he was very open about his own relationship with his parents and his mother had serious depression. She would lock herself away in the room and he would try and kick the door in to get to her because he was afraid that she was harming herself. When the dad would come home, he would see the black marks on the door and mother would blame the young fella and say that he was unruly or that he was ... just to hide her difficulties or issues that she was having. So, the kid would get in trouble. So that was that cycle for him. I think that's some of the difficulty. It's the complexity of the relationships I worry more about." (3)

Family conflict from the parents own childhood can be a huge underlying issue, an issue which needs consideration – is drug use a solution to a problem or is it the problem in and of itself?

"I think that's the underlying thing. I think we focus a lot on the drugs and rightly, on the substance itself but I think sometimes, and especially in the family we have to look at, is the drug use a solution to a problem or is it the problem in and of itself? Because most of the people I talk to have drug solutions to other problems as opposed to problems with the drug and it's about finding out what is that." (3)

This intergenerational cycle can be perpetuated by a pervasive deficit based sweeping narrative which often infers a direct causal one directional link between parental substance misuse and negative outcomes for children, without contextualising the interaction of additional risk and protective factors, laying blame for parental substance misuse and its impact on children predominantly and sometimes solely on the individual using the substance. This narrative can impact on the initiation of, maintenance of and treatment for the substance misuse.

“Some peoples’ substance misuse problems don’t have as detrimental an impact on people as people or maybe the public would perceive. That would be my view.” (5)

#### *Subtheme 2.5: Protective Factors within the family*

Other contextual factors that exist are protective factors. Across the research literature, protective factors can originate at the level of the individual, level of the family, level of service, level of community, wider environment and society at large. However, throughout these interviews, service providers reported very few explicit protective factors for children. Where protective factors were overtly listed, the majority of them were reported as originating at the service level. These included schools, education and awareness raising programmes, drug treatment services, child and family services, and the wider community.

“Protective factors can include school, mental health programs, programs about resilience, services for parents of parental substance misuse, child and family services, and the wider community.” (1)

For drug service providers, the key protective factor for children from their viewpoint, was their parent engaged with drug treatment services and achieving and sustaining recovery.

“We refer to social services in cases where children of parental substance misuse may be at risk. This is our protective factor as we deal with adults only in our drug service. Our protective factor is that we refer to social services to make an assessment. We give them information to inform that assessment process and to see what other protective factors can be put in place. From our perspective, the only protective factors that we could put into place would be regular contact with the parent and feeding that back. And that can become a protective factor that the client is engaged with the service and they’re attending their appointments.” (5)

In these interviews, protective factors were not listed per se, but rather inferred as noted above in this theme, in that different factors such as type of drug use can increase or minimise risk. For service providers, gaps at service provision level is the key risk factor for children of parental substance misuse and addressing these gaps would create a key protective factor.

Across these interviews, other than the protective factors listed above, only two other explicit protective factors were reported. One at the level of the individual child, and one at the level of the family.

At the level of the individual, only one service provider reported protective factors originating at this level. In this instance it was a child and family service provider who reported that at the level of the child, protective factors include the help-seeking skills of the child themselves.

“If they have their own help-seeking skills then that can help.” (1)

No other explicit protective factors originating with the child themselves were reported by any service providers. This is an important finding and will be explored in further detail in the discussion. This is also a finding across all cohorts interviewed. Fundamental to the Bronfenbrenner’s ecological systems model is acknowledgement of the role the child plays in their own development and the bi-directional nature of this role. Key literature specific to the area of risk and protective factors for children of parental substance misuse also highlights the role of the child’s individual level factors which incorporates factors such as an internal locus of control, active agency, resilience etc. However, protective factors were reported on in relation to service provision which has a role to play in incorporating ways of helping the child deal with their environment. The role of service provision in addressing risks and protective factors is discussed in detail in Theme 3.

A second protective factor originating at the level of the family unit external to the parent who used substances, was reported by the same child and family service provider. This protective factor was One Good Adult.

“Well hopefully there will be a protective adult there, maybe a mother and father who isn’t using, or other family members.” (1)

However, this service provider also cautioned of the potential double edge sword nature of the one good adult within the family setting. This was based on three issues. Firstly, in many instances within services, the presence of one good adult, in particular a non-substance using parent, can be a, or *the* determining factor in whether or not to refer a case on to child services. The caution being raised here by this service provider is in relation to the fact that the status of the One Good Adult can change but that this may not be brought to the attention of service

providers. This can have obvious ramifications for the child. Identification, assessment and referral procedures are reported on in Theme 3.

“When discussing this with the Social Work Department it really is the protective factor. You know, is there a protective adult within the family home and if the Social Worker can see that then they tend to look at PPFs – that’s the Prevention Partnership Family Support work, the Meitheal side of things, being in Meitheal can meet that kind of need you know. I think when it begins to border on, when the parents are, but what we have though is a lot of one-parent families where maybe the dad is still involved to some degree, and they may have access and stuff and are still influencing but have serious chronic substance misuse issues so it’s still impacting hugely on the family. You could have that legacy issue. But if a mam is living at home with the family, Social Work don’t see that as a priority because mam is the protective adult in that. But that’s fine but as I said all that legacy stuff is still there, dad may see them you know but there could be arguments over the phone or whatnot. And then you have the issue of and it happens in domestic violence situations all the time or maybe mam and dad get back together again post, you know, mam gets the barring order or the dad will get the barring order but they may split up. Again, I would always see domestic violence very linked to substance misuse issues in a lot of situations, but family’s circumstances change.” (1)

Secondly, the one good adult can have differing views on substance misuse within the family, and on different types of substance misuse, thus acting as an enabler for the person misusing the substance by preventing the issue coming to the attention of services or dismissing the impact on the child. This was found to particularly be the case in relation to alcohol. How we as a society respond to alcohol is expanded on in subtheme 2.7.

“But some family members, they can be a bit of an enabler, families, as well. You know if you do have a granny there are you covering up that fact that maybe the family need a lot more than just getting, especially in relation to alcoholism being a big one you know, I think that everyone ... their jaws drop when they hear heroin, or cocaine or a lot of class A drugs, but with alcohol being such a massive issue within that we kind of turn a blind eye or we don’t fully ever see that as very problematic as well, you know.” (1)

Finally, the one good adult may be within the extended family and assume the role of carer for the child. However, caution is raised by the service provider in relation to this as substance misuse in families does not occur in isolation and may create risks of its own for the child.

“You could say on paper extended family – but that requires a full assessment of the family to see whether the extended family are suitable and usually ... in my experience of 20 years you don’t find one substance misuse problem in isolation in a family. There’s usually a history or there are other extended family members who have substance misuse problems. It doesn’t mean that it’s to the extreme of people we get maybe, but it’s more about the other people’s ability to parent I would say”. (5)

“A lot of times the grandparents are taking care of the kids. Getting paid and ... in actual fact, there’s a whole side of that inter-generational effect of older people minding kids because developmentally it’s a mismatch.” (3)

This is an important finding, especially given the significant number of children who are cared for by grandparents during parental substance misuse. This issue will be explored in detail in the discussion in light of these comments and the themes arising from the grandparent cohort interviews. A second service provider, a drug service provider, also reported the importance of One Good Adult, someone in the child’s life who knew what was going on. But it is unclear if this one good adult refers to someone within the family setting or someone external such as service providers.

“But in terms of the protective factors I think it’s other people being involved, other people being aware of the situation in the house, all the stuff around where the drugs are being kept, stored, all the kind of issues around the general childcare part would be protective.” (4)

#### *Subtheme 2.6: Community level resources – barriers to accessing services*

In terms of additional risk factors and protective factors for children of parental substance misuse, the service providers reported factors originating within a wider context than just that of the immediate family setting by discussing the key responsibility and role that they believe service provision plays in relation to these issues. The role of services is reported on in the third and final theme. Service provision itself, however, can also be impacted by factors external to

the service itself in relation to wider community level issues. This broad ecological lens aligns with the Bronfenbrenner understanding of childhood development.

This subtheme relates to risks to parent and child as a result of varying degrees of accessibility to required services across the catchment area. A key critical protective factor for children of parental substance misuse from the perspective of drug service providers is the successful recovery of the parent. Service providers reported challenges with their own service and recognised that these challenges can be exasperated by community level issues.

*Rural area specific issue- Accessing services:*

There was an overarching risk in relation to accessing services as a result of extensive rural areas across the catchment area, where despite high numbers of people, service provision was low. This accessibility risk applied to both parents accessing drug treatment services, and children accessing supportive services such as breakfast clubs and after school clubs. These access difficulties at a community level consist of an uneven distribution of services across rural areas, compounded by transport access issues and transport cost issues. Service provision tends to gravitate towards larger urban areas.

“As far as the gaps are concerned or what could be done, I think County X is very different to the rest of the counties, in the sense that there are huge rural patches to County X and the town, so to get access to facilities that probably aren’t there. Either breakfast clubs, where kids get their breakfasts, after school clubs etc. Transport is an issue, even getting from town to town. The geographical spread of County X means there hasn’t been a concentration of services even though there are more people in it than County Y, but it’s a city- geography is an issue. Large rural area tends to be forgotten about. Rural areas may have more people but less services as services gravitate to cities.” (5)

“I think County X, as well, our geographical spread while good in one way has meant that we haven’t had maybe a concentration of services either. To compare us to County Y, I think we maybe have 20 or 30,000 more people but we have less services as County Y is a classified as a city and services tend to gravitate to cities. So geographically as well there are issues.” (1)

“Access to services within communities I think is a big thing. it would be great if there was more resources and greater services within communities. I suppose no matter how many services you have there’ll always be another community ten miles down the road but if there was a balance somewhere along the way.” (6)

CVS sector undermined: In conjunction with this, at a community level, the community and voluntary sector have been hit by significant funding cuts, policy and structural changes, and limited resources. These issues are particularly pertinent for the rural areas, putting children at increased risk.

“The whole community and voluntary sector has been really undermined you know over the last few years. Because the community development projects are all gone now. Unless they’ve been subsumed into the local development companies, they’ve found it really impossible to continue. We had a couple of them here in X that tried to continue after their core funding was gone but it was a struggle for them, it was too difficult. And then the local development companies, a lot of their programmes are focused on activation and employment so it’s all about getting people back into the market force and into the labour market, so they have a small concentration on community development but it’s not anything like it used to be.” (2)

Accessing Childcare: Childcare is reported as an additional access challenge for parents wishing to access any drug treatment service, which service providers believe creates risks for the child as parent may be unable to access the treatment and help, they need.

“So, one of the things in terms of accessing services is about the availability of the services and the parent having children going to school, that they can access services around that. So that it fits in with the care of the child.” (6)

“In terms of the needs of the child, obviously childcare and all of that for when the parents are attending appointments and that they can be with them as much as possible.” (7)

“Having access for children to access a crèche for example, when the parents access treatment would be a protective factor, but childcare isn’t always available and can be a barrier for parents.” (4)

Accessing Residential Treatment: This issue is compounded for parents wishing to access residential treatment. Accessing residential treatment is difficult for many reasons. Firstly, cost is an issue. In the absence of private health insurance, access can be limited to those who have a probation worker, to residential services where social welfare payments are accepted, or through completion of prior counselling sessions through a gateway system via statutory services which can be a lengthy process.

In all cases reported, accessing residential treatment requires people to travel beyond their own locale.

“Most of our clients won't have private health insurance so they can't access these services. If they don't have a Probation Worker, then there's no way of paying. Residential service X is about €7000 for a 28-day treatment so then I have to link them in with the Health service executive substance misuse team and then they require a person to see a counsellor for a number of times before they'll even put their name forward. So, then the service user is being bounced around a service not because they want that service, but they have to jump through hoops to get the money. So, if they go to an addiction counsellor, they've already done a whole piece of work with outreach so what ... the counselling isn't for say the therapeutic piece of work around an issue or that. They want to go into a treatment centre and then we're told well it's a finite resource, money, dah dah dah and it puts people off.” (7)

In addition to barriers to access because of cost and location, childcare presents another access barrier for many parents wishing to access residential treatment. At the time of these interviews, there was only one residential treatment service within Ireland that allowed women and children to reside together during treatment, but this service is located many miles from the location of the service participants, and acceptance into this service is determined based on certain prerequisites which require attendance at a number of prior meetings. The previous transport and cost issues combine to create additional barriers to access here for parents in conjunction with the fact that the person wishing to access the service will more than likely be experiencing chaos of their own compounding the impact of these access issues.



“And people down the county would have to go up to the city so people have to pay for a bus, if they've children who's going to mind the children? How are they going to get there? I don't know the place ... you know loads of barriers?” (7)

“So, for this young woman that I worked with, she was a 23-year-old heroin user. Kids in care. Social workers involved. She was still abusing so she was a high risk. Baby was at risk. On a methadone programme. She had to go get a bus from her home for a two-hour bus journey to location X and be there for a specific time, for a type of drop in service for people who wanted to go to the residential child and mother centre. She had to do that. So, she had to get there on time. Often, she was 45 minutes late depending on a bus or it could be her own chaos either, whichever. So, then she missed it. She'd turn up and they'd say you've missed the group; you were to be here at 2. And this is like a pregnant woman coming from X - a young woman. So, she actually, she actually did go to about 6 of them but she still was kind of pushed, shuffled around, nothing was clear on when she'd get in and she fell by the wayside and ended up in prison. It was impossible. You know and you're ringing up and you're trying to advocate on her behalf, and I know all the services in urban area X are really busy, and I also know as someone who worked in this area ... whoever is there is given more priority. They are. People down the country ... allowances aren't made as readily. There are huge barriers to treatment.” (7)

For all other residential treatments, access for the parent requires that the parent secures a way for children to be minded while they attend treatment.

Gender Differences in Accessibility to Treatment: Service providers reported childcare and access to any type of drug treatment being a particularly gendered issue. Factors contributing to this are that in the majority of cases, it is the mother who is the primary and very often sole carer for the children. In addition to this, whilst all parents can be subjected to stigma and judgment for their substance misuse, specific targeted judgment is reserved for women who misuse substances and in particular, mothers.

“Certainly, substance misusing parents who come into treatment service, substance misusing women in particular. For father it doesn't seem to be as big an issue. So, there

is a gender difference there. We've always had that in terms of women and men in substance misuse. Women who drink are thought of as worse than men who drink. Women who take drugs are thought of as worse than men who take drugs. And then bring parenting into that, and as a father who takes drugs – oh Jesus! But a mother who takes drugs is really beyond the pale. So, it's mothers we're probably talking about mostly in that situation." (4)

The final yet significant access barrier reported is fear, the parents fear of losing their child if they access help and treatment.

"Fears for people attending are fears for parents and particularly for mothers are probably with social services. So that's a big thing. Social services getting involved and then once social services are involved then, it's their understanding then of substance misuse and addiction and things like that." (6)

This can lead to mothers feeling an intense degree of fear about attending any service for help for fear of what will happen her children. This issue of an appropriate service response to parental substance misuse where children are involved is a critical theme in the service provider findings and is reported on in the final theme, Theme 3, When worlds collide- merging siloes of expertise. There is a growing acknowledgement of the need for drug treatment services and child and family services to collaborate in relation to responding to this issue. Progress and challenges relating to the interaction between these two sectors are reported on. Before exploring this final theme however, for service providers another key risk factor reported as operating at the family and community level that can exasperate the child's exposure to parental substance misuse is our cultural response to alcohol.

#### *Subtheme 2.7: Turning a collective blind eye – sure its only alcohol*

At a wider level of the ecosystem, a key concern for all service providers was the role that Irish culture and society have in relation to downplaying the role of alcohol.

"I don't know international stuff but certainly our tolerance in terms of drinking to excess is acceptable in Ireland I think is something that is way too high in my opinion. But that's kind of led into other things in relation to substance misuse as well. It's created that kind of ... alcohol being an acceptable one and everything else being

unacceptable, so I think that there is that kind of undercurrent there of people using.”

(1)

This can have a direct impact on the risks to the child as many families can be protective, particularly around alcohol but this can be an enabler for parents to continue misusing alcohol without seeking treatment.

“But they can be a bit of an enabler, families, as well. You know if you do have a granny there are you covering up that fact that maybe the family need a lot more than just getting, especially in relation to alcoholism being a big one you know, I think that everyone ... their jaws drop when they hear heroin, or cocaine or a lot of class A drugs, but with alcohol being such a massive issue within that we kind of turn a blind eye or we don't fully ever see that as very problematic as well, you know.” (1)

Alcohol is also a drug and people might take longer to engage as theirs so much normalisation and a culture of tolerance around it. This can present sustained exposure to risks for children.

“In terms of needs, we talk about drugs, I talk about substances usually, I don't talk about drugs and because of that and because there's a tendency to see drugs as illegal street drugs and it isn't. It's alcohol. It's prescription medication. They have a big part to play as well and the needs for people with alcohol, they'll still present to substance misuse services the same as anyone else. There may be needs around health issues. Alcohol can often be, for some people they can be engaged in problematically for longer and their health needs might be bigger..... It can make it harder but you also have the normalisation and it's the culture around .. you know, the Irish culture around drinking so that can be a bit of an issue and people even recognising safer levels of drinking and what is considered normal and acceptable”.

“Depending on the substance that they are using, that will highlight different risks. So, if someone is using alcohol, they are potentially putting their children at high risk of ... because they are intoxicated, you know, even basic things like cooking. Did they turn the gas on/off, driving the car ... sometimes we have mothers who tell us that they drive their children to school, and they start drinking before they drive them to school. So, it's assessing .. are you drinking before school, before the drive/after the drive, so it's breaking down all the questions”. (5)

Theme 1 explored the risks to children of parental substance misuse and its impact on children. This second theme provided additional context in relation to the findings in theme one and challenges the reader to be mindful of the destructive impact of sweeping statements void of context. That factors external to the parent using the substance, and the immediate family setting that can also exacerbate the risk a child is exposed to and the subsequent impact on the child. The final theme, theme three explore the role that service providers articulate as being instrumental in relation to risk and protective factors for children of parental substance misuse- i.e., service response.

### *Theme 3 When Worlds Collide –Merging Silos of expertise*

The following theme explores the challenges and progress made in relation to addressing harms to children from parental substance misuse from the perspective of drug service providers and child and family service providers. In very recent times, both policy and practice have made inroads in acknowledging children of parental substance misuse as a cohort in need of prioritisation and we have seen the emergence of a ways of supporting these. However, the proposed new ways of working to address the needs of these children requires significant systemic cultural and practice changes both within each sector separately and across the sectors and services collaboratively. Change of this magnitude can present significant challenges. Challenges exist both within each service sector individually and in relation to collaborating together in order to holistically respond to the needs of the child. These challenges are intertwined and complex.

#### *Subtheme 3.1: Identification, assessment, referral challenges and use of data*

The first subtheme explores challenges drug services reported as existing within their own service in relation to responding to the needs of children of parental substance misuse. A key challenge reported related to existing identification and assessment procedures. Service providers, reported concerns with the current lack of a systematic approach to identifying parents where children may be in need, challenges with existing assessment and referral procedures and limited knowledge and resources in relation to responding to children of parental substance misuse

The issue is complex for drug services. This is uncharted territory for many. Historically the focus of drug services has been on the adult receiving treatment. Whilst acknowledging that children of parental substance misuse may be exposed to many risks which can impact a child

in many ways, responding to this issue can be a fraught and difficult process. Drug service providers in these interviews acknowledged that there is an issue and are endeavouring to respond to it, but there are many challenges to this.

A key challenge for drug service providers is balancing the risk of the parent disengaging or never engaging with the service because of fear of repercussions in relation to their children, with that of meeting the needs of the child. Given that drug service providers report parents recovery as a key protective factor for the child, this can be a very sensitive position for the services to be in. Service providers need to balance identifying the needs of children whilst simultaneously ensuring that parents do not feel so threatened by the process that they disengage, or never engage with a drug service, compromising the child's well-being even further.

Currently, across certain drug services, people who misuse substances who are parents are not systematically identified or assessed in any way. The result of this can mean that risks to the child remain unknown.

“The chief risk for children of parental substance misuse for me, is that they're not identified, and their needs aren't assessed. So, I suppose my fear is that the risks are unknown. Because we don't systematically identify people that we know are substance misusing, problematically substance misusing, that are parents. And that's as far as we go.” (4)

In addition to this, in cases where they are identified, no follow up procedure is in place.

“We do an assessment, or we don't, the services do an assessment, and they say you're using this, you're using that and who do you live with? Children. Grand. And they've questions, how old are you? Are you taking this? This is madness. We know this person has a problem; we know they've got children at home. Some of them are parenting alone so they are the only parent in the home, and we know the extent of their drug or alcohol problem, but we don't bother asking anything after that you know. If somebody does present for treatment and they are a parent, there is no way flag on a system. I wouldn't like to say that there's no worker in the region in substance misuse who is not considering these issues. There are maybe but they are isolated. There's no system for

them to be able to do it. There's no 'let me grab Form 7'. 'Let me send Form 7 to our childcare coordinating unit' or whatever." (4)

"And one of the protective factors there is early identification. We don't do that. We have a national form that we fill in that says I'm a parent but after that there's no question. I think we need proper assessments. I think we need a responsibility - and I know they say it's there with the Meitheal, but it's not there with the Meitheal. There are substance misuse services that aren't identifying, unless it's a child protection order." (3)

Whilst data is collected by service providers asking the parent if they have children and how many they have, no further follow up is carried out on this data. (Collecting this information in relation to whether or not the adult in treatment has children and the number of children, is currently collected to align with recent (2016) national requirements to return this information to the National Drug Treatment Reporting system (NDTRS). This addition to the existing reporting form was made in an effort to address the gap in existing national datasets in relation to the numbers of children of parental substance misuse). The drug service providers in this research however reported that while the data that is returned to the NDTRS is reported on, it is not acted on.

"Nothing is ever done with the data on children of parental substance misuse that we submit. It's just data collection, feed it to your tick-box. Great. No one has ever turned around and said, what does that tell us. What does that tell us that we need to be doing in our area? So, my organisation as X, what am I trying to do about this - I'm trying to highlight the issue. I'm trying to say we have an area of need here, we don't know exactly what that need is but we do know that it's likely to be a significant need. It's likely to be leading to situations for children that are far from optimal. We do have a responsibility to try and address those kinds of needs." (4)

Interviewer: "do you automatically collect that data?"

"It's only demographics; so, it's number of kids, and only recently, we're asking the ages of those kids but that's it, it's demographic. And that's the problem that we've identified ourselves, with no screen. If you had a screen of some sort, then you could actually do

screens and you're going to do a comprehensive assessment on the family to see if everything is ok. And you build that in as part of their care package, but we haven't found one of those yet. it's across the board, there is no screening tool. You have for alcohol or drugs the DODIT, no parental screening tool that may give you an indication of a problem.” (3)

Interviewer: “so specifically what do you ask them?”

“Just demographic, we don't ask them who their kids are with at the moment. None of that information that may tell us a risk. It's not on the assessment. It's the blind-spot. It's that thing we do in Ireland, it's takes us a while. And those questions are done on the HRB form, so even changing those and while they are very open to change that only happens every so often. So, everyone that comes into the service has to fill out the HRB form, and that information is collated nationally to give us some sort of indication of the use of services and stuff like that.” (3)

The data that is collected and reported on, also only represents the children of parents in treatment. Whilst having a parent in treatment does not guarantee that the children in need are identified or responded to, for those families where no service engagement of any kind has taken place, additional vulnerabilities and risks are likely. Not only are the needs of these children unknown, but the scale of the problem is also unknown, making the provision of services to address the issue untenable.

“Now that only tells us obviously what happens in terms of people coming forward for treatment, it doesn't tell us anything about people who didn't come forward for treatment which is probably the other nine-tenths of the iceberg.” (4)

There is also no systematically adhered to assessment process in place across many of the drug services. An assessment framework was designed and rolled out, the National Drug Rehabilitation Framework (NDRF), but is it not consistently used across the intended drug services, and where it is used, different services use different parts of the assessment. Service providers reported that this framework was not implemented consistently and governing bodies that were responsible for its implementation were disbanded, partly because of a lack of

agreement as to what services are required to do and how to do it, and even whether drug services should be doing anything in terms of standardisation.

“We are using the National Drug Rehab Framework Assessment but it’s not being used consistently at all. NDRIC as it was called back in the day is the drug rehab framework – NDRIC was the committee, the National Drug and Rehabilitation and Implementation Committee. I think it’s been disbanded, it was going for about 8 years, and they still haven’t managed to come up with anything really very solid. For the drug rehab framework, we don’t have standardised assessments; if you go to area X it will be different to area Y and that’s within our region. If you go outside of our region, it’s entirely different. People seem to just choose something they fancy, make one up yourself. I’ve been looking at the assessments processes around the country and it really is make it up yourself. Whereas we know there are validated scales for various things – AUDIT being a great example, CUDIT, there are various ones on the screening level and there are some good initial assessments”. (4)

This was reported to be in contrast to the child service assessment framework, Meitheal, which drug service providers report as having been implemented successfully, standardised, manualised, with training and supervision provided.

“Meitheal started maybe five years into that process, that’s the assessment framework in child services, and did it the right way in my view which was to standardise, manualise, train, supervise ... it’s not rocket science. But now if you go into the childcare services in the State now, they’d be able to pull off the Meitheal manual off the shelf for you, they’d show you the different assessments that they use, they’re all standardised, there’s scores there, the outcome is clear.” (4)

The idea of these separate frameworks was that each would be implemented correctly and would complement the work of each service to provide a robust assessment and care plan. However, the failure of the NDRF implementation process has compromised the capacity for a collaborative response. This compromises service capacity to meet the needs of children of parental substance misuse. Consideration as to why the child and family assessment framework was implemented in a more structured and supported manner will be explored within the discussion.



“The childcare services are using Meitheal and that seems to be across the country. That’s been well thought through, designed, trained and now the managers are supervising people’s implementation and application of that process. We’re supposed to have the same with the drug rehab framework, standardised assessment processes leading to clear decisions about what happens and the involvement of different people. So theoretically it should be possible to combine those two processes that have a really robust system for dealing with the children of substance misusing parents It’s the drugs side where that isn’t happening. So, we can’t combine two systems, when one of them isn’t a system, it’s a framework that loose ... we should do an assessment and then you should have a care plan.” (4)

Within drug services however, even if the NRDF assessment had been successfully implemented, the assessment does not target specifically risks for children of parental substance misuse. Service providers reported that an assessment tool that specifically addresses the risks to children should be considered. An example of a recognised successful assessment tool which is in place in the United Kingdom, is called the Standard Conference on Drug Abuse (SCODA), which is a framework for assessing problem drug use and impact on parenting - specifically addressing risks to the child.

“I think there’s an interesting ... the SCODA, the Standing Conference on Drug Abuse, an assessment format for assessing parental drug and alcohol risk. It’s quite good as it gets beyond are you stoned or are you incapacitated questions into things like where are the kids when you’re going to buy drugs, where are the kids when you’re using drugs, who else is in the house when you’re using drugs, who else in the house when you’re going out to buy them? Where do you put your needles? How do you store your drugs? You know, sensible questions.” (4)

“If you look at the UK where they have this comprehensive assessment, the SCODA assessment for family need. We don't have a screening that's the problem. There's no screening tool available to tell you whether or not maybe an indicator of maybe an additional problem. It's based on a number of factors. It's based on observation by the worker itself. But there's no validated screen.” (3)

However, service providers while recognising the merit in introducing a measure like this that can target the needs of children, are concerned that carrying out an assessment such as this on initial engagement may deter further and or initial engagement from parents.

Interviewer: “And questions like those asked in the SCODA aren’t asked anywhere that you know of?”

“Not that I’m aware of. It’s quite an intrusive assessment process if you follow that. I’m not sure that it would be appropriate to have that at an initial meeting as I don’t think you’d have any parents coming back if you start going into that.” (4)

A solution proposed to this was the introduction of a screening tool, which would be a less intrusive initial assessment process, and therefore less intimidating to parents, and which could flag parents where children were an issue of concern and could lead to further follow up with a more intensive assessment at a later date.

“But with other things, say you have a screening process, audit-type thing where you have ten questions like; do you have an alcohol problem, well if so, let’s get intrusive about your alcohol. I would love to see some kind of screening process there for parental substance misuse risk that said ok, a couple of answers there that we need to do this at a future session. That’s what I’d love to get to so for me the risks are, that we don’t know the risks, we know them generally, but we don’t ask specifically. We need to come up with some kind of standard, brief, process that everybody goes through. That doesn’t scare parents into not coming forward into substance misuse services yet does allow us to identify at a broad level those that require further assessment from those that don’t require any further assessment. And then those that do require further assessment to have a comprehensive assessment of the home situation with regards to the children. Until that’s done, then we have no hope of meeting the needs of those children.” (4)

A suggested solution to this issue was to reconsider, at a systemic level, the factors contributing to the fear parents have in relation to their children if they engage with drug treatment services and explore ways systemically, we could begin to challenge the status quo in terms of service response. It was reported in the service provider interviews that currently a key risk for children

of parental substance misuse is the parents fear, and in particular mother's fear of engaging with drug services for treatment, for fear of losing their children. The fear parents feel is reported in the interviews as being substantiated by the current state response which could be viewed as a punitive unsupportive approach, whilst still acknowledging that concern for the child is what may be driving that response. However, is there an opportunity within all the current changes that are going on in relation to responding to children of parental substance misuse, to consider a state response that is not punitive, but provides all the supports the parent and family need to help prevent the child being removed from the family.

“But we possibly need to turn that on the other end of its head as well that the scare is that you're going to lose your kids. Now, is that because that's what the State's response generally is as opposed to, if you get identified here, you're going to get all of this support in terms of your family. No, we don't think of it in those terms because it's not true. There isn't huge levels of support that are going to be provided to you because you have this huge level of need. The State response is probably going to be 'we're going to protect the children by removing them from your care'. It doesn't happen in every circumstance, but that would be the perception. Certainly, substance misusing parents who come into treatment service ... substance misusing women in particular. Fathers - and it doesn't seem to be as big an issue. So, there is a gender difference there. We've always had that in terms of women and men in substance misuse. Women who drink are thought of as worse than men who drink. Women who take drugs are thought of as worse than men who take drugs. And then bring parenting into that, and as a father who takes drugs – oh Jesus! But a mother who takes drugs is really beyond the pale. So, it's mothers we're probably talking about mostly in that situation” (4)

Whilst a barrier to asking questions about the children can be based on a fear that the parent will cease treatment if feeling threatened in relation what may happen their children if they proceed, another reason reported is because there is no capacity, knowledge or resources about how to respond to the needs of children.

“I think just because of the system. I think workers don't like asking those questions because when you ask it, the issue is there. There is no service, where do you go with it? We have no 'think family' organisations, we have no capacity to be able to be able to say, 'where does this family go to for help?' because they're all taken as individuals.” (3)

Child and family services also reported concerns with identification whereby existing processes may not capture that substance misuse was a key issue, but rather record it under something else e.g., emotional abuse.

“Data Collection and identification is tricky. Generally, what happens is that the vast majority of my referrals come as a step down or a diversion from Social Work usually from the Intake and Assessment team. So that’s our front of house. But I suppose, we can only go on what’s coming in. So, I suppose it’s kind of that hidden harm. So, a lot of referrals may come in as domestic violence so under the standard processes, that box would be ticked. But then you actually look at it and you read more into it. When the gardaí were called out, they were called out at 2AM and the family had either engaged in ... both parties were drunk maybe .. or stuff and that’s a substance misuse issue. Sometimes there are drugs involved but the primary thing was emotional abuse. You see it’s classified as a risk to the child, you know what I mean - domestic violence as a factor might be ticked on the box, you know. I should have probably brought you the leaflet, but you’d tick 1, 2 or 3 but generally people would only label it 1 or 2, you may not be capturing it and again, I suppose people who have those kinds of issues can keep that very, very hidden.” (CFS)

Additional challenges for child and family services were reported in relation to a lack of clear protocols and guidelines around parental substance misuse, a haphazard system.

“I think there is probably a lack of very clear protocols and guidelines around substance misuse of parents and children. I think it is a little bit haphazard at the minute and that’s one of the reasons why we’re looking to get this piece of work done so we can be clear around that. I think we have all the expertise but as I said they’re in separate silos you know and it’s about getting that formal communication mechanism. Things can work very well on an individual basis but often it’s due to the personalities involved more than actually a very clear way of working.” (1)

In addition to this, currently, the child and family service using methadone have no way of knowing if the parent is in treatment. Drug services are not allowed to divulge this information for

consent reasons. There is no cross referencing between drug services and child and family services for these service providers in this interview.

“Not every family that comes in is getting that initial assessment by the Social Work Department. And even the initial assessment by itself you wouldn’t be able to capture a lot of that stuff either, I would think you know. So there’s lots of that stuff you know. And unless you know, like we wouldn’t know who’s in a particular treatment programme at any one time. I certainly wouldn’t have a list that I could cross-reference against a HSE ... if a family was in say a mental health service or in a drug treatment service, or had ever been unless that family voluntarily told us themselves? Now we would when we go through the Meitheal, we do ask those questions ourselves but it’s up to the parent whether they choose to answer that correctly or not. I suppose where we are ... we’re strictly a voluntary service as well so it is based on the information given to Social Work they decide well, does this or does this not meet a threshold. It could be that the child has missed a few days of school, you know but I mean maybe because.” (1)

### *Subtheme 3.2: Show me the way- How should we meet the needs of children?*

Drug service providers all reported challenges within their services of knowing how to respond to the needs of children if and when they are identified. These challenges are compounded by competing priorities, and limited funding and resources.

Historically drug services have responded to the needs of the adult presenting for treatment and extended this support for family members, and in many cases, to parents who were struggling to manage their own teenage child’s substance misuse. Parenting programmes have also been provided by these services.

However, service providers reported limited services targeting children of parental substance misuse.

“There haven’t really been any good responses that I’m aware of in terms of substance misuse or in terms of childcare services I haven’t really heard of anybody doing anything very effective on that within our region. Even external to our region, I know there are some services where children are accommodated within the adult drug treatment day service, but I am unclear if the children get access to any supports themselves during this process other than being cared for while their parent accesses treatment.” (4) .

“I think some of the guys, the community-based workers, are a constant support. I know the parents that I've seen, they've really helped them stabilise. What they will say is 'I don't get judged', 'I'm just supported all the time'. They get that space to work certain things out. They get that help. I think that's been the biggest ... because our guys aren't specialised in parental interventions in that way. There isn't any ... we have no programmes. We're only delivering individually based programmes, so we don't have any specialised services trying to deal with parental substance misuse unless your issue is heroin use. There might be family resource centres.” (3)

A challenge to providing a suitable response stems in one way from not knowing what the response should be. Drug service providers are not experts in childcare. Child and family services are not experts in addiction treatment. In conjunction with this are competing priorities, limited funding and significant logistical implementation challenges. Whilst at a regional level research can be commissioned to advise on what the best response is to the issue, given the critical nature of the issue, the well-being of children, direction needs to be provided from a national level.

### *Subtheme 3.3: Merging siloes of practice*

At a wider systemic level, additional challenges exist, in that at an operational and structural level, a significant degree of intersectoral work between child and family services, and drug services would be required to holistically address children's needs and these structures are not in place. However, in order to do this, significant systemic cultural and practice change is required. In terms of a joint service response to parental substance misuse and children, a key risk reported across these interviews consisted of siloed service responses.

“In terms of the systemic issues, yes well, we're working in silos and that continues to be a problem. The childcare services aren't really involved in substance misuse and vice versa. So, we don't have those links either at a strategic level or operational level. So that causes a big problem. In terms of each side, if you talk about them in terms of sides, I don't want to do that but let's talk about them as sides for the moment, these groupings, don't necessarily know as much about each other, not in terms of their own workings but in terms of their own client group. I mean I know quite a lot about drugs, I know very little about childcare. I'd imagine a lot of people in childcare know an awful lot about childcare but know very little about drugs. So, in terms of how they can interact with each other from positions of weakness and lack of knowledge.” (4)

“I think we have all the expertise but as I said they’re in separate silos you know and it’s about getting that formal communication mechanism. Things can work very well on an individual basis but often it’s due to the personalities involved more than actually a very clear way of working.” (1)

“Sometimes the danger is to look at services in isolation providing solutions that don’t work. Substance misuse can only do what it can do. Child and family services can only do what they can do. You can’t provide over-arching services to meet the needs of children that clearly need services, but I don’t know if we’re the answer to that or whether it’s more joint working and what the needs are. Maybe that the children need breakfast in the morning before they go to school, organising that with the schools, after school clubs where they can get their homework done, maybe they can get some dinner there. Personally, I think it’s quite naive that either Social Services or Substance Misuse can find solutions in isolation because they don’t work like that.” (5)

It was acknowledged in the interviews that steps to address these siloed responses are beginning to take place, but that at the time of interview, these two systems were not operating in a synergistic way, with ramifications for both the child and the parent. Translating theory into practice is a significant challenge.

“Child services have the Meitheal assessment process which is an ecologically based assessment. According to DTS this framework was implemented well with supervision and training provided. In theory this framework accommodates an inter sectoral interagency holistic approach to responding to needs of children and thus when substance misuse is an issue, then substance misuse services are invited into the process. However, experience of this on the ground has reported that while in theory this may work, in reality, the silos of expertise, and different understandings of addiction, have resulted in ongoing confusion in relation to what is expected of the parent to ensure reunification. Service providers themselves have reported that navigating the child and family system is difficult even as a service provider, with unclear guidance on goals for reunification and consistent shifting of goals, resulting in parents “jumping through hoops” to ultimately be told that they are not allowed access despite having made significant improvements, which often leads to relapse which can be detrimental to both parents and the child.” (4)

There are both historical and current reasons for these ongoing predominantly siloed responses. These services traditionally operate from opposing focuses, with child and family services focus on the child, and drug services focus predominantly on that of the person using the substance. And in conjunction with these factors, both of these services currently operate from different models of understandings of addiction, with many drug services operating from a harm reduction model, yet child and family services operating from an abstinence-based model of addiction. These alternative models, and limited understanding of addiction, present specific difficulties at the critical juncture of the ultimate aim of reunification of parents and children in cases where children have been removed from parents. Drug service providers reported numerous challenges for parents and drug service providers in working with child protection services. The national child and family system were reported as being a chaotic, crisis intervention service, with unclear and often unrealistic goals for parents, which can have significant impacts on the child especially if parent relapses.

“You have to be so on the ball to deal with this. I mean I find it difficult as a worker sifting through it and dealing with it and trying to keep my head calm sometimes and trying to think logically and trying to look at the perspectives. So if I was going through hell and trying to stay in recovery and all my stresses and housing and all of these other issues and then having this very clouded mish-mashy entity, which seems to be ... what's going on with Tusla and the plans, not knowing ... you're not being really straightforward and clear, that's adding to my stresses. And you know, it affects people's recovery. And then if they slip, it's oh, and they're being hammered for that.” (7)

“What I am hearing from people who are working in substance misuse is that when children do end up in the care system, there's a lot of confusion as to how they can come back out of that system. So the interagency working there in terms of how you engage substance misuse within the care plan for that child assuming that the ultimate aim of those care plans is to reunite as far as possible within the realms of safety of the child then there's something that needs to be happening there. The research would say that if a child ends up in care because there is drink and drugs, they take something like five times longer to come out of care than they do for any other purpose.” (4)

A lack of understanding of addiction is believed to underpin the child and family response.



“In relation to substance misuse, huge amount of training needs to be done and an understanding of addiction. I came across one social worker down here who was actually from Cork and when I met her I was so relieved because she'd such a good understanding of addiction, the social worker was just able to turn to the parent and say ok I understand you have a heroin addiction. I also understand you love your daughter and your daughter has a really strong bond even though the daughter has been in foster care for years. I just ask that you don't turn up to access stoned or under the influence. And after that we can work with anything. She just said it like that in a real compassionate way and my God it made such a difference. Unbelievable.” (7)

“Fears for people attending are fears for parents and particularly for mothers are probably with social services. So that's a big thing. Social services getting involved and then once social services are involved then, it's their understanding then of substance misuse and addiction and things like that.” (6)

“... you've taken the child away and the child is safe. You're looking to reunite them and ... the parent, and it can be a great motivator for some of the substance misuse treatment parents are to get your kids back and then you sort your own situation out. It can be a great motivator but only if you know what those hoops you need to jump through are. So unless the Meitheal process is going to be clear with substance misuse providers, if the parent does dah dah dah then we're looking at reunification. If that was clear, then there's work there for a care plan for the substance misuse services for the parents then we're very clear here about what you need to do and why. It's a question of how you're doing to do that, if you're going to do that but, as I understand it at the moment, is you jump through this hoop, that one and then it's slightly changed when you come back from the next meeting that actually now we're not going to have you do this, and this. There needs to be some level of clarity around that.” (4)

Child and family service providers also recognised this deficit in knowledge and skills in relation to addiction and advocate that the way to resolve these gaps is by developing close working relationships with substance misuse services.

“Because you know it wouldn’t be my particular skill being able to deal with substance misuse like that but it’s about having those close working relationships with those who are involved and equally too, they probably say the same in relation to child protection and social work and just below that with myself in terms of the Meitheal programme. I think they can complement each other very well.” (1)

“Is it ok that you’re on medication for depression for 5+ years? Is that something you know ... how do we tackle that? It’s just such a complex area that often scratching your head and dealing with young people. And there’s a new word for you know ... you thought you got cannabis and don’t understand. And you have all this synthetic stuff and you got all the head shops stuff that’s being going on for a while and that’s got driven underground. So it’s always trying to keep up with the terminology and all the different stuff as they come in and out of fashion.” (1)

Setting unrealistic goals for parents and not acknowledging significant improvements in relation to the parents substance use are believed to stem from opposing models of addiction.

“So if someone say is engaged with social services and they have a social worker for the child; so it's either child welfare or child protection, we would work from a harm reduction model. We would work from a stabilisation and things like that and it depends, it's not across the board, but sometimes you might find that there's more of an emphasis on abstinence and that kind of the model within social services. So I understand that they're there for the child so they have the duty of care over the child but you know somebody could be reducing dramatically what they're using. If they're judging them on screens then, so on urine analysis they may still have positive screens but they could have reduced massively. So they've really made great progress but it's not always recognised. But that's not across the board with all social workers or anything like that but it's just something that.” (6)

Whilst acknowledging the working difficulties emerging between drug services and child and family services in relation to parental substance misuse and the child, drug service providers were adamant that they are not saying this to reflect badly on the service. Drug service providers reported that these workers are hard workers, but operating within a difficult, under-resourced system.

“I’m not blaming social workers, they're in a shit system and they're not properly resourced. They're all over worked and they're all stressed and the amount of social workers that leave so families have 3/4 social workers because the social workers get burnt out and they're gone. Ah disaster.” (7).

“Social Services and social services are excellent and are clearly overworked.” (5)

“I don't want to be hammering social workers either. There is a good relationship with them as well.” (6)

Child service providers also reported challenges in addition to their lack of skill base in dealing with addiction. This issue relates back to identification. Currently, the child and family service using Meitheal have no way of knowing if the parent is in treatment. Drug services are not allowed to divulge this information for consent reasons. There is no cross referencing between drug services and child and family services for these service providers in this interview.

“not every family that comes in is getting that initial assessment by the Social Work Department. And even the initial assessment by itself you wouldn't be able to capture a lot of that stuff either, I would think you know. So there's lots of that stuff you know. And unless you know, like we wouldn't know who's in a particular treatment programme at any one time. I certainly wouldn't have a list that I could cross-reference against a HSE ... if a family was in say a mental health service or in a drug treatment service, or had ever been unless that family voluntarily told us themselves? Now we would when we go through the Meitheal, we do ask those questions ourselves but it's up to the parent whether they choose to answer that correctly or not. I suppose where we are ... we're strictly a voluntary service as well so it is based on the information given to Social Work they decide well, does this or does this not meet a threshold. It could be that the child has missed a few days of school, you know but I mean maybe because.” (1)

Despite challenges reported above with implementing in practice the systemic change necessary to address the needs of the child, there is a clear acknowledgment, and willingness to do everything in their power to meet the needs of the child and the parent.

“But certainly whether it’s substance misuse services invited into the Meitheal process or whether it be childcare services invited into the supposed drug rehab framework process, one of those needs to happen.” (4)

All service providers are driven by the need for this change and the need for a new type of response- a trauma informed, holistic, whole family approach. This is discussed in the final subtheme.

#### *Subtheme 3.4: Making the new way work*

Service providers were in agreement that the status quo is not addressing the needs of the child and that services need to be holistic. Drug service providers reported that although they acknowledge in their practice the wider effect on community and family on substance misuse, but that translating that into effective holistic services on the ground can be challenging. Historically, most interventions are mainly individual level behaviour modification approaches aimed at stopping or reducing usage.

“I think we think very specific in our field. I think there's a level of thinking about things ... a little bit wider than our own particular field. Most substance misuse counselling or intervention would say there's a wider effect on the community and a wider effect on the family. Yet most interventions focus on behaviour modification and either stopping or reducing the drug use itself. As opposed to, well if we were to consider it as being a systemic issue. Like we have functional family therapists in the southeast, they deal with 18-year-olds and adolescences who are using drugs in their family. They bring the whole family in for therapy. The results are better because you're not taking the individual out, focussing on the individual issue.” (3)

Implementation challenges are significant so that even with the everything lined up, logistical realities, competing priorities, and resources and extensive inter-agency work will require a very streamlined, funded, managed implementation and supervision procedure with clear guidance from a national level that is a priority and a priority that will be properly resourced.

“Because even if I did part of that job perfectly and identified the perfect programme – to get that implemented in the Southeast? It would perhaps be impossibility. I’ve got five counties, so I’ve got 2-3 different Meitheal processes within the region In terms of

local authorities with the housing, there's five of them, four different garda divisions, three ETBs, you know. So I would have to re-negotiate this every day of the week with different agencies across the Southeast to try and get that happening. And that's one little aspect. For me, implementation and coordination of the National Drugs Strategy, the child bit really is barely in the strategy. So 95% of the things I'm supposed to be dealing with I couldn't spend the time doing that so if we do identify something whether it's the assessment process or the intervention programme or whatever it is, it needs to be coming down from on high to say from now on lads, this is how you assess, this is how you respond." (4)

All service providers from both drugs and child and family services acknowledged that across sectors and within services, workers are trying their best to respond to need, but reported an over-burdened and under-resourced, fractured system, where services are operating in silos of expertise. Key issues at present relate to processes regarding use of data, identification of children at risk, assessment, and referral, and the absence of clear and realistic criteria in relation to goals the parent needs to achieve to ensure reunification with children in cases where children have been removed from the home. Service providers recognised and acknowledged that steps are being made to address these issues, but that systemic change of this magnitude requires a structured, resourced national implementation and that while in theory bridging the gap between cross service and inter-agency working is the ideal outcome, that the practicalities of this are extremely complex. In conjunction with this, while acknowledgement that children of parental substance misuse are mentioned within the National Drug Strategy, that currently, responding to needs of the children is only a minor component of the overall strategy, and that with limited resources and competing priorities, that in the absence of a national drive to prioritise this issue, that the needs of children of parental substance misuse may remain a goal but not a priority.

A multi-sectoral multi agency coordinated response may be costly and complex, and therefore a challenge for professionals who are overloaded with cases, competing priorities and constrained by limited resources.

Children are falling through gaps in services; and professionals involved, either with adults or children, feel increasingly ill-equipped to deal with the combination of issues highlighted in this chapter. In addition, the "care management culture" results in families' problems being

compartmentalised and distributed across services so that professionals rarely get a complete picture. Childcare professionals' express concerns about their lack of knowledge about alcohol, drugs and their effects and impact. Adult care professionals express equal uncertainty about addressing parenting issues in their work, and a lack of confidence in identifying child welfare issues. Professional boundaries, territorial anxieties, client loyalty and confidentiality are also central concerns.

## 8.4 Conclusions

In this chapter we explore service providers experience of risk and protective factors for children of parental substance misuse. A key finding is that while service providers reported risks for the child within the home as a result of parental substance misuse, (risks which the service providers emphasised are influenced and fluid based on factors such as type of substance, intensity and exposure, legacy issues, age of child, birth order of children, and presence of and access to protective factors) the focus of responses from service providers lay in exploring how systems external to the family also contribute to what the child is exposed to, and what supports are there for the child.

The themes elicited from the interviews challenge us to question further the possibility that prevailing narratives may contain sweeping statements regarding parental substance misuse, that are damaging to both the parent's chance of recovery and the child's subsequent development. A narrative around risk and protective factors for children of parental substance misuse that doesn't focus solely on risk and protective factors attributable to the individual using the substance but steers the lens and focus towards understanding the role that factors external to the individual have in also contributing to both the initiation and retention of substance misuse, or in many cases to relapses during recovery.

That a trauma informed, non-judgemental, holistic response to addiction is imperative for both the parent and the child. This type of response must be provided across sectors and agencies involved with both drug service provision and child and family services. Achieving change of this magnitude has its challenges but with structured implementation, and sufficient resources and support, this change is possible.

When endeavouring to address the needs of children of parental substance misuse, are we asking the right questions? Are we focusing on the right issue? Are we considering our own role as a society in how the needs of these children are met? How are we as a society collectively

contributing to the unmet needs of children of parental substance misuse? How dangerous is our cultural tolerance of alcohol, except in extreme cases where significant neglect is reported? How effectively are services responding to the child's unmet need and in what way is the response driven by a collective narrative underpinned in many instances by unsubstantiated blanket statements about direct causal links between parental substance misuse is isolation and negative childhood outcomes

Research experts in this area have reported that there can be clear and significant risks to children of parental substance misuse in terms of their subsequent development. However, research has also shown that the presence of a substance misusing parent does not always result in a negative outcome for the child. In these instances, researchers report the presence of mediating protective factors. Systemic changes are needed in the way we think about and thus communicate about parental substance misuse, and in how we respond to parental substance misuse.

Supporting children and families affected by parental problematic substance use is critical and that policy and practice progress is being made to address this issue. There are a number of protective factors and processes which can mitigate against children having poor outcomes as a result of their experiences of parental substance misuse and we can build children's resilience to such adversities. It is therefore vital that practitioners who engage with these children and their families develop a full understanding of what protective factors and processes may be present or available that can be part of the response and help offered. Teaching about the effects on children and how to develop resilience needs to become part of core training for service providers

### 8.5 Summary of findings across stakeholders

Both convergences and divergences across stakeholders emerged in the findings. There was a strong convergence in relation to a shared experience of a fragmented system, including issues in relation to power access and influence. However, there were different rationales for this experience, in particular between grandparents and parents. There was a particularly strong convergence between drug treatment service providers and parents, in relation to interfacing with child protection services and an overarching risk focused deficit framing stigma and narrative. While the protective factor of kinship care was recognised, there was little awareness of the significant challenges grandparents face which create significant risks for the children. For

the adult children, the potency of cumulative risk factors was central. The fragility of recovery and lack of support at that phase was reported by all. Protective factors, when reported, were mainly community-based services and one good adult. For grandparents protective factors were aspirational. Figure 3 below outlines the themes across stakeholder groups. In appendix 4a and 4b, Figure 4 provides a map of these themes with subthemes also, and Figure 5 illustrates the location of these themes using Bronfenbrenner's conceptual framework,



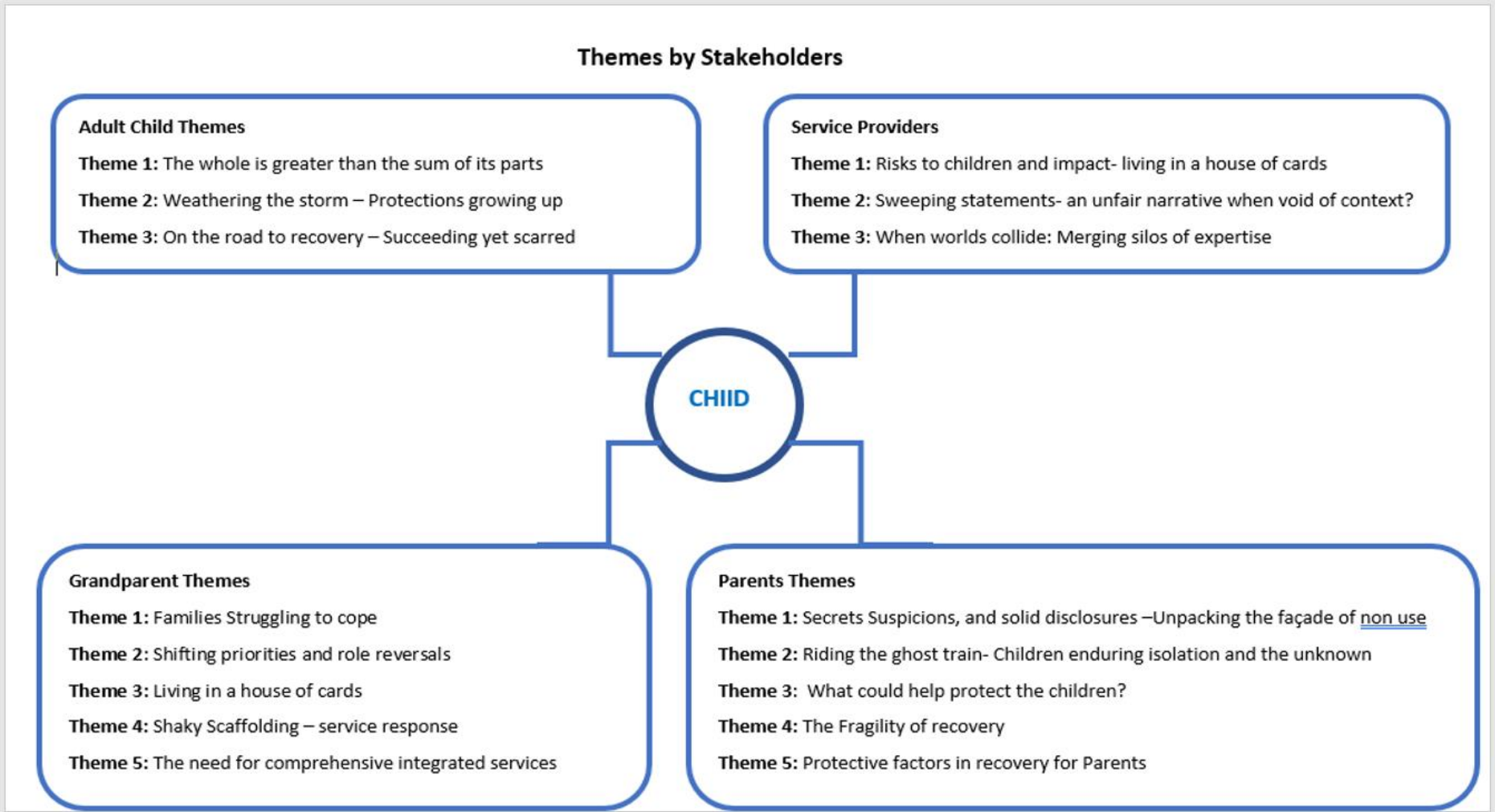


Figure 3: Summary of themes by stakeholder groups

## Chapter Nine: Discussion

The overall aim of this study was to explore multiple key stakeholders lived experiences of risk and protective factors of children of parental substance misuse, to gain a more holistic insight into the area of enquiry. Developments in qualitative research reported in the introduction chapter highlighted the recognition of the value of widening the focus of research to incorporate the key role that stakeholders external to the parent child dyad play in relation to the parental substance misuse (Rostill-Brookes *et al.* 2011, Larkin *et al.* 2019). Larkin *et al.* (2019) argue that the experience of living with an adverse situation is not solely located within the accounts of those with the 'diagnosis', nor is it limited to the children of these parents. The phenomenon is also located within the accounts of other people who belong to the "lived world" (Larkin *et al.* 2019) and those who play a part in responding to the 'lived world' (Hogan 1997, Houmøller *et al.* 2011, Rostill-Brookes *et al.* 2011, Larkin *et al.* 2019).

Information gleaned from this study contributes to a growing body of research that directly examines the risk and protective factors influencing children of parental substance misuse (Park & Schepp 2015, Velleman & Templeton 2016, Włodarczyk *et al.* 2017, Murnan & Ferber 2020). Findings from the current study extend and contextualize our knowledge of risk and protective factors that influence children of parental substance misuse from multiple perspectives.

A unique contributory feature of this current study relates to the widening of the focus of participant views to incorporate the views of not only the parent, the parent-child dyad, or the views of the grandparent, but simultaneously capturing the viewpoints of all these key family level stakeholders, in conjunction with that of key service providers from both child and family services, and drug treatment service, at one point in time. The population of interest represents a marginalised and difficult to engage population of parents, children, and grandparents.

This current study also adopted the Bronfenbrenner (1979) ecological model as a useful conceptual framework to investigate children of parental substance misuse (Hogan 1998, Moe *et al.* 2007, Dawe *et al.* 2008, Scaife 2008, Templeton 2013). Adopting such a model helped capture the complexity of influences that impinge on child of parental substance misuse, by focusing attention both on child and context as they relate to each other (Hogan 1998), and avoided implicitly adopting a model of parental drug misuse which locates all risk factors for child outcomes in the skin of drug-misusing parents (Scaife 2008).

Bronfenbrenner's core argument is that human development is a complex process of reciprocal interaction between the individual and a multi-layered system of contexts, ranging from the immediate environment of the home to the societal level. The model considers the interrelation between four factors : person (characteristics of the developing person), process (the mechanisms operating to influence psychological outcomes), context (persons and events at different levels of proximity to the developing person from the Microsystems of the home and local community to the macrosystem of the culture) and time (the historical time period in which the events take place) (Bronfenbrenner 1993). In the case of parental drug use, it therefore implies consideration of the interaction between individual characteristics of the child him- or herself, such as age and gender, and multiple levels of context such as their parent's drug-related behaviours and caregiving competencies in the home, relations between family and school, the support available on the community, and the socio-economic position and service provision for drug users in the broader society in a particular time period. (Hogan 1997). From a developmental perspective, Cleaver & Unell (2011) in their research into children's needs and parenting capacity, reported that deficits in early life would be expected to be more pervasive and severe in their effects than later parenting problems. The reason for this is because from this perspective, developmental competencies build up over time, each are dependent and reliant upon successful negotiation of previous stages (Cleaver & Unell 2011). Individual variations in how children respond are, in part, a function of the severity, characteristics and social and cultural context of their parents' problems (Cleaver & Unell 2011).

Using Bronfenbrenner's model in this study highlighted that risk and protective factors for children of parental substance misuse exist and interact across multiple levels of the ecosystem, and while factors originating within the child's microsystem were important, at the exosystem level, disparities that underpin challenges in relation to the critical interface experience with child/family services and drug treatment services, were central for the stakeholder groups in this thesis, in addition to macro system level and exosystem levels factors of a pervasive stigma underpinned by a predominantly risk focused pathologizing narrative contributing to the individualisation of parental substance misuse, which inadvertently can worsen the situation for children.

The combination of including the voices of multiple key stakeholders of the lived world of the child, of examining both protective and risk factors and of contextualising these findings through

the lens of the Bronfenbrenner Ecological framework lends a unique contribution to the existing literature in the area of risk and protective factors for children of parental substance misuse

### **9.1 Parents' perspectives**

In this study, the parents lived experience of risk and protective factors for children, had many similarities despite variations in drug of use, and exposure to significant life events. However, gender differences were strongly evident in relation to accessing treatment as a parent, including childcare needs, and a specific heightened stigma for parents who are mothers. These findings echo those of the United Nations Office on Drugs and Crime (UNODC), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Pompidou group, who recognise that drug-using parents are stigmatized and live with fear of being considered neglectful and that their children will be taken away from them, with this point being particularly acute in the case of women (Giacomello 2021). In this thesis research, of the mothers interviewed, their children experienced a range of disruptions in their lives including kinship care by grandparents, the prolonged engagement of child protection services, and in certain cases, children were taken into state care. Conversely for the children of the fathers in this study, all children remained living with their own mothers, as seeking alternative care arrangements was not required for the fathers. The inclusion of fathers as part of the parent group addressed a key gap reported in the literature whereby research studies predominantly recruit mothers as parents (Scaife 2008, Velleman & Templeton 2016). This is despite research showing that parental gender influences the role of protective factors (Velleman & Templeton 2016).

Findings revealed risk and protective factors being reported at a number of levels of the Bronfenbrenner's ecosystem (Bronfenbrenner 1979). Parents reported risk and protective factors for both the parent and the children. The risks and protective factors were evident across three phases of addiction – the active addiction stage, the road to recovery and dealing with life sober.

During the parent cohort interviews, many parents expressed concern that their own children would follow in their footsteps and misuse substances. They attributed this to both the fact that children saw their parents doing it, a learned behaviour, and also a coping strategy as a result of exposure to parental substance misuse growing up, in conjunction with a possible genetic pre-disposition for substance misuse. This unprompted discussion in the parent interviews involved discussions about the role of nature and nurture and this discussion was made more difficult to decipher when only certain children followed in their parents' footsteps, despite all

children being exposed to the same parental environment and socio-economic environment. Moe *et al.* (2007) in their research argue that despite the obvious risk of growing up with a parent who misuses substances, many of these children do not become substance users themselves, and many move on to live healthy, adaptive lives as adults (Moe *et al.* 2007). The authors highlight that research that contributes to an understanding of factors that lead to resilience has enormous implications for practitioners and researchers alike, and caution against the tendency to use a deficit framework in characterizing children of parental substance misuse. In addition to this, Bronfenbrenner's (1979) bio-ecological development theory stipulates that factors contributing to child development are variously located (e.g. in a child's individual biology, immediate environment, socioeconomic and cultural context; (DeHart *et al.* 2000)) and that events in one location may influence events in another (Scaife 2008). In this model, context is of critical importance, but that other factors are at play, a pivotal factor being the role of proximal processes in child development. Proximal processes involve the bi-directional interaction between child and environment, including child and parent, and is influenced by the child's own characteristics including demand characteristics, resource characteristics, and force characteristics.

In terms of protective factors for children, parents reported protective factors that exist across the different levels of the Bronfenbrenner EST, highlighting that children are influenced not only directly through their own microsystem but also through the parent's access to protective factors that originate in the child's mesosystem, exosystem, macrosystem, and chrono system levels. However, unfortunately in this study, most of these protective factors reported were done so in an aspirational manner with only inconsistent access to these protective factors being reported.

From the perspective of the parents own substance misuse, parents spoke of the existing protective role of community level drug treatment services, including access to a community employment scheme, the protective factor of family and in particular grandparents in relation to the children. However, in relation to child protection services specifically, protective factors were in the main aspirational and included an unstigmatized service experience, and a deeper understanding of addiction, including more realistic goals around reunification. Parents did report some positive experiences with child services and acknowledged that the system is under immense strain and that many workers are doing their absolute best to provide services in a complex environment. A gender difference in experience of services was reported, with mothers experiencing numerous challenges at the service level including access to childcare, and

transport. However, wider than these direct service level challenges were the entrenched stigma experienced by parents who were mothers.

At the level of the child, protective factors reported included the key role of children having someone to talk to, family who can help care for the child, services that suit family routine, children being educated about addiction, service provision that accommodates different communication styles of children, peer support groups, and activities for children to engage in. However, parents reported inconsistent access to these protective factors, and in some cases, no access. In the main, protective factors reported were aspirational and were reported in the context of future recommendations.

## 9.2 Child perspectives (adult children)

The aim of this research is not to determine or measure the degree to which parental substance misuse impacted the child's development and subsequent outcomes, but rather to understand from their lived experience of growing up with parental substance misuse, what they perceived as the being the risk and protective factors for them in this situation.

What emerged from the findings of adult children who had a parent who used substances was that while participants shared an experience of growing up in a home with parental substance misuse, and both reported some similar risks and protective factors, there were also other risk and protective factors reported to be at play in conjunction with the parental substance misuse. These other factors contributed to variations in their lived experience of the perceived risk and protective factors of growing up with parental substance misuse. The risks for children of parental substance misuse can be compounded in the presence of additional adverse circumstances and compounded further in the absence of protective factors to mediate the impact (Park & Schepp 2015, Velleman & Templeton 2016, Włodarczyk *et al.* 2017).

These divergences incorporated different exposure as children to the degree of parental substance misuse (AC1 had two parents who misused substances), different outcomes of having a parent with mental health issues (AC1 father died by suicide when he was 7), different exposure to additional adverse childhood experiences (ACEs) in conjunction with the parental substance misuse, different pressures and responsibilities within the home as a result of the combination of ACEs and parental substance misuse, and different socio-economic environments growing up including different peer types of peer groups.

These additional factors are important to consider when exploring the risk and protective factors for children of parental substance misuse. Research has shown that the intensity of exposure can result in different types of stress and experiences, and in conjunction with this, the presence of protective factors can mediate the potential impact of parental substance misuse (Velleman & Templeton 2007, Velleman & Templeton 2016). Ultimately, e.g., while having a parent who misuses substances can be a risk for a child, having both parents misusing substances can compound this risk, and this is particularly pertinent if there is also a lack of alternative protective factors (Velleman & Templeton 2016). Furthermore, Bronfenbrenner's bio-ecological development theory (Bronfenbrenner 1996) stipulates that factors contributing to child development are variously located (e.g. in a child's individual biology, immediate environment, socioeconomic and cultural context; (DeHart *et al.* 2000)) and that events in one location may influence events in another (Scaife 2008). While context is of critical importance, that other factors are at play, a pivotal factor being the role of proximal processes in child development. Proximal processes involve the bi-directional interaction between child and environment, including child and parent, and is influenced by the child's own characteristics including demand characteristics, resource characteristics, and force characteristics (Bronfenbrenner 1979).

In terms of protective factors, the adult children reported both protective factors growing up, and protective factors in their adolescent life and current life. Despite the diversity in circumstances additional to parental substance misuse growing up, both participants articulated almost identical protective factors. These protective factors included One good adult, sport, and the safe haven of youth clubs. In terms of the one good adult, in both cases this was predominantly a family member (older sibling, grandparent). Sport was reported as a protective factor available outside of the home for both participants, and in both cases, both participants stated that it was their capacity to play sports that enabled them to stay on in school. At the level of the community, both participants described an extremely positive and critical protective role for them was the availability of youth clubs to them- youth clubs played a critical protective role in their lives growing up. In terms of the protective role of peers however, the participants diverged here. While one participant reported the key role of peers as a protective factor growing up, the other reported the detrimental impact that a negative peer group had.

Finally, similar to the parent interviews above, the key protective role of community level drug treatment services and the community employment scheme were reported by both adult child participants as being a critical protective factor in their adolescent and later adult childhood in relation to their own subsequent substance misuse. These services were reported as providing a non-stigmatised supportive environment, which provided a safe space for upskilling, emotional support, employment, meaning, structure and hope.

### 9.3 Grandparents perspective

During the grandparent interviews, the grandparent participants described their lived experience of risk and protective factors of parental substance misuse on their grandchildren. The location of these factors could vary across multiple levels of the ecosystem and varied depending on a number of issues such as the stage of addiction, the number of parents with addiction, the number of relapses, and the support structures in place.

Grandparents reported themes ranging from families struggling to cope, shifting priorities, role reversals, and financial, legal and health challenges. These findings mirror the extant literature (Gair *et al.* 2018, Zuchowski *et al.* 2019). Grandchildren were reported as living in a house of cards—living on a psychological knife edge. Across the interviews, grandparents reported grandchildren feeling a gamut of negative emotions, an emotional hunger, abandonment, fear, nervousness, and that these feelings often transferred to external situations including the school environment. Grandchildren were reported as being immersed in a rollercoaster of emotions mirroring the parent’s journey through addiction with the exquisite fragility of recovery penetrating the grandchildren’s psyche as they grapple with the ever-changing landscape. Grandparents reported how they began to notice their grandchildren learning to adapt to their environment, with some children developing manipulation as a survival skill, different children being impacted differently, and ultimately all children living in a parallel universe, where guidelines on right and wrong were often either absent or inconsistent. A number of grandparents reported that a significant gap for the grandchildren is emotional and psychological support. Feelings of abandonment is one of the key emotions that grandparents reported, with grandparents voicing concern for the obvious ramifications this could have for children both in the short and long term. In this study, the focus was on the lived experience of the child, thus these interviews add to the existing literature (MacDonald *et al.* 2016)



The most strongly reported risk factor for children of parental substance misuse however in the grandparent interviews related to a “Shaky Scaffolding” – i.e., the service response. Throughout the grandparents’ journey to help the grandchildren, an engagement with services was necessary. Grandparents reported experiencing multiple risk factors for the grandchild during this journey. Grandparents reported having no voice in relation to the child, a strained system, and an ongoing battle to secure the right to care of children. They also reported the impact of high turnover of staff in services, on the children, and the lack of psychological services for these children. Grandparents also reported the stresses associated with caring for their grandchildren as being compounded by social services viewing kinship care (family provided care) as being less in need or deserving of formal support than non-relative formal carers. These findings mirror the findings reported in the literature (O’Leary & Butler 2015, Mac Donald 2016). Grandparents recommended the need for comprehensive integrated services, early age awareness raising, and comprehensive recovery-based family focused responses.

In terms of protective factors grandparents reported that very few protective factors were in place for the children. A key protective factor reported related to the parents’ engagement with treatment and successful recovery. In the interim the role of the grandparent was viewed as protective for the grandchild. The remaining protective factors reported were aspirational and require the gaps in services reported in this chapter being addressed in policy and practice, with particular attention needed on addressing the unmet emotional needs of the grandchild, and the role of grandparents being recognised and valued, including having their voice heard in social services and schools. These are discussed in the conclusion in section 9.8

#### **9.4 Service provider perspective**

During the service provider section, we explored the experience of risk and protective factors for children of parental substance misuse from the viewpoint of service providers from both child and family services, and drug and alcohol services.

All service providers reported that parental substance misuse can present a myriad of risks for the child within the home, which can have significant impacts on children both within the home and in external settings. Many of these impacts may not manifest until the child is older and trying to assimilate into the world as an adult. However, throughout these interviews, service providers responses focused predominantly in exploring the role that systems external to the family also play in contributing to what the child is exposed to, and what supports are there for

the child. The nature of these contributory factors varied in some cases across the two different types of service providers. The key themes emerging from the service provider interviews related to the risks to the child in the home setting with drug services in particular highlighting however, that there are multiple variations of this risk within the home including the substance being used, the number of parents using, the absence of one good adult, and the age of the child, the impact of the prevailing narrative pertaining to parental substance misuse, on both the child and the parent, and family overall, and the final theme related to the ongoing challenges and realities of merging siloes of expertise between child and family services and drug treatment services.

The themes elicited from the interviews challenge us to question further the possibility that prevailing narratives may contain sweeping statements that negate context regarding parental substance misuse, that are damaging to both the parent and the child. Findings in this study demonstrated that there are risk and protective both factors at community level, and service level that mediate or exacerbate these risks. Central to these is the role of service provision. Very few explicit protective factors for children were reported by the service providers but the key protective factor reported was the parents' engagement with treatment. However, for service providers, outstanding challenges at the service systems level are also one of the key risk factors for children of parental substance misuse and addressing these gaps would create essential protective factors. A trauma informed, non- judgemental, holistic response to addiction is imperative for both the parent and the child.

The interviews with service providers acknowledged the progress made in relation to addressing harms to children from parental substance misuse from the perspective of drug service providers and child and family service providers. In very recent times, both policy and practice have made inroads in acknowledging children of parental substance misuse as a cohort in need of prioritisation and we have seen the emergence of ways of supporting these (United Nations Office on Drugs and Crime 2016, Velleman & Templeton 2016, Health Service Executive & TUSLA 2017, 2019). However, the proposed new ways of working to address the needs of these children requires significant systemic cultural and practice changes both within each sector separately and across both child and family services and drug treatment service sectors collaboratively. Prior to this to this these service systems have had opposing focuses -that of the child and that of the adult. Achieving change of this magnitude involves significant implementation challenges.

Challenges exist both within each service sector individually and in relation to collaborating together in order to holistically respond to the needs of the child. These challenges are intertwined and complex.

Service providers, reported concerns with the current lack of a systematic approach to identifying parents where children may be in need, challenges with existing assessment and referral procedures and limited knowledge and resources in relation to responding to children of parental substance misuse. The issue is complex for drug services. This is uncharted territory for many. Historically the focus of drug services has been on the adult receiving treatment. Whilst acknowledging that children of parental substance misuse may be exposed to many risks which can impact a child in many ways, responding to this issue can be a fraught and difficult process. Drug service providers in these interviews acknowledged that there is an issue and are endeavouring to respond to it, but there are many challenges to this.

A key challenge for drug service providers is balancing the risk of the parent disengaging or never engaging with the service because of fear of repercussions in relation to their children, with that of meeting the needs of the child. Given that drug service providers report parents recovery as a key protective factor for the child, this can be a very sensitive position for the services to be in. Service providers need to balance identifying the needs of children whilst simultaneously ensuring that parents do not feel so threatened by the process that they disengage, or never engage with a drug service, compromising the child's well-being even further.

A challenge to providing a suitable response can stem from not knowing what the response should be. Drug service providers are not experts in childcare. Child and family services are not experts in addiction treatment. In conjunction with this are competing priorities, limited funding and significant logistical implementation challenges. Whilst at a regional level research can be commissioned to advise on what the best response is to the issue, given the critical nature of the issue, the well-being of children, direction needs to be provided from a national level.

At a wider systemic level, additional challenges exist, in that at an operational and structural level, a significant degree of intersectoral work between child and family services, and drug services would be required to holistically address children's needs and these structures are not

in place. However, in order to do this, significant systemic cultural and practice change is required. In terms of a joint service response to parental substance misuse and children, a key risk reported across these interviews consisted of siloed service responses. It was acknowledged in the interviews that steps to address these siloed responses are beginning to take place, but that at the time of interview, these two systems were not operating in a synergistic way, with ramifications for both the child and the parent. Translating theory into policy and policy into practice is a significant challenge. Both historical and current reasons for these ongoing predominantly siloed responses were reported. These services traditionally operate from opposing focuses, with child and family services focus on the child, and drug services focus predominantly on that of the person using the substance (Dawe *et al.* 2008, Velleman & Templeton 2016).

In conjunction with these factors, both of these services currently operate from different models of understandings of addiction, with many drug services operating from a harm reduction model, yet child and family services operating from an abstinence-based model of addiction. These alternative models, and limited understanding of addiction, present specific difficulties at the critical juncture of the ultimate aim of reunification of parents and children in cases where children have been removed from parents. Drug service providers reported numerous challenges for parents and drug service providers in working with child protection services.

The national child and family system were reported during the parent and grandparent interviews as being a chaotic, crisis intervention service, with unclear and often unrealistic goals for parents, which can have significant impacts on the child especially if parent relapses. Child service providers also reported challenges in addition to their lack of skill base in dealing with addiction. This issue relates back to identification. Currently, the child and family service using Meitheal have no way of knowing if the parent is in treatment. Drug services are not allowed to divulge this information for consent reasons. There is no cross referencing between drug services and child and family services for these service providers in this interview. Despite challenges reported above with implementing in practice the systemic change necessary to address the needs of the child, there is a clear acknowledgment, and willingness to do everything in their power to meet the needs of the child and the parent. All service providers are driven by the need for this change and the need for a new type of response- a trauma informed, holistic, whole family approach.

Service providers were in agreement that the status quo is not addressing the needs of the child and that services need to be holistic. Drug service providers reported that although they acknowledge in their practice the wider effect on community and family on substance misuse, but that translating that into effective holistic services on the ground can be challenging. Historically, most interventions are mainly individual level behaviour modification approaches aimed at stopping or reducing usage. Implementation challenges are significant so that even with the everything lined up, logistical realities, competing priorities, and resources and extensive inter-agency work will require a very streamlined, funded, managed implementation and supervision procedure with clear guidance from a national level that is a priority and a priority that will be properly resourced.

All service providers from both drugs and child and family services acknowledged that across sectors and within services, workers are trying their best to respond to need, but reported an over-burdened and under-resourced, fractured system, where services are operating in silos of expertise. Key issues at present relate to processes regarding use of data, identification of children at risk, assessment, and referral, and the absence of clear and realistic criteria in relation to goals the parent needs to achieve to ensure reunification with children in cases where children have been removed from the home. Service providers recognised and acknowledged that steps are being made to address these issues, but that systemic change of this magnitude requires a structured, resourced national implementation and that while in theory bridging the gap between cross service and inter-agency working is the ideal outcome, that the practicalities of this are extremely complex. In conjunction with this, while acknowledgement that children of parental substance misuse are mentioned within the National Drug Strategy (Department of Health 2017), that currently, responding to needs of the children is only a minor component of the overall strategy, and that with limited resources and competing priorities, that in the absence of a national drive to prioritise this issue, that the needs of children of parental substance misuse may remain a goal but not a priority.

A multi-sectoral multi agency coordinated response may be costly and complex, and therefore a challenge for professionals who are overloaded with cases, competing priorities and constrained by limited resources.

Children are falling through gaps in services; and professionals involved, either with adults or children, feel increasingly ill-equipped to deal with the combination of issues highlighted in this chapter. In addition, the “care management culture” results in families’ problems being

compartmentalised and distributed across services so that professionals rarely get a complete picture. Childcare professionals' express concerns about their lack of knowledge about alcohol, drugs and their effects and impact. Adult care professionals express equal uncertainty about addressing parenting issues in their work, and a lack of confidence in identifying child welfare issues. Professional boundaries, territorial anxieties, client loyalty and confidentiality are also central concerns.

A key finding is that while service providers reported risks for the child within the home as a result of parental substance misuse, and the subsequent impacts these risks may have on the child, the focus of responses from service providers lay in exploring how systems external to the family also contribute to what the child is exposed to, and what supports are there for the child. The themes elicited from the interviews challenge us to question further the possibility that prevailing narratives may contain sweeping statements regarding parental substance misuse, that are damaging to both the parent's chance of recovery and the child's subsequent development. Findings highlight that a trauma informed, non-judgemental, holistic response to addiction is imperative for both the parent and the child. This type of response must be provided across sectors and agencies involved with both drug service provision and child and family services. Achieving change of this magnitude has its challenges but with structured implementation, and sufficient resources and support, this change is possible.

### **9.5 Overarching issues**

The themes elicited from the interviews across the multiple stakeholders provide a thought-provoking context from which to consider future developments in the area concerning children of parental substance misuse. Each stakeholder group experience of risk and protective factors for children of substance misuse collectively provides an in-depth insight into the key issues that require attention. The inclusion of all these voices in the one study facilitated the emergence of both convergences and divergences, both within these stakeholder groups and between these stakeholder groups. Whilst all stakeholders were in agreement that children exposed to parental substance misuse can be impacted in a myriad of negative ways, the main focus of the respondent answers did not lie solely at the level of the parent-child dyad or the immediate family context, but of that at the wider level of the ecosystem.

Participants reported how different children were impacted differently, reflecting the developmental perspective of Cleaver & Unell (2011). When exploring risk and protective

factors using the Bronfenbrenner's ecological framework, Participants also reported differing environmental contexts and ecological systems which contributed, and interacted, in their opinion, to their experiences, the impact of these experiences, and subsequent life trajectories. Central to these experiences was the key role of services and supports external to the family unit.

At the macro level, an overarching issue related to stigma—stigma surrounding parents' ability to care for children and to seek help without punishment were reported by all participants, albeit to differing degrees. At the level of parents, mothers in particular reported experiencing a deeply entrenched stigma specific to mothers who misused substances, whereby when women were using substances and their use influenced their children, mothers reported fear of seeking help due to fear of punishment or custody removal. The community level drug service providers strongly reiterated this finding in their interviews. These findings mirror those of a body of the extant literature (Hogan 1997, Murnan & Ferber 2020). (Hogan 1997, Giacomello 2021,

In the context of maternal substance misuse our society needs to take prevention and intervention efforts to help women build their sense of self-efficacy for parenting to help them overcome the stress associated with these conflicting identities and, in turn, give women the psychological and social support to strengthen their relationships with their children (Murnan & Ferber 2020).

Another key finding from this research is the need to question our narrative around parental substance misuse. A narrative around risk and protective factors for children of parental substance misuse that doesn't focus solely on risk and protective factors attributable to the individual using the substance but steers the lens and focus towards understanding the role that factors external to the individual have in also contributing to both the initiation and retention of substance misuse, or in many cases to relapses during recovery (O'Gorman 2016, Velleman & Templeton 2016, Carrà *et al.* 2017, Murnan & Ferber 2020).

When endeavouring to address the needs of children of parental substance misuse, are we asking the right questions? Are we focusing on the right issue? Are we considering our own role as a society in how the needs of these children are met? How are we as a society collectively

contributing to the unmet needs of children of parental substance misuse? How dangerous is our cultural tolerance of alcohol, except in extreme cases where significant neglect is reported? How effectively are services responding to the child's unmet need and in what way is the response driven by a collective narrative underpinned in many instances by unsubstantiated blanket statements about direct causal links between parental substance misuse is isolation and negative childhood outcomes?

Research experts in this area have reported that there can be clear and significant risks to children of parental substance misuse in terms of their subsequent development (Horgan 2011). However, research has also shown that the presence of a substance misusing parent does not always result in a negative outcome for the child. In these instances, researchers report the presence of mediating protective factors. Systemic changes are needed in the way we think about and thus communicate about parental substance misuse, and in how we respond to parental substance misuse (Dawe *et al.* 2008, Park & Schepp 2015, Velleman & Templeton 2016).

It is clear that supporting children and families affected by parental problematic substance use is critical and that both in policy and practice progress is being made to address this issue. There are a number of protective factors and processes which can mitigate against children having poor outcomes as a result of their experiences of parental substance misuse and we can build children's resilience to such adversities. It is therefore vital that practitioners who engage with these children and their families develop a full understanding of what protective factors and processes may be present or available that can be part of the response and help offered. Teaching about the effects on children and how to develop resilience needs to become part of core training for service providers.

At the microsystem level, all cohorts interviewed reported that engagement in substance misuse influenced their proximal relationships with their children. While the parent-child relationship was not the sole focus of this research, it is important to note that respondents, in alignment with prior research, extensively discussed how treatment engagement and sobriety increased their awareness for the risks of their children, motivated them to improve and repair their parent-child relationships, and made them want to support the well-being of their children.



The respondents also identified additional micro-level protective factors. All respondents reported when their children engaged in relationships with one good adult, the functioning of the children appeared to be better. This study's findings have implications for social service agencies and other contexts such as early childhood environments, schools, and community-based programs. Opportunities to access supports such as positive peers, caring adults in their schools, and access to positive youth development contexts are often protective factors shown to buffer environmental risks to promote resilience (Murnan & Ferber 2020).

## 9.6 Strengths and limitations

The overall aim of this thesis study was to explore the multi-perspectives on the lived experience of risk and protective factors of children of parental substance misuse. The researcher utilised a growing, innovative use of Interpretative Phenomenological Analysis, by drawing on the use of a multi-perspectival design, in order to capitalise on the integrative benefits of a systemic view of the phenomenon under investigation. However, there are both strengths and limitations to this study which are explored below.

### 9.6.1 Strengths

A key strength of this research centred on the holistic perspective approach by incorporating the voices of multiple key stakeholder groups on the lived experience of risk and protective factors of children of parental substance misuse, allowing a rich narrative to emerge, and adding important experiential and systemic dimensions to the majority of existing research which has been criticised in the past both for de-contextualising and isolating views of key stakeholders (Rostill-Brookes *et al.* 2011, Staton Tindall *et al.* 2013, Larkin *et al.* 2019). A potential advantage to these sorts of designs is their capacity for greater impact. The convergence and triangulation of viewpoints can be more persuasive than an analysis drawn from a single sample (Larkin *et al.* 2018).

In terms of the recruitment of participants, a total of 37 participants took part in this study, which included marginalised and vulnerable family members. To overcome difficulties accessing participants who share a lived experience, the researcher recognised and applied sustained engagement, and rapport with the gatekeeper. For this study, interactions with, and the role of the gatekeeper was a fundamental component. Gaining access to this number of participants is a particular strength to this study and reflects sensitivity to context.

Additionally, this study incorporated a strength based protective factor focus, addressing a key challenge with research in this area in terms of a predominant deficit focus, narrow approach (Moe *et al.* 2007, Dawe *et al.* 2008, Velleman & Templeton 2016). Also this research adopted the use of the Bronfenbrenner ecological framework as a lens through which to explore the risk and protective factors (Bronfenbrenner 1979). Using this framework highlighted that risk and protective factors for children of substance misuses are variously located (e.g., immediate environment, socioeconomic and cultural context) and that events in one location can influence events in another. While there were risk and protective factors reported across all levels of the ecosystem, factors outside of the child's family level microsystem were significant. In particular the role of community services was one of the key protective factors. Key risk factors included stigma, deficit focused service design and narrative, unequal power access and influence between actors and intersectoral challenges.

Within these stakeholder groups, particular strengths were also evident. The parent stakeholders included both fathers and mothers. The inclusion of fathers is important as most research to date has taken place with mothers, thus addressing a significant gap in the literature (Scaife *et al.* 2008, Velleman & Templeton 2016). The inclusion of both sexes of parents provided deeper insight to the lived experience of risk and protective factors for children, including stigma, and gender specific barriers to accessing services. Within the grandparent cohort, a key strength relates to the fact that the grandparents in this group assumed different types of care roles- i.e., informal versus formal care roles, allowing exploration of factors in relation to both of these care provision options. In addition to this, the focus of the study facilitated the exploration of risk and protective factors for the child, rather than solely focusing on the grandparents' experience of being a carer. These strengths add to the existing literature in terms of the focus of this study, as the majority of existing studies with grandparents focused on the caregivers experience, rather than the experience for the children, and as such there was an acknowledged lack of information about the children living in kinship placements and in particular those in informal care arrangements (Mac Donald *et al.* 2016). Finally, the service provider stakeholder groups represented both child and family services and drug treatment services. The findings for these stakeholders allowed detailed insights into both the convergences and divergences in experiences of risk and protective factors for children of parental substance misuse and highlighted the specific challenges inherent within each system individually and across systems. Including both service system voices addressed gaps reported in the literature whereby typically the voices of child and family services and or drug treatment

services are captured separately with little being done to bridge the gap between these voices, by examining how one might serve both goals (Staton-Tindall *et al.* 2013, Rostill-Brookes *et al.* 2011). The findings from these multi-perspectives have important implications for policy practice and research.

Finally, Jonathon Smith, the founder of IPA, drew particular attention to the work of Yardley (2000), in relation to assessing quality and validity of IPA studies (Smith *et al.* 2009). Based on the work of Yardley (2000), there are four broad principles for assessing the quality and validity of qualitative work - sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Smith *et al.* 2009 p. 180). In this thesis study, the researcher applied and adhered to these criteria as described in Chapter 3 of this thesis.

### 9.6.2 Limitations

While the study yielded valuable findings, it was not without its limitations. These limitations are discussed below.

Given the qualitative nature of the study, while facilitating a rigorous understanding of the issue under investigation, a possible limitation is that the that the findings may not represent general experiences and may be limited to reflecting the experiences of those interviewed. However, the underpinning methodology provides a robust rationale for this approach. In addition to this, the multi-informant perspective of parents, grandparents, adult children and both child and family services and drug service provider, culminating in a sample of 37 participants, allowed for triangulation and credibility of the findings. A potential advantage to these sorts of designs is their capacity for greater impact. The convergence and triangulation of viewpoints can be more persuasive than an analysis drawn from a single sample (Larkin *et al.* 2018).

In terms of the composition of the stakeholder groups, there are a number of possible limitations. Firstly, for the parent stakeholder groups, all participating parents were currently in, seeking or had previously engaged in substance misuse treatment. Generally, treatment seeking behaviours are thought to be associated with higher levels of motivation and higher functioning. As a result, children of non-treatment seeking parents may experience lower levels of risk despite parental substance misuse treatment representing a potential protective factor. It is also difficult to discern how parental substance misuse independently influence the children.

Secondly, the size of the stakeholder groups was not consistent across the various groups, in particular only two adult children were available to participate in the adult child group. The reasons for this were due to external factors of prolonged extreme weather conditions, which prevented the successful rescheduling of interviews with the timeframe available. While five adult children had volunteered to take part in the study, only two participants were available to take part in the research study. Both participants were male. However, in this study, the reduced number of participants in the adult child group did not result in the voices of this stakeholder group not being heard as extensive detailed analysis was carried out on both participant experiences, and convergences and divergences highlighted. The findings in the adult children stakeholder group while consisting of only 2 participants, both residing in the same geographic location, and both of a similar age, suggest -that while the lived experience of parental substance misuse was for a feature for both, the range of additional risk factors varied, as did the accessibility and range of protective factors leading to variations in lived experiences above and beyond the parental substance misuse itself. Within this stakeholder group however, while both adult children grew up with parent (s) who used substances, neither child experienced being cared for by a grandparent, or any other non-parent care provider. The inclusion criteria in this study for the adult child group, did not require that the children had received kinship care. Rather the focus of the study was in relation to a lived experience of parental substance misuse. However, future research would benefit from exploring the child's perspective of kinship care arrangements.

An additional possible limitation of this study relates to not having the direct voice of children under the age of 18 in this study. Significant consideration to incorporating the voice of children under the age of 18 was given initially to this study, but upon further examination, challenges arose in relation to ethical concerns, accessibility, funder concerns and time constraints. Other researchers have reported similar challenges (Kroll 2003). However, capturing the lived experience of children is not limited to only those currently under 18. Capturing the voice of children over the age of 18 is also important. The age range of 15-27 is a transitional phase, a key developmental phase, and this age range facilitates reflection on past experiences (Dooley & Fitzgerald 2012). Backett-Milburn *et al.* (2008) reported that where research does exist with children of parental substance misuse, the tendency has been to focus mainly on younger children, which the author argues limits the understanding of the nature and impact of the problem on children as they grow up, and their own responses to it (Backett-Milburn *et al.* 2008). In this study, the adult child cohort were able to reflect on their lived experience not

only in relation to their early childhood, but to reflect on their adolescent lived experience and subsequent young adult trajectory. The findings provided powerful insights into the lived experience of parental substance misuse.

In relation to the overall findings of the study, combining the scope of the study, with the high number of participants (37) and the commitment to IPA level analysis, in particular to the additional complexities of a multi-perspective IPA design, was extremely challenging, as in order not to lose sight of the importance of idiographic findings, findings required and included both individual and group level analysis, and explored also both convergences and divergences between and within groups and between individuals. The choice of methodology in combination with the ambitious scope of the study aim resulted in a higher density of findings to present in this final thesis, than originally anticipated. However, as a result of the commitment in this research to this demanding analysis, a key strength was that the findings allowed a rich narrative to emerge, from multiple key stakeholder perspectives adding an important contribution to the existing literature. Qualitative research exploring the lived experience of risk and protective factors of children or parental substances misuse, in particular from multi-perspectives, remains under-developed internationally, and in an Irish context is almost absent.

In summary, using the combination of approaches adopted in this thesis study, facilitated a holistic and thorough examination of the lived experience of risk and protective factors, from both multiple levels of the ecosystem, and multiple perspectives, providing much needed additional insight into the area under investigation. While the chosen methodology supported intensive detailed analysis and findings, future research could build on the findings in this study, in particular in relation to the existing and aspirational protective factors identified, and ways to strengthen these.

## 9.7 Researcher Reflections

When engaging with qualitative research, it is essential in the research undertaken that reflexivity – a proactive ‘explicit evaluation of self’, takes place. This is particularly significant in IPA because interpretation plays such a central role (Shaw 2010 p.9).

Reflexivity is not simply an awareness-raising activity that we engage in prior to and during data collection, rather it is a vital component of each stage of the research journey (Shaw 2010). Reflexivity is linked to the quality and credibility of research, as it requires researchers to be

willing and able to acknowledge and take into account the many ways in which they can influence their findings (Clancy 2013).

The overall aim of this PhD was to identify and explore lived experience of the risk and protective factors for children of parental substance use from an intergenerational and service provider perspective. As such, I began this PhD process on a reflexive footing. My motivation for this particular PhD topic was strong and linked to both personal and professional experiences. As such I was mindful that this could lead to inaccurate interpretations, overlooking critical observations, or drawing premature conclusions as experienced by other researchers in the field (Clancy 2013). Thus, since the very beginning of this process, I engaged in deep personal reflections on the issue, including the need to remain vigilant for the potential of a latent yet potentially potent presupposition to get triggered, or an unhealed trauma to get activated when discussing issues as sensitive and emotive as substance misuse and children.

Throughout this PhD study, adopting the core principles of IPA was critical, adopting the phenomenological attitude, bracketing of pre-conceptions, ongoing reflection throughout each stage of the process, and applying commitment and rigour, in the analysis and interpretation of the data including adherence to the idiographic nature of IPA.

Having received ethical approval, the process of accessing participants commenced.

The collaboration and assistance I received from the RDATAF and the steering committee, in gaining access to the participants for this study was incredible, and without them this research would not have been possible. Sensitivity to context was instrumental from the conception of this PhD to its completion. Prior to the recruitment phase, the researcher and gatekeeper were aware of the potential of triggering trauma in participants when asking them to discuss their lived experience of risk and protective factors for their children, which is particularly relevant in relation to their stage in recovery. Thus, during the recruitment phase, the gatekeeper highlighted with potential participants, the potentially triggering capacity of the research topic, and as such cautioned those early in their recovery journey about participation. Additionally, supports were in place before during and after the interviews, and the location of the interviews in the service provider setting was confirmed in advance by potential participants as somewhere the participants felt safe, and familiar with, with their key workers on standby should any issues arise.

Having gained access to the participants, the process of carrying out the in-depth interviews commenced. Conducting research in a reflexive manner denotes that the researcher

acknowledges that he/she is not 'other' from those that are being studied (Bulpitt and Martin 2010), This reflexive process also requires awareness of the power dynamics which can exist in an interview setting (Kvale 2006), thus how I presented myself and my capacity to develop rapport was essential to the success of the interviews. During the interviews, numerous participants reported that they found me very easy to talk to which as a researcher carrying out qualitative research on a sensitive topic was very much appreciated as this dynamic facilitated a safe space for exploring their lived experiences.

During the interviews, participants willingly and openly shared their lived experience. However, despite my many years working with marginalised communities, I found hearing the lived experience of these participants, extremely emotional at times. It was particularly powerful hearing the different stakeholder perspectives and how each sees the system both differently at times and the same at times. Each time I moved from one stakeholder groups perspective to the next stakeholder groups perspective, it required significant reflection on any previous assumptions, or beliefs that I held. I expand on this further in this section.

In the parent and adult child interviews, the lives that some people had endured, yet the resilience they showed was almost jarring at times. It was jarring in that I was struck by how the 'black sheep' mentality had penetrated the psyche of so many, and how much self-blame, guilt and stigma shrouded their existence at the individual level. Yet despite this, the lived experiences shared suggested incredible recovery, resilience, and hope for the future. Some of the lived experiences were particularly harrowing, and it took every ounce of professionalism in two of these interviews in particular, to not get upset in the interview. On the one hand, a number of the disclosures still haunt me today, yet on the other hand, the resilience and recovery witnessed through the supports provided in the community, provided a story of hope for all families impacted by parental substance misuse. In these interviews, being a parent was a key motivational factor for recovery, both for those who had lost access to their children, and in the adult child interviews, the want to break the intergenerational cycle. Challenges remain however with service systems, and the need for a trauma informed focus.

I was also particularly struck by how calmly the lived experiences were relayed. I wondered what may be behind this – was it simply how far in the recovery journey these participants were that they could recount these experiences so calmly, or was it something else? Had years of exposure to stigma and shaming created a worldview in which experiences like this were believed to be just what they deserved? Following the interview, I checked in with the service manager to reflect on this aspect and to ask her thoughts. The service manager said from her

experience it was a combination of both. But that she too has always noticed this trait and believes it to be a belief instilled from how society views parents who use substances, in particular mothers.

Another feature of these interviews that struck me deeply was how sobriety or significant progress in the recovery journey, if achieved, is really just the tip of the iceberg. Many spoke of the abject isolation they now lived in. That while participants drew on protective factors and coping strategies to navigate their way to sobriety and recovery. Having reached this milestone, many now lived a very isolated existence. Sitting opposite someone sharing their lived experience is a humbling, deeply emotional interaction. You can see in the eyes of the person you are interviewing, the pain that often still remains. This is particularly the case when you are hearing repeated traumatic experiences, yet before you also sits someone who has come so far at overcoming these. I was acutely aware and grateful of how privileged I was to be in the position to be allowed to sit and hear these lived experiences, and to bring to light through this research, the reality of this lived world. The key protective role of community services was prolific across all the family participant interviews.

During the grandparent interviews I was struck by one grandparent saying it would be easier for her and the grandchild if the parent wasn't around anymore, and the group nodded in agreement. There was a sense of despair and resignation, an exhausted stakeholder group. Having just completed the parent interviews, their world view was at the forefront of my mind, and I found this a difficult part of the discussion. Yet I understood both group perspectives and could empathise with both. I noted that silent reaction in my journal and ensured that when analysing the interviews that I would not let this influence my interpretations. Similarly, when interviewing the adult children, and hearing directly what it was like growing up with substance misuse, there was a need to again reflect on any interpretations from the parent interviews. These examples highlight how important it is to ensure an ongoing reflexive process is in place. It also highlighted how important it is to gather perspectives from participants other than the person using the substance or the immediate family only. The service provider perspectives in addition to the family level perspectives provided a very comprehensive view of the lived world. Undertaking research with an experiential component like this is an emotional reflexive experience.



To be fully reflexive, I needed to stand back from understandings and views of the world to see how and why interpretations have been made, before documenting full conclusions. Writing things down and reviewing them later, significantly facilitated this process.

The analysis process was the most challenging aspect of this study. At the level of the overall PhD aims and objectives, it was during the analysis process itself that I began to realise how ambitious the scope of the study was, in terms of both its aim to establish prevalence estimates, and exploring phenomenologically 5 stakeholder perspectives, across 37 participants, on the lived experience of both risk and protective factors, across all levels of the child's ecosystem, across children of all ages, and across substance misuse in general. The volume of data collated through the use of multi-perspectives, resulted in data from a higher number of individuals than initially anticipated. Combining the high number of participants with the commitment to IPA level analysis, and in particular to additional complexities of a multi-perspective IPA design, was extremely challenging, as in order not to lose sight of the importance of idiographic findings, findings included both individual and group level analysis, and explored also both convergences and divergences between and within groups and between individuals. As a sole researcher managing this volume of data analysis, I found the process overwhelming at many stages. Multi-perspective IPA analysis is much more complex than traditional IPA analysis (Larkin *et al.* 2018). IPAs idiographic nature centres on the examination in detail of a particular case. For Multi-perspective IPA however, caseness is a multi-layered concept- Any given participant within a multi-perspective study constitutes a case at the personal level. Layered above that however are more complex forms of case, each of which can be conceptualised differently. In addition to this, good IPA analysis requires going beyond the first level description to interpretation. Interpretation plays a central role. Thus, engaging in reflexivity during analysis helped to navigate through the participant's account and my responses to it. Thinking through one's reactions in this way brings to the fore one's assumptions and the mechanisms that construct those assumptions. This often involved revisiting the data and reflecting throughout the analysis process. Sometimes it was important to distance oneself from the data, and then return to it; other times, it was worth seeking another perspective. However, as a result of the commitment and rigour in this research to this demanding analysis, a key strength was that the findings still allowed a rich narrative to emerge, from multiple key stakeholder perspectives, adding important experiential and systemic dimensions to the majority of existing research which has been criticised in the past for de-contextualising and isolating views of key stakeholders to the lived world.

Two additional key strategies that assisted with this process was the availability in IPA of clear guidelines on how to analyse data using the IPA method, and to regularly obtain the support of my supervisors in terms of discussing challenges with data analysis, to check in at times on my interpretations based on the data, and also in terms of self-reflection and self-care from the emotional impact of the study- to debrief as it were.

The final stage involved the writing up of the study. This stage of the process was more enjoyable as it allowed the analysis to come to life through the final written report. However, challenges also arose in relation to distilling the volume of data into a comprehensive study and involved me repeatedly checking that I had each person's perspective captured accurately, and that my interpretations reflected accurately the lived experience.

When using phenomenological research methodology such as IPA, research conclusions rely on a credible and transparent interpretation of participant's accounts (Larkin *et al.* 2018). To achieve this, as a researcher, required being aware of one's positionality in the research, which involves an often difficult analysis of many factors including personal values, beliefs, feelings, motivations, role. By conducting a thorough self-analysis, I endeavoured to become aware of any influences that may affect data collection or analysis. Reflexivity provided an active process by which I was able to take time to understand both myself and the research more fully. This is vital, particularly in interpretative research, as it allows a more rigorous approach, adds quality, offers enhanced credibility and limits bias (Smith *et al.* 2009).

My supervisors were invaluable to navigating my way through this research process. I drew on their expertise both personally and professionally relentlessly throughout the process and without them, I would not have been able to complete this PhD.

Overall, this PhD journey has involved deep personal growth as well as academic improvements. I immersed myself 100% into this process. Despite the challenges I experienced with the IPA multi-perspective methodology, I am very happy with this choice of methodology given the key aims and objectives of this study, which allowed a rich narrative to emerge, from multiple key stakeholder perspectives. I embraced the process and in terms of quality and validity, adhered to the four key principles for assessing the quality and validity of IPA work - sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Smith *et al.* 2009 p. 180).

The PhD required a significant reflexive process which has shaped me both personally, and professionally- a process which I hope has allowed a rich narrative to emerge, from multiple key stakeholder perspectives, adding important experiential and systemic dimensions to the majority of existing research which has been criticised in the past for de-contextualising and isolating views of key stakeholders to the lived world. Reflecting on the journey of this PhD through the experiences of the participants, my next goal is to endeavour that the voices and lived experiences are utilised effectively in shaping the direction of future responses to parental substance misuse and the risk and protective factors for children.

### **9.8 Conclusions: Implications for Policy, Practice and Research**

The findings from this thesis study allowed a rich narrative to emerge from multiple key stakeholder perspectives. Convergences in perspectives between the parent stakeholders, in particular mothers, and the drug treatment service providers were particularly strong and mirror the extant literature (Scott *et al.* 2002, Staton-Tindall *et al.* 2013). While all stakeholders reported risk factors originating in the child's microsystem, in particular the parent child and family setting, in this study, key overarching risks originated outside of the child's microsystem.

A key risk reported, which originates at the macrosystem level, related to the insidious presence of a pervasive stigma, and a narrative that is still predominantly risk focused and pathologizing, contributing to the individualisation of social issues, which inadvertently worsens the situation for children. Furthermore, in this study, it was reported that this stigma and narrative both framed and infiltrated service design and delivery. These findings resonate with other literature in the field (Scott *et al.* 2002, O' Gorman 2016, Giacomello 2020, Comiskey *et al.* 2021). Shifting goals around reunification and recovery milestones and the lack of a voice that parents had in relation to this reunification process, and to the welfare of their child, were also believed to be underpinned in part by this stigma and narrative. This is particularly problematic as a parents engagement with drug treatment was reported as being a key protective factor, across every stakeholder group, for both the parent and the child. These issues manifested further in the child's mesosystem, (which includes interactions between a parent and an alternative caregiver for the child), whereby significant tensions and conflicts were reported, and children often became triangulated in this conflict. Similar findings were reported in the literature (Murnan *et al.* 2020, Smith *et al.* 2002, Scott *et al.* 2008). These findings have implications for policy practice and research. A systemic approach to addressing the significant barrier that this stigma and narrative presents to parents, and in particular mothers, is needed. This stigma impacts on parents' engagement with services, and subsequent recovery (Giacomello 2021). To address

this issue, the author recommends the Monitoring and managing of narrative at media, research and policy levels, similar to recommendations by O’Gorman (2016). Additionally, the author recommends a dedicated policy analysis, building on the work of Flack (2018) and Whitaker *et al.* (2020), to consider the representation of parental drug use in key policy documents, in order to attend to its development as an important site for concern and intervention. Future research is also recommended to explore at a systemic level, ways to consider a state response that is not punitive, a response that provides and resources the supports that the parent and family reported needing. At the service level, professional training is recommended for child and family services in relation to addiction and in particular in relation to achievable goals in terms of reunification of child and parent. It is recommended that this training also incorporates anti-stigma training to raise awareness of the nature of drug-related stigma and how it can manifest in the delivery of services, its consequent impact on the parent and child, and to identify aspects of service delivery where change may be possible. This recommendation builds on previous work and recommendations by Comiskey *et al.* (2021) and Barron *et al.* (2019). The issue of professional training is documented currently in the Hidden Harm initiative, but the content of this training and the processes to monitor implementation and effectiveness of this are needed. Building on this, the author recommends that transparent guidelines and information for families and services on how decisions are made in relation to children, their welfare, protection and care, in the context of agreed thresholds are made available. To ensure consistency and equity across services and systems on the information provided, auditing of this process is recommended.

Whilst it was recognised in the literature and by participants in this study, that both policy and practice have made steps in recognising children of parental substance misuse as one in need of prioritisation (AMCD 2003, United Nations Office on Drugs and Crime 2016), with promising ways of supporting these children being designed and implemented to varying degrees (Velleman & Templeton 2016), significant additional outstanding challenges and risks were reported. The Hidden Harm *inter*-sectoral collaborative systemic change initiative (AMCD 2003, Health Service Executive & Tusla 2019), which is heralded as a key player in responding to children of parental substance misuse, was reported in this thesis by stakeholders as being fraught with significant systemic implementation and resourcing challenges. *Intra* agency issues identified included a lack of data, identification and assessment barriers, lack of understanding of addiction/child needs, resourcing issues, competing priorities, and a lack of national direction. *Interagency* challenges included also financial restrictions and competing priorities, service sector differences in terms of existing implementation support and resources, and perceived

power imbalances between the proposed actors. In particular it was reported that the community and voluntary sector within an Irish context has suffered significant reductions in funding, policy shifts, and restructuring, yet it was these very services that were reported across all stakeholder groups as providing critical protective factors for parents, children and grandparents. These implementation challenges were reported as so significant that ‘even with the everything lined up, logistical realities, competing priorities, and resources, that this level of extensive inter-agency work will require a very streamlined, funded, managed implementation and supervision procedure with clear guidance from a national level that is a priority and a priority that will be properly resourced’.

These findings have significant Implications for policy practice and research. In order to deliver and sustain a lasting impact on the lives of young people and their families, National level direction, resourcing, commitment, and supervision is needed including a comprehensive fully resourced implementation strategy. Similarly, from a review of Hidden Harm, three years on (AMCD 2007), the authors emphasised that clear leadership, cross governmental, and cross sectoral coordination is critical, and that there is a significant problem in terms of securing long term mainstream funding to support work with children and their parents at local level. Thus, the author recommends that at a policy level, the findings in this thesis in relation to the outlined implementation challenges, are reviewed and addressed by policy makers including dedicated and sufficient resourcing of local community and voluntary services, and an examination of the complex relationships of power, access and influence between the different actors involved and ways to address this, to ensure maximum sustainable impact, and to prevent the side-lining of these critical community level protective factors. The adequate resourcing of the community sector was a key focus of recommendations in similar research (O’ Gorman 2016, Offiong *et al.* 2020). The author also recommends that awareness is raised, and information disseminated on age-appropriate disclosure to children. Parents in this study reported a lack of guidance from services, and confusion and conflicting beliefs within families and within themselves as individuals, in relation to what should be told to children in relation to parental substance misuse. From a research perspective, a future recommendation relates to a resourced national level evaluation to monitor implementation and effectiveness of the Hidden Harm initiative. In the following sections we will explore the role of kinship care, and a resilience led approach which incorporates additional implications for policy practice and research.

A key finding in this study related to the significant and multiple risks to children of parental substance misuse as a result of significant challenges for parents, in particular mothers, in

relation to service systems. In relation to this, and the dynamics of power, access and influence alluded to above, similar dynamics were also reported to manifest in a number of cases, in relation to alternative care arrangements for children of parental substance misuse, which in this study was predominantly the grandmother. While the kinship carer role overall was reported as being a key protective factor for the child, complexities inherent in this role presented numerous risks for the child. Grandparents similar to parents reported significant challenges with child service systems, and in many cases, limited capacity to assist child in school settings, and significant challenges with justice systems. Supports for grandparents including financial, and legal, were reported as being extremely limited and impacted by a culture of being taken for granted by services, resulting in differing supports being available for kinship care relative to non-relative carers and differences in supports and status of formal versus informal relative carer was also raised. Many grandparents reported their experience of being in a 'legal twilight zone' (Burns *et al.* 2021), in relation to caring for their grandchildren, which can create all sorts of challenges and risks for the child. It is important to also note here that from the parent's perspective, they viewed this dynamic differently in that for them, it was they the parent, who were being side-lined, dismissed, and had no voice in relation to their own child in these alternative care arrangements. The grandparent often felt powerless in relation to both systems within the state, and the parent, whereas the parent reported the same lived experience but from their standpoint. And in all cases, the child was caught in the middle. The voice of the child however is limited in the literature.

These findings have implications for policy practice and research. The needs of kinship caregivers are distinct from non-relative caregivers for a multitude of reasons, including the conditions under which the children enter kinship care and often, the demographics of the kinship caregivers. At a state level, policymakers need to be aware of the impact parenting grandchildren has on both families and systems related to health and welfare of, children, the aging population, and financial security. A review of existing policies is recommended to establish ways in which kinship care arrangements can be supported including equitable financial, legal and other support when necessary. A number of other authors have also emphasised the need for, and recommendation of policy change in relation to this area (Gair *et al.* 2018, Zuchowski *et al.* 2019, Davis *et al.* 2020, Burns *et al.* 2021). At the service practice level, a key finding from this thesis related to the need for a trauma informed accessible whole family response. This was a recommendation across stakeholder cohorts. Thus, it is recommended that an overall approach of trauma-informed care, to provide the family members with positive support networks and access to resources is implemented. For child

welfare services caseworkers to best partner with kinship caregivers, it is further recommended that specific training is provided child welfare and protection caseworkers in order to understand the unique needs of kinship caregiving families and how best to support these placements. It is also recommended that Kinship caregivers are involved in planning and placement decisions, which require increased collaboration, coordination and contact with child welfare agencies. In relation to future research, in line with recommendations from other authors, research is needed into the views and experiences of children of kinship care. There is currently a limited information base for this particular component in the literature (Mac Donald *et al.* 2016, Burns *et al.* 2021). Additionally, the author of this thesis recommends research which examine the complex relationships of power access and influence between the different actors involved in kinship care practice, and research regarding inclusive decision making in the best interests of the child. This builds on earlier recommendations in relation to both stigma and service response to parental substance misuse and children.

Finally, in terms of protective factors and building resilience, in this thesis study, protective factors, when reported, were reported as either being in existence, being limited or transient, or being aspirational. The key protective factors reported in this thesis which were in existence, were overwhelmingly the community sector services. These included youth clubs, sporting facilities, community drug treatment services, community employment schemes and peer support services for grandparents. The parents' engagement with treatment, and the presence of one good adult were additionally identified as key protectives factor by all stakeholders. Other protective factors included shielding the child from the truth of the parents' substance use. However, there were mixed feelings and confusion in relation to the protective factor of non-disclosure of parental substance misuse, including that despite best efforts, children often knew either way but couldn't discuss it. While the active agency role of the child themselves is evident in the literature as a protective factor, in this thesis study, while it was alluded to in this thesis, only one participant explicitly reported the help-seeking skills, coping skills and temperament of the child as being a protective factor.

There are many important implications for policy practice and research. At a policy level and in line with Velleman & Templeton (2016), the author of this thesis recommends that policy makers lead change by adopting a resilience approach in relation to children of parental substance misuse. Additionally, awareness raising initiatives are needed to make family and service providers aware of the extensive range of protective factors that exist, including the

child's own active agency, and how these can be encouraged. These recommendations mirror those of other authors in the field (Velleman & Templeton 2016, Whittaker *et al.* 2020). The author in this thesis also recommends the mainstreaming of Prevention strategies that focus on increasing protective factors shifting the focus from problems, to developing a child's strength. At practice level, further work is needed to encourage, support, and train professionals to work in a more focused and integrated way, examining the child's needs, within a broader context, with consideration of protective as well as risk factors. Additionally, future research is recommended in two key areas, firstly to explore and examine further practice delivery which has adopted a resilience focus approach, with consideration of multi-perspectives on the impact in the lived experiences of this approach. Secondly, protective factors at the level of the individual require further exploration. The current literature highlights a number of factors at the level of the young person that can mediate the impact of parental substance misuse- these include the young person's own active agency, internal locus of control, personal qualities and social skills, hobbies, talents, own substance use, religious faith, coping skills, intellectual capacity, and achieving a balance between looking after themselves and supporting the parent (Velleman & Templeton 2016). However, the authors highlighted that this area there is limited research with a focus on internal protective characteristics. In this thesis individual level protective factors were significantly under-reported by stakeholders. Accepting such agency by children and young people, and the protective role that this may have for them, is an important addition to understanding this area, and needs to be researched further and incorporated into service models.

In conclusion, the findings from this thesis study allowed a rich narrative to emerge, from multiple key stakeholder perspectives, extending and contextualizing our knowledge of risk and protective factors that influence children of parental substance misuse. Bronfenbrenner's Ecological systems theory was used a conceptual framework as it places the child as central whilst concurrently facilitating the exploration of the influence of different contexts on the child (Bronfenbrenner 1994). Adopting this model helped captured the complexity of influences that impinge upon children of parental substance misuse and avoided adopting a model of parental drug use that locates all risk factors for children of parental substance misuse in the skin of the parent who uses substances (Hogan 1998, Scaife 2008). The findings add important experiential & systemic dimensions to the majority of the existing research which has been criticised in the past for decontextualising and isolating views of key stakeholders (Smith *et al.* 2002, Rostill-Brookes *et al.* 2011, Staton-Tindall *et al.* 2013). Implications for policy practice and research



were articulated. The findings highlight the complexity of the area of children of parental substance misuse and emphasise the need for consideration of protective factors in addition to the risk factors, within a broad ecological framework, to enable the appropriate allocation of resources and interventions. The wellbeing of our children is critical. The child lives in an ecosystem. All levels of this ecosystem contribute to the child's development and outcomes. We all have our part to play in building the children of our future and supporting the families in the best way possible.

## Bibliography

Adamson J. & Templeton L. (2012) Silent voices: Supporting children and young people affected by parental alcohol misuse.

Advisory Council on the Misuse of Drugs (2003) *Hidden harm: Responding to the needs of children of problem drug users*. Home Office London.

Advisory Council on the Misuse of Drugs (ACMD), (200). *Hidden harm three years on: Realities, challenges and opportunities*. Home Office London

Ahmed A. & Sil R. (2012) When multi-method research subverts methodological pluralism—or, why we still need single-method research. *Perspectives on Politics*, 935-953.

Ainsworth F. & Berger J. (2014) Family inclusive child protection practice: The history of the family inclusion network and beyond. *Children Australia* **39**(2), 60.

Alexander C. (2015) The Runnymede School Report: Race, Education and Inequality in Contemporary Britain.

Alison L. (2000) What are the risks to children of parental substance misuse. *Substance Misuse and Child Care: How to Understand, Assist and Intervene when Drugs Affect Parenting*, Lyme Regis, Russell House Publishing.

American Psychological Association (2014) *The road to resilience*. Washington, DC: American Psychological Association.

Ammerman R.T., Kolko D.J., Kirisci L., Blackson T.C. & Dawes M.A. (1999) Child abuse potential in parents with histories of substance use disorder. *Child abuse & neglect* **23**(12), 1225-1238.

Anguera M.T., Blanco-Villaseñor A., Losada J.L., Sánchez-Algarra P. & Onwuegbuzie A.J. (2018) Revisiting the difference between mixed methods and multimethods: Is it all in the name? *Quality & Quantity* **52**(6), 2757-2770.

- Anthony E.J. & Cohler B.J. (1987) *The invulnerable child*. Guilford Press.
- Australian Institute of Health and Welfare (2017) *Child Protection Australia 2015–16*. Australian Institute of Health and Welfare, Canberra. Retrieved from <https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2015-16/contents/table-of-contents> on 24.05.2021.
- Backett-Milburn K., Wilson S., Bancroft A. & Cunningham-Burley S. (2008) Challenging Childhoods: Young people's accounts of getting by in families with substance use problems. *Childhood* **15**(4), 461-479.
- Backhouse J. & Graham A. (2012) Grandparents raising grandchildren: Negotiating the complexities of role-identity conflict. *Child & Family Social Work* **17**(3), 306-315.
- Bailey S.J., Letiecq B.L. & Porterfield F. (2009) Family coping and adaptation among grandparents rearing grandchildren. *Journal of Intergenerational Relationships* **7**(2-3), 144-158.
- Bancroft A. (2004) *Parental drug and alcohol misuse: Resilience and transition among young people*. Joseph Rowntree Foundation.
- Barnard M. (2007) *Drug Addiction and Families*. Jessica Kingsley Publishers.
- Barnard M. & Bain C. (2015) Resisting your good intentions: substance-misusing parents and early intervention to support and monitor children in need. *Child & Family Social Work* **20**(2), 171-180.
- Barnard M. & Barlow J. (2003) Discovering parental drug dependence: silence and disclosure 1. *Children & Society* **17**(1), 45-56.
- Barnard M. & McKeganey N. (2004) The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction* **99**(5), 552-559.
- Barron-McKeagney T., Woody J.D. & D'Souza H.J. (2002) Mentoring at-risk Latino children and their parents: Analysis of the parent-child relationship and family strength. *Families in Society* **83**(3), 285-292.
- Bernays S. & Houmøller K. (2011) See me, not just the problem: Hiding, telling and coping with a difficult family life.
- Bloor M. & McIntosh J. (1990) Surveillance and Concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting. In *Readings in Medical Sociology*, Routledge, London.

Boetto H. (2010) Kinship care: A review of issues. *Family Matters* (85), 60.

Brewer J. & Hunter A. (2006) *Foundations of multimethod research: Synthesizing styles*. Sage.

Bronfenbrenner U. (1979) *The ecology of human development: Experiments by nature and design*. Harvard university press.

Bronfenbrenner, U. (1986) Ecology of the family as a context for human development: research perspectives. *Developmental Psychology*. 22(6), 723 - 742.

Bronfenbrenner, U. (1989) Ecological systems theory. In *Annals of Child Development*. (Vasta, R. ed), JAI Press, Greenwich, Vol. 6, pp. 187– 249.

Bronfenbrenner U. (1993) The ecology of cognitive development: Research models and fugitive findings. *Development in context: Acting and thinking in specific environments* **3**, 46.

Bronfenbrenner, U. and Ceci, S.J. (1994) Nature-nurture reconceptualized in developmental perspective: A bioecological model. *Psychological Review*. 101 (4), 568 - 586.

Bronfenbrenner U. (2009) *The ecology of human development*. Harvard University Press, Cambridge.

Bronfenbrenner U., Morris P.A., Damon W. & Lerner R.M. (2006) Handbook of child psychology. *The ecology of developmental process*. Wiley Publishers.

Brookoff D., O'Brien K.K., Cook C.S., Thompson T.D. & Williams C. (1997) Characteristics of participants in domestic violence: Assessment at the scene of domestic assault. *Jama* **277**(17), 1369-1373.

Brooks C.S. & Rice K.F. (1997) *Families in recovery: Coming full circle*. Paul H Brookes Publishing Company.

Buckley H. (2017) Service users as receivers of risk-dominated practice. *Beyond the risk paradigm in child protection*, 77-90.

Bulpitt, H. and Martin, P.J. (2010) Who am I and what am I doing? *Nurse Researcher*. 17(3), 7 - 16.

Burns K., O' Mahony C., & Brennan R. (2021) Private family arrangements for children in Ireland: The informal space between state care and the family home. *British Journal of Social Work* **00**, 1-18

Bush T. (2012) Authenticity in Research: Reliability, Validity and Triangulation. *Research methods in educational leadership and management*, 175.

Camara M., Bacigalupe G. & Padilla P. (2017) The role of social support in adolescents: are you helping me or stressing me out? *International Journal of Adolescence and Youth* **22**(2), 123-136.

Carrà G., Crocamo C., Borrelli P., Tabacchi T., Bartoli F., Popa I., Montomoli C. & Clerici M. (2017) Area-level deprivation and adverse consequences in people with substance use disorders: findings from the psychiatric and addictive dual disorder in Italy (PADDI) study. *Substance Use & Misuse* **52**(4), 451-458.

Central Statistics Office (2011) CSO Online Database: 2011 Census Data.

Chaffin M., Kelleher K. & Hollenberg J. (1996) Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child abuse & neglect* **20**(3), 191-203.

Cleaver H. & Unell I. (2011) *Children's needs-parenting capacity: child abuse, parental mental illness, learning disability, substance misuse, and domestic violence*. The Stationery Office.

Cleaver H., Unell I. & Aldgate J. (1999) *Children's needs: Parenting capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*. Stationery Office London.

Comiskey C. (2019) *Addiction debates: Hot topics from policy to practice*. SAGE.

Comiskey C., Kelly P., Leckey Y., McCullough L., O'duill B., Stapleton R. & White E. (2009) *The ROSIE study: Drug treatment outcomes in Ireland*. Stationery Office.

Conners N.A., Bradley R.H., Mansell L.W., Liu J.Y., Roberts T.J., Burgdorf K. & Herrell J.M. (2003) Children of mothers with serious substance abuse problems: An accumulation of risks. *The American Journal of Drug and Alcohol Abuse* **29**(4), 743-758.

Connolly M., Kiraly M., McCrae L. & Mitchell G. (2017) A kinship care practice framework: Using a life course approach. *The British Journal of Social Work* **47**(1), 87-105.

Connor S. (2006) Grandparents raising grandchildren: Formation, disruption and intergenerational transmission of attachment. *Australian Social Work* **59**(2), 172-184.

Corbett V. (2005) 'I Just Knew to Keep it Quiet...' Living with Parental Problematic Substance Use. *Adoption & Fostering* **29**(1), 98-100.

Council on the Ageing (2010) Listening to grandparents: Report of the NSW Grandparenting Forum. NSW Ministerial Advisory Committee on Ageing Sydney.

Cox C. (2014) Personal and community empowerment for grandparent caregivers. *Journal of Family Social Work* **17**(2), 162-174.

Creswell J.W. (2007) *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Daley D.C., Smith E., Balogh D. & Toscaloni J. (2018) Forgotten but not gone: The impact of the opioid epidemic and other substance use disorders on families and children. *Commonwealth* **20**(2-3).

Dallos R. & Denford S. (2008) A qualitative exploration of relationship and attachment themes in families with an eating disorder. *Clinical Child Psychology and Psychiatry* **13**(2), 305-322.

Daniel B. & Wassell S. (2002) *Adolescence: Assessing and promoting resilience in vulnerable children* 3. Jessica Kingsley Publishers.

Davis M.T., Warfield M.E., Boguslaw J., Roundtree-Swain D. & Kellogg G. (2020) Parenting a 6-year old is not what I planned in retirement: trauma and stress among grandparents due to the opioid crisis. *Journal of gerontological social work* **63**(4), 295-315.

Dawe S., Harnett P. & Frye S. (2008) Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do.

DeHart G.B., Sroufe L.A. & Cooper R.G. (2000) *Child development: Its nature and course*. McGraw-Hill.

Department of Children and Youth Affairs (2014) *The national policy framework for children and young people 2014–2020*. Retrieved from <https://www.gov.ie/en/publication/775847-better-outcomes-brighter-futures/> on 17.05.21.

Department of Community Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009-2016*, Ireland. Retrieved from <http://www.webcitation.org/6CI0GNiVD> on 17.05.21.

Department of Health (2000) *Framework for the Assessment of Children in Need and Their Families. Guidance Notes and Glossary for: Referral and Initial Information Record, Initial Assessment Record and Core Assessment Record*. The Stationery Office London.

Department of Health (2017) *Reducing Harm, Supporting Recovery 2017-2025*. The Stationery Office London, Dublin, Ireland. Retrieved from <https://www.gov.ie/en/publication/4e5630-reducing-harm-supporting-recovery-2017-2025/> on 17.05.21.

- Dilthey W. (1976) The development of hermeneutics. *W. Dilthey: Selected*, 161.
- Dooley, B. & Fitzgerald, A. (2012) My World Survey 1: The National Study of Youth Mental Health in Ireland. Jigsaw and UCD School of Psychology.
- Drew L.M. & Silverstein M. (2007) Grandparents' psychological well-being after loss of contact with their grandchildren. *Journal of family psychology* **21**(3), 372.
- Eatough V. & Smith J.A. (2006) I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice* **79**(1), 115-135.
- Esteves J. & Pastor J. (2004) Using a multimethod approach to research enterprise systems implementations. *Electronic journal of business research methods* **2**(2), 69-82.
- European Monitoring Centre for Drugs and Drug Addiction (2015) *European drug report 2018: trends and developments*. Office for Official Publications of the European Communities.
- European Union Institutions B., Offices and Agencies, (2017) *EU Action Plan on Drugs 2017-2020*. Retrieved from [https://www.drugsandalcohol.ie/27680/1/http\\_eur-lex.europa.eu\\_EU\\_Action\\_plan\\_on\\_drugs.pdf](https://www.drugsandalcohol.ie/27680/1/http_eur-lex.europa.eu_EU_Action_plan_on_drugs.pdf) on 17.05.21.
- Executive Office of the President of the United States (2010) *National Drug Control Strategy*, The White House. Retrieved from <https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/ndcs2010.pdf> on 17.05.21.
- Executive Office of the President of the United States (2016) *National Drug Control Strategy*, The White House. Retrieved from [https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/2016\\_ndcs\\_final\\_report.pdf](https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/2016_ndcs_final_report.pdf) on 17.05.21.
- Facchin F. & Margola D. (2016) Researching lived experience of drugs and crime: A phenomenological study of drug-dependent inmates. *Qualitative health research* **26**(12), 1627-1637.
- Famularo R., Kinscherff R. & Fenton T. (1992) Parental substance abuse and the nature of child maltreatment. *Child abuse & neglect* **16**(4), 475-483.
- Farrell A.D. & White K.S. (1998) Peer influences and drug use among urban adolescents: Family structure and parent-adolescent relationship as protective factors. *Journal of consulting and clinical psychology* **66**(2), 248.

Featherstone B., Morris K. & White S. (2014) *Re-imagining child protection: Towards humane social work with families*. Policy Press.

Fernandez E. (2014) Child protection and vulnerable families: Trends and issues in the Australian context. *Social Sciences* **3**(4), 785-808.

Ferrari R. (2015) Writing narrative style literature reviews. *Medical Writing* **24**(4), 230-235.

Finlay L. (2008) A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of phenomenological psychology* **39**(1), 1-32.

Finlay L. (2011) *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Fisher R. & Hutton-Baas T. (2017) Supporting grandparent/grandchild contact under the Care of Children Act 2004: Assessment and a call for change. *Aotearoa New Zealand Social Work* **29**(3), 30-41.

Flacks S. (2019) Dangerous drugs, dangerous mothers: Gender, responsibility and the problematisation of parental substance use. *Critical Social Policy* **39**(3), 477-497.

Flores P.J. (2001) Addiction as an attachment disorder: Implications for group therapy. *International journal of group psychotherapy* **51**(1: Special issue), 63-81.

Forrester D. & 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), 325-335.

Forrester D. & Harwin J. (2011) *Parents who misuse drugs and alcohol: Effective interventions in social work and child protection*. 30. John Wiley & Sons.

Foster C.E., Horwitz A., Thomas A., Opperman K., Gipson P., Burnside A., Stone D.M. & King C.A. (2017) Connectedness to family, school, peers, and community in socially vulnerable adolescents. *Children and Youth Services Review* **81**, 321-331.

Foucault M. (1980) The eye of power in 'power/knowledge'. *Harvester: C. Gordon and Brighton*.

Fraser C., McIntyre A. & 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), 846-866.

Gair S. (2017) Missing grandchildren: Grandparents' lost contact and implications for social work. *Australian Social Work* **70**(3), 263-275.

Gair S., Zuchowski I., Munns L., Thorpe R. & Henderson D. (2018) Grandparents matter: Optimizing grandparents' involvement after child safety concerns. *Child & Family Social Work* **23**(4), 684-692.

Gair S., Zuchowski I., Thorpe R., Henderson D. & Munns L. (2019) 'In the Firing Line': Grandparent Carers at Risk of Family Violence. *Journal of family violence* **34**(4), 321-329.

Galligan K. & Comiskey C. (2017) *Estimating the number of children of parents who misuse substances, including alcohol across the communities of the Tallaght Drug and Alcohol Task Force (TDATF) region, Dublin, Ireland*. Retrieved from [https://www.drugsandalcohol.ie/29251/1/Estimating\\_the\\_number\\_of\\_children\\_of\\_parents\\_who-misuse-substances.pdf](https://www.drugsandalcohol.ie/29251/1/Estimating_the_number_of_children_of_parents_who-misuse-substances.pdf) on 24.05.2021.

Galligan K. & Comiskey C.M. (2019) Hidden harms and the number of children whose parents misuse substances: A stepwise methodological framework for estimating prevalence. *Substance Use & Misuse* **54**(9), 1429-1437.

Garfinkel H. (1967) *Studies in ethnomethodology*. Englewood cliffs. Y.: *Prentice-Hall*.

Garnezy N. (1974) *The study of competence in children at risk for severe psychopathology*.

Garnezy N.E. & Rutter M.E. (1983) *Stress, coping, and development in children*. Seminar on Stress and Coping in Children, 1979, Ctr for Advanced Study in the Behavioral Sciences, Stanford, CA, US. Johns Hopkins University Press.

Giacomello C. (2021) *Children whose parents use drugs: a preliminary assessment and proposals*. Retrieved from <https://www.coe.int/en/web/pompidou/childrenv>, Italy 30.04.2022

Giorgi A. (2010) Phenomenology and the practice of science. *Existential Analysis: Journal of the Society for Existential Analysis* **21**(1).

Gladstone J.W., Fitzgerald K.-A.J. & Brown R.A. (2013) Social workers' use of power in relationships with grandparents in child welfare settings. *British Journal of Social Work* **43**(6), 1073-1091.

Glaser G. & Strauss L. (1967) *The discovery of grounded theory: strategies for qualitative research*. New York, *Adline de Gruyter*.

Government of Ireland (2001) *Ireland's National Drugs Strategy 2001-2008*. Stationery Office Ireland



- Grant M.J. & Booth A. (2009) A typology of reviews: an analysis of 14 review types and associated methodologies. *Health information & libraries journal* **26**(2), 91-108.
- Harbin F. & Murphy M. (2000) *Substance Misuse and Child Care: How to Understand, Assist and Intervene when Drugs Affect Parenting*. Russell House, Lyme Regis.
- Hay G., Gannon M. & McKeganey N. (2005) Estimating the number of children affected by parental substance misuse in Glasgow. *Centre for Drug Misuse Research: University of Glasgow*.
- Health Service Executive & TUSLA (2017) *Hidden Harm Strategic Statement: Seeing Through Hidden Harm to Brighter Futures*. Health Service Executive & TUSLA. Retrieved from [www.hse.ie](http://www.hse.ie) on 17.05.21.
- Health Service Executive & TUSLA (2019) *Hidden Harm Strategic A Practical Guide: Seeing Through Hidden Harm to Brighter Futures*. Health Service Executive & TUSLA. Retrieved from [www.hse.ie](http://www.hse.ie) on 17.05.21.
- Hefferon K. & Gil-Rodriguez E. (2011) Interpretative phenomenological analysis. *The psychologist*.
- Herlofson K. & Hagestad G.O. (2012) Transformations in the role of grandparents across welfare states. *Contemporary grandparenting: Changing family relationships in global contexts*, 27-50.
- Hidden Harm National Steering Group (2015) *Seeing through hidden harm to brighter futures*. The Hidden Harm Project, Dublin:.
- Hill L.C. (2012) Revealing lives: a qualitative study with children and young people affected by parental alcohol problems.
- Hill S.Y., Tessner K.D. & McDermott M.D. (2011) Psychopathology in offspring from families of alcohol dependent female probands: a prospective study. *Journal of psychiatric research* **45**(3), 285-294.
- Hogan D. (1997) *The social and psychological needs of children of drug users*. Dublin: Children's Research Centre, Trinity College.
- Hogan D. & Higgins L. (2001) Children's exposure to drug-use: Concerns of drugusing and non-drug-using parents. *Understanding Children: Changing Experiences and Family Forms*, 119-144.

Hogan D.M. (1998) Annotation: The psychological development and welfare of children of opiate and cocaine users: Review and research needs. *Journal of Child Psychology and Psychiatry* **39**(5), 609-620.

Hollywood E.M. (2020) Children who live in disadvantaged areas: a case study of the health and well-being related perceptions and experiences of school-aged children and their families.

Horgan J. (2011) *Parental Substance Misuse: Addressing Its Impact on Children: Key Messages and Recommendations from a Review of the Literature*. Stationery Office. Retrieved from <https://www.drugsandalcohol.ie/16114/> on 17.05.21.

Houmøller K., Bernays S., Wilson S. & Rhodes T. (2011) Juggling harms: Coping with parental substance misuse.

Houston S. & Mullan-Jensen C. (2012) Towards depth and width in qualitative social work: Aligning interpretative phenomenological analysis with the theory of social domains. *Qualitative Social Work* **11**(3), 266-281.

Howe D. (1999) *Attachment theory, child maltreatment and family support: A practice and assessment model*. Macmillan international higher education.

Hunter A. & Brewer J.D. (2015) Designing multimethod research. In *The Oxford handbook of multimethod and mixed methods research inquiry*.

Huxley A. & Foulger S. (2008) Parents who misuse substances: Implications for parenting practices and treatment seeking behaviour. *Drugs and Alcohol Today*.

Hyslop I. (2017) Child protection in New Zealand: A history of the future. *British Journal of Social Work* **47**(6), 1800-1817.

Ipsos M. (2011) *General population survey on drug prevalence 2010*. 2011. Technical Report.

Irizarry C., Miller K. & Bowden M. (2016) Kinship care: Child safety or easy option? Staff and carers' perspectives. *Journal of Family Social Work* **19**(3), 199-219.

Ivec M., Braithwaite V. & Harris N. (2012) "Resetting the relationship" in Indigenous child protection: Public hope and private reality. *Law & Policy* **34**(1), 80-103.

Jaffee S.R. (2007) Sensitive, stimulating caregiving predicts cognitive and behavioral resilience in neurodevelopmentally at-risk infants. *Development and Psychopathology* **19**(3), 631.

Jansson K. (2007) *British Crime Survey-measuring crime for 25 years*. Citeseer.

Jaudes P.K., Ekwo E. & Van Voorhis J. (1995) Association of drug abuse and child abuse. *Child abuse & neglect* **19**(9), 1065-1075.

Johnson J.L. & Leff M. (1999) Children of substance abusers: Overview of research findings. *Pediatrics* **103**(Supplement 2), 1085-1099.

Kearney F. (2017) 'Voices of a sample of Irish young people affected by parental substance misuse and parents with a substance misuse issue: Uncovering harm and system fragmentation. Dublin City University.

Klee H. (1998) Drug-using parents: analysing the stereotypes. *International Journal of Drug Policy* **9**(6), 437-448.

Kroll B. (2004) Living with an elephant: Growing up with parental substance misuse. *Child & Family Social Work* **9**(2), 129-140.

Kroll B. & Taylor A. (2003) *Parental Substance Misuse and Child Welfare*. Jessica Kingsley Publishers.

Kumpfer K.L. (1999) Outcome measures of interventions in the study of children of substance-abusing parents. *Pediatrics* **103**(Supplement 2), 1128-1128.

Kvale, S. (2006) Dominance through interviews and dialogues. *Qualitative Inquiry*. **12**, 480 - 500.

Kvale S. (2007) Analyzing interviews. *Doing interviews*, 102-120.

Laming H.B. (2009) *The protection of children in England: A progress report*. 330. The Stationery Office.

Lander L., Howsare J. & Byrne M. (2013) The impact of substance use disorders on families and children: from theory to practice. *Social work in public health* **28**(3-4), 194-205.

Larkin M., Shaw R. & Flowers P. (2019) Multiperspectival designs and processes in interpretative phenomenological analysis research. *Qualitative Research in Psychology* **16**(2), 182-198.

Larkin M., Watts S. & Clifton E. (2006) Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology* **3**(2), 102-120.

- Letiecq B.L., Bailey S.J. & Kurtz M.A. (2008) Depression among rural Native American and European American grandparents rearing their grandchildren. *Journal of family Issues* **29**(3), 334-356.
- Levenson J. (2017) Trauma-informed social work practice. *Social Work* **62**(2), 105-113.
- Long M. & Sephton R. (2011) Rethinking the “best interests” of the child: Voices from Aboriginal child and family welfare practitioners. *Australian Social Work* **64**(1), 96-112.
- Lonne B., Harries M., Featherstone B. & Gray M. (2016) *Working Ethically in Child Protection*. Routledge.
- MacDonald M., Hayes D. & Houston S. (2018) Understanding informal kinship care: a critical narrative review of theory and research. *Families, Relationships and Societies* **7**(1), 71-87.
- Magura S. & Laudet A.B. (1996) Parental substance abuse and child maltreatment: Review and implications for intervention. *Children and Youth Services Review* **18**(3), 193-220.
- Manning V. (2011) Estimates of the numbers of infants (under the age of one year) living with substance misusing parents. *London: NSPCC*.
- Manning V., Best D.W., Faulkner N. & 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), 1-12.
- Masten A.S. (1994) Resilience in individual development: Successful adaptation despite risk and adversity: Challenges and prospects. In *Educational resilience in inner city America: Challenges and prospects*, Lawrence Erlbaum, pp. 3-25.
- McKellar S. & Coggans N. (1997) Responding to family problems, alcohol and substance misuse: a survey of service provision in the Glasgow area. *Children & Society* **11**(1), 53-59.
- McLaughlin A., O’Neill T., McCartan C., Percy A., McCann M., Perra O. & Higgins K. (2015) Parental Alcohol Use and Resilience in Young People in Northern Ireland: A study of family, peer and school processes. *Policy* **12**, 13.
- Moe J., Johnson J.L. & Wade W. (2007) Resilience in children of substance users: In their own words. *Substance Use & Misuse* **42**(2-3), 381-398.
- Morse J.M. (2003) A review committee's guide for evaluating qualitative proposals. *Qualitative health research* **13**(6), 833-851.

Moustakas C. (1994) *Phenomenological research methods*. Sage publications.

Munn Z., Peters M.D., Stern C., Tufanaru C., McArthur A. & Aromataris E. (2018) Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC medical research methodology* **18**(1), 1-7.

Murnan A. & Ferber M.F. (2020) Familial Influences on Treatment and Substance Use Among Mothers Engaged in Prostitution. *Family Relations*.

National Advisory Committee on Drugs (2011) Drug Use in Ireland and Northern Ireland: 2010/2011 Drug Prevalence Survey, Dublin.

National Advisory Committee on Drugs & Cox G. (2003) *Approaches to estimating drug prevalence in Ireland: an overview of methods and data sources*. Stationery Office, Dublin. Retrieved from <https://www.drugsandalcohol.ie/5438/> on 24.05.21.

National Drug Treatment Reporting System (2015) Prevalence Data.

Newman T. (2002) Promoting Resilience. *Centre for Evidence Based Social Services*.

Noble-Carr D., Barker J., McArthur M. & Woodman E. (2014) Improving practice: The importance of connections in establishing positive identity and meaning in the lives of vulnerable young people. *Children and Youth Services Review* **47**, 389-396.

O'Connor L., Forrester D., Holland S. & Williams A. (2014) Perspectives on children's experiences in families with parental substance misuse and child protection interventions. *Children and Youth Services Review* **38**, 66-74.

O'Gorman A. (2016) Chillin, buzzin, getting mangled, and coming down: Doing differentiated normalisation in risk environments. *Drugs: Education, Prevention and Policy* **23**(3), 247-254.

O'Leary M. & Butler S. (2015) Caring for grandchildren in kinship care: what difficulties face Irish grandparents with drug-dependent children? *Journal of Social Work Practice in the Addictions* **15**(4), 352-372.

Offiong A., Powell T.W., Lewis Q., Smith B. & Prioleau M. (2020) "I missed open arms": The need for connectedness among Black youth affected by parental drug use. *Children and Youth Services Review* **114**, 105072.

Onwuegbuzie, A., Collins, K., and Frels, R. (2013) Using Bronfenbrenner's ecological systems theory to frame quantitative, qualitative and mixed research. *International Journal of Multiple Research Approaches*. 7(1), 2 - 8.

- Ostaszewski K. & Zimmerman M.A. (2006) The effects of cumulative risks and promotive factors on urban adolescent alcohol and other drug use: A longitudinal study of resiliency. *American journal of community psychology* **38**(3), 237-249.
- Padgett, D. K. (2017) *Qualitative Methods in Social Work Research*. Sage, London and Singapore.
- Park S. & Schepp K.G. (2015) A systematic review of research on children of alcoholics: Their inherent resilience and vulnerability. *Journal of Child and Family Studies* **24**(5), 1222-1231.
- Polit D.F. & Beck C.T. (2008) *Nursing research: Generating and assessing evidence for nursing practice*. Lippincott Williams & Wilkins.
- Price-Robertson R., Obradovic A. & Morgan B. (2017) Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health* **15**(2), 108-120.
- Queensland Child Protection Commission of Inquiry & Carmody T.F. (2013) *Taking responsibility: A roadmap for Queensland child protection*. Queensland Child Protection Commission of Inquiry.
- Reid K., Flowers P. & Larkin M. (2005) Exploring lived experience. *The psychologist*.
- Rigby E., Gair S. & Thorpe R. (2016) Surviving intervention: Grandparents' struggle to maintain relationships with their grandchildren following contact with child protection services. *Children Australia* **41**(2), 98.
- Ronel N. & Levy-Cahana M. (2011) Growing-up with a substance-dependent parent: Development of subjective risk and protective factors. *Substance Use & Misuse* **46**(5), 608-619.
- Rostill-Brookes H., Larkin M., Toms A. & Churchman C. (2011) A shared experience of fragmentation: Making sense of foster placement breakdown. *Clinical Child Psychology and Psychiatry* **16**(1), 103-127.
- Rubin H.J. & Rubin I.S. (2011) *Qualitative interviewing: The art of hearing data*. sage.
- Rutter M. (1985) Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *The British journal of psychiatry* **147**(6), 598-611.
- Rutter M. (1987) Psychosocial resilience and protective mechanisms. *American journal of orthopsychiatry* **57**(3), 316-331.
- Rutter M. (1999) Resilience concepts and findings: Implications for family therapy. *Journal of family therapy* **21**(2), 119-144.

Sameroff A.J., Seifer R., Barocas R., Zax M. & Greenspan S. (1987) Intelligence quotient scores of 4-year-old children: Social-environmental risk factors. *Pediatrics* **79**(3), 343-350.

Saunders H. & Selwyn J. (2008) Supporting informal kinship care. *Adoption & Fostering* **32**(2), 31-42.

Scaife V.H. (2008) Maternal and paternal drug misuse and outcomes for children: Identifying risk and protective factors. *Children & Society* **22**(1), 53-62.

Schaeffer C.M., Swenson C.C., Penman J.E. & Tuten L.M. (2014) Implementing Reinforcement-Based Treatment (RBT) for substance use disorders within child protective service systems in Europe. *International Journal of Prevention and Treatment of Substance Use Disorders* **1**(2), 38-52.

Schneiders J., Drukker M., Ende J.v.d., Verhulst F.C., Os J.v. & Nicolson N.A. (2003) Neighbourhood socioeconomic disadvantage and behavioural problems from late childhood into early adolescence. *Journal of Epidemiology & Community Health* **57**, 699–703.

Scott A.L., Pope K., Quick D., Aitken B. & Parkinson A. (2018) What does “recovery” from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress. *Children and Youth Services Review* **87**, 95-102.

Shaw R.L. (2011) Women's experiential journey toward voluntary childlessness: An interpretative phenomenological analysis. *Journal of community & applied social psychology* **21**(2), 151-163.

Sheran M. & Swann C.A. (2007) The take-up of cash assistance among private kinship care families. *Children and Youth Services Review* **29**(8), 973-987.

Shinebourne P. (2011) The Theoretical Underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis* **22**(1).

Singer M. (2006) A dose of drugs, a touch of violence, a case of AIDS, part 2: Further conceptualizing the SAVA syndemic. *Free Inquiry in Creative Sociology* **34**(1), 39-54.

Smith J.A. (1996) Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and health* **11**(2), 261-271.

Smith J.A. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology* **1**(1), 39-54.

- Smith J.A. (2007) Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on health and Well-being* **2**(1), 3-11.
- Smith J.A. (2010) Interpretative phenomenological analysis: A reply to Amedeo Giorgi. *Existential analysis* **21**(2), 186-193.
- Smith J.A. (2011a) Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review* **5**(1), 9-27.
- Smith J.A. (2011b) Evaluating the contribution of interpretative phenomenological analysis: A reply to the commentaries and further development of criteria. *Health psychology review* **5**(1), 55-61.
- Smith J.A., Flowers P. & Larkin M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*. London.
- Smith J.A. & Osborn M. (2003) *Qualitative psychology: A practical guide to research methods*. Sage Publications, Inc.
- Smith N. (2002) Reunifying families affected by maternal substance abuse: Consumer and service provider perspectives on the obstacles and the need for change. *Journal of Social Work Practice in the Addictions* **2**(1), 33-53.
- Social Survey Division of the Office for National Statistics (2001) *Psychiatric morbidity among adults living in private households, 2000*. Department of Health, The Scottish Executive,
- National Assembly for Wales,, London: The Stationery Office. Retrieved from <http://doc.ukdataservice.ac.uk/doc/4653/mrdoc/pdf/4653userguide2.pdf> on 25.05.21.
- Staton-Tindall M., Sprang G., Clark J., Walker R. & Craig C.D. (2013) Caregiver substance use and child outcomes: A systematic review. *Journal of Social Work Practice in the Addictions* **13**(1), 6-31.
- Steiner R.J., Sheremenko G., Lesesne C., Dittus P.J., Sieving R.E. & Ethier K.A. (2019) Adolescent connectedness and adult health outcomes. *Pediatrics* **144**(1).
- Strauss A. & Corbin J.M. (1997) *Grounded theory in practice*. Sage.
- Tarrant A., Featherstone B., O'dell L. & Fraser C. (2017) "You try to keep a brave face on but inside you are in bits": Grandparent experiences of engaging with professionals in Children's Services. *Qualitative Social Work* **16**(3), 351-366.



Tashakkori A. & Teddlie C. (2003) Issues and dilemmas in teaching research methods courses in social and behavioural sciences: US perspective. *International journal of social research methodology* **6**(1), 61-77.

Taylor A., Toner P., Templeton L. & Velleman R. (2008) Parental alcohol misuse in complex families: The implications for engagement. *British Journal of Social Work* **38**(5), 843-864.

Templeton L. (2013) *Building Resilience and Reducing Risks in Children Affected by Serious Untreated Parental Mental Illness, Problematic Substance Use and Domestic Violence*. Retrieved from <https://www.clwk.ca/wp-content/uploads/buddyshared/Building-Resilience-and-Reducing-Risks-Literature-Review-Final-7-October-2013.pdf> on 25.05.21.

Templeton L., Zohhadi S., Galvani S. & Velleman R. (2006) Looking Beyond Risk”: Parental substance misuse, a scoping study. Final report to the Scottish Executive. *Substance Misuse Research Team*.

Testa M.F. & Smith B. (2009) Prevention and drug treatment. *The Future of Children*, 147-168.

Thorpe R. & Ramsden K. (2014) Resourceful friends: An invaluable dimension in family inclusive child protection practice. *Children Australia* **39**, 65-73.

Tobin K. & Ritchie S.M. (2012) Multi-method, multi-theoretical, multi-level research in the learning sciences. *Asia-Pacific Education Researcher* **21**(1).

Todorova I. (2011) Explorations with interpretative phenomenological analysis in different socio-cultural contexts: Commentary on J. Smith: ‘Evaluating the contribution of interpretative phenomenological analysis’. *Health psychology review* **5**(1), 34-38.

Tufford L. & Newman P. (2012) Bracketing in qualitative research. *Qualitative Social Work* **11**(1), 80-96.

Tuffour I (2017) A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *J Healthc Commun*. Vol. **2** No. 4:52

United Nations Children's Fund (1999) United Nations Convention on the Rights of the Child, 1989. *Geneva, Switzerland: UNICEF*.

United Nations Office on Drugs and Crime (2016) *World Drug Report*, New York. Retrieved from [https://www.unodc.org/doc/wdr2016/WORLD\\_DRUG\\_REPORT\\_2016\\_web.pdf](https://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf) on 17.05.21.

United Nations Office on Drugs and Crime (2018) *World Drug Report*, New York. Retrieved from <https://www.unodc.org/wdr2018/> on 17.05.21.

Unrau Y.A., Seita J.R. & Putney K.S. (2008) Former foster youth remember multiple placement moves: A journey of loss and hope. *Children and Youth Services Review* **30**(11), 1256-1266.

Valentine K., Jenkins B., Brennan D. & Cass B. (2013) Information provision to grandparent kinship carers: Responding to their unique needs. *Australian Social Work* **66**(3), 425-439.

Van Manen M. (1990) Beyond assumptions: Shifting the limits of action research. *Theory into practice* **29**(3), 152-157.

Velleman R. & Orford J. (1999) *Risk and Resilience: Adults who Were the Children of Problem Drinkers*. Psychology Press.

Velleman R. & Templeton L. (2007) Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric treatment* **13**(2), 79-89.

Velleman R., Templeton L., Taylor A. & Toner P. (2003) Evaluation of the Pilot Family Alcohol Service: Final Report. *Report to the Camelot Foundation*.

Velleman R. & Templeton L.J. (2016) Impact of parents' substance misuse on children: An update. *BJPsych Advances* **22**(2), 108-117.

Wakefield A. (2014) Searching and critiquing the research literature. *Nursing Standard (2014+)* **28**(39), 49.

Werner E.E. (1986) Resilient offspring of alcoholics: a longitudinal study from birth to age 18. *Journal of studies on alcohol* **47**(1), 34-40.

Werner E.E. (1989) High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American journal of orthopsychiatry* **59**(1), 72-81.

Whittaker, A., Martin, F., Olsen, A. and Wincup, E (2020). Governing Parental Drug Use in the UK: What's Hidden in "Hidden Harm?". *Contemporary Drug Problems*, **47**(3), pp.170-187.

Willig C (2008) *Introducing qualitative research in psychology (2nd edn.)*. Open University Press, UK

Wilson K., Sinclair I. & Gibbs I. (2000) The trouble with foster care: The impact of stressful events' on foster carers. *British Journal of Social Work* **30**(2), 193-209.

Winstanley E.L. & Stover A.N. (2019) The impact of the opioid epidemic on children and adolescents. *Clinical therapeutics* **41**(9), 1655-1662.

Włodarczyk O., Schwarze M., Rumpf H.-J., Metzner F. & Pawils S. (2017) Protective mental health factors in children of parents with alcohol and drug use disorders: A systematic review. *PloS one* **12**(6), e0179140.

Woodcock J. & Sheppard M. (2002) Double trouble: Maternal depression and alcohol dependence as combined factors in child and family social work. *Children & Society* **16**(4), 232-245.

Yardley L. (2000) Dilemmas in Qualitative Health Research. *Psychology & Health*, 15, 215-228.

Yardley, L. (2008). Demonstrating validity in qualitative research in J.A. Smith (ed.) *Qualitative psychology: A practical guide to research methods* 2nd edn, pp. 235-251 London: Sage.

Zohhadi S., Templeton L. & Velleman R. (2006) Parents and children together (PACT): Evaluation of the pilot. *Final report to Clouds*.

Zuchowski I., Gair S., Henderson D. & Thorpe R. (2019) Convenient yet neglected: The role of grandparent kinship carers. *The British Journal of Social Work* **49**(3), 615-632.

## Appendices

### Appendix 1: Participant Information Sheet

#### *Appendix 1a: Information Sheet for Service User*

#### Research Information Sheet for Service Users attending service for substance use

##### **Introduction:**

In Jan 2016, in an effort to gather essential information needed to plan for appropriate service provision in the X region Drug and Alcohol task force area, the X Drugs and Alcohol Task Force (RDATF) advertised research to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the X Regional Drug & Alcohol Task Force (RDATF).

The aim of this study is to inform the X RDATF strategic plan in relation to planning and implementation of services addressing the needs of children of parents who use substances. In April 2016 researchers in Trinity College Dublin in conjunction with X RDATF were asked to carry out the research.

*A key part of this research is to ask service users who are parents, what you feel the needs are for children with a parent who is attending a service for substance use in the area, what helps in caring for your child(ren), what hinders in caring for your child(ren), what the service gaps are, and what works well in the services.*

To achieve this, we need your help to provide us with your opinions on the items above.

##### **How can I help?**

To help with this study, you could take part in a focus group with other parents using the service, and a researcher from Trinity, who will explore the questions above with the group.

##### **How long will it take?**

The focus group will last 30-40 minutes, or longer if the group wish to continue.

##### **Where will it take place?**

Focus groups will take place in a private space in your local drug and alcohol task force service, to ensure confidentiality.

##### **When will it take place?**

The focus group will take place in October-December 2016, organized by the research committee on a date and time that suits you.

##### **How can I take part?**

If you are interested in taking part, you can let your service manager know. The manager will provide you with a consent form in addition to this information sheet. You will then be given 7-10 days to decide whether or not to participate, using this information leaflet, and the consent form and by asking the service manager and/or the researcher from Trinity College, any queries you may have about the study during this time.

**What are my rights:**

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed. You have the right to omit or refuse to answer or respond to any question that is asked of you. If you are unable to read or understand either documents provided, the researcher will explain or read aloud the documents. If the participant cannot understand either document, consent will not be obtained. If you have any questions as a result of reading this information sheet, you should contact the research team directly before the study begins. Data will be retained securely for 5 years in a secure password protected folder in a secure folder on the TCD server.

**Benefits of participation:**

A potential benefit to taking part in this study is that key stakeholders have the chance to give valuable input in relation to the needs of children of parental substance misuse. These findings will help inform policy at both the HSE Tusla child and family level and the Drug Service provision level through publication of findings and through goals identified from this study for the Drugs Strategy.

**Confidentiality/ Anonymity:**

A participant study number will be issued for each participant. Potentially identifiable information such as contact details are required for study purposes such as to schedule interview times and will be kept in one document. Contact details will be linked to the study number and stored in a password-protected folder on a secure TCD server.

Access to this folder will be restricted to the TCD researchers on this project. This folder will be separate to the study data with study number only. If a participant wishes to withdraw from the study at any point, it will be possible for the researcher to trace the relevant information and subsequently delete as per request. Any hard copies of data will be brought from the point of collection to the School of Nursing and Midwifery will be stored securely in a locked fire proof filing cabinet, with access strictly restricted to personnel working on the study. *No identifying information will be made available at any stage in the reporting of this study.*

The interview will be recorded with your permission using a digital recorder. All transcripts, audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by you will be treated confidentially and all comments will be reported anonymously. You have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, you or the researcher has the right to terminate

**Contact details if further assistance is required for participation:**

**Title:** Ms. Karen Galligan, PhD Candidate and researcher, School of Nursing and Midwifery, Trinity College Dublin, University of Dublin, The Gas Building, 24 D'Olier Street, Dublin 2 *Tel:* XXXXXXXXX  
*E-mail:* XXXXXXXX@tcd.ie

*Appendix 1b: Information Sheet for Family Member*

Research Information Sheet for Family member

**Introduction:**

In Jan 2016, in an effort to gather essential information needed to plan for appropriate service provision in the X region Drug and Alcohol task force area, the X Regional Drugs and Alcohol Task Force ( X RDATAF) advertised research to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the South East Regional Drug & Alcohol Task Force ( X RDATAF).

The aim of this study is to inform the X RDATAF strategic plan in relation to planning and implementation of services addressing the needs of children of parents who use substances. In April 2016 researchers in Trinity College Dublin in conjunction with X RDATAF were asked to carry out the research.

**How Can I help?**

To achieve this, we need your help to provide us with your opinions in a focus group, regarding what you feel the needs are for children with a parent who uses a substance, what helps in caring for these child(ren), what hinders in caring for these child(ren), what the service gaps are, and what works well in the services.

To participate you must currently have a family member who is attending a service for substance use, and who is also a parent/guardian to one or more children.

Participation will involve a focus group with other people who also have a family member who is attending services for drug and or alcohol use and who is a parent

**How long will it take?**

The focus group will last 30-40 minutes, or longer if the group wish to continue.

**Where will it take place?**

Focus groups will take place in a private space in your local drug and alcohol task force service, to ensure confidentiality.

**When will it take place?**

The focus group will take place in October-December 2016, organized by the research committee on a date and time that suits you.

**How can I take part?**

If you are interested in taking part, you can let your service manager know. The manager will provide you with a consent form in addition to this information sheet. You will then be given 7-10 days to decide whether or not to participate, using this information leaflet, and the consent form and by asking the service manager and/or the researcher from Trinity College, any queries you may have about the study during this time.

**What are my rights:**

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed. You have the right to omit or refuse to answer or respond to any question that is asked of you. If you are unable to read or understand either documents provided, the researcher will explain or read aloud the documents. If the participant cannot understand either document, consent will not be obtained. If you have any questions as a result of reading this information sheet, you should contact the research team directly before the study begins. Data will be retained securely for 5 years in a secure password protected folder in a secure folder on the TCD server.

**Benefits of participation:**

A potential benefit to taking part in this study is that key stakeholders have the chance to give valuable input in relation to the needs of children of parental substance misuse. These findings will help inform policy at both the HSE Tusla child and family level and the Drug Service provision level through publication of findings and through goals identified from this study for the Drugs Strategy.

**Confidentiality/ Anonymity:**

A participant study number will be issued for each participant. Potentially identifiable information such as contact details are required for study purposes such as to schedule interview times and will be kept in one document. Contact details will be linked to the study number and stored in a password-protected folder on a secure TCD server.

Access to this folder will be restricted to the TCD researchers on this project. This folder will be separate to the study data with study number only. If a participant wishes to withdraw from the study at any point, it will be possible for the researcher to trace the relevant information and subsequently delete as per request. Any hard copies of data will be brought from the point of collection to the School of Nursing and Midwifery will be stored securely in a locked fire proof filing cabinet, with access strictly restricted to personnel working on the study. *No identifying information will be made available at any stage in the reporting of this study.*

The interview will be recorded with your permission using a digital recorder. All transcripts, audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by you will be treated confidentially and all comments will be reported anonymously. You have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, you or the researcher has the right to terminate

**Contact details if further assistance is required for participation:**

**Title:** Ms. Karen Galligan, PhD Candidate and researcher, School of Nursing and Midwifery, Trinity College Dublin, University of Dublin, The Gas Building, 24 D'Olier Street, Dublin 2 *Tel:* XXXXXXXX  
*E-mail:* XXXXXXXX@tcd.ie

*Appendix 1c: Information Sheet for Service Provider Interview*

**Service Providers Interview Information Sheet**

**Research Title:** Proposal for assessing the numbers, needs, risks, and evidence-based interventions for children impacted by parental substance misuse across communities of XXXXXXXX Regional Drugs and Alcohol Task Force (X RDATEF).

**Introduction:**

In Jan 2016, in an effort to gather essential information needed to plan for appropriate service provision in the South eastern region Drug and Alcohol task force area, the South Eastern Drugs and Alcohol Task Force (X RDATEF) advertised research to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the South East Regional Drug & Alcohol Task Force (X RDATEF).

This study will be conducted in conjunction with the School of Nursing and Midwifery in Trinity College Dublin. The Principal Investigators of this study are Professor Comiskey, a Professor in Healthcare Statistics at Trinity College and Karen Galligan PhD Candidate Trinity College Dublin.

The aim of this study is to inform the X RDATEF strategic plan in relation to planning and implementation of services addressing the needs of children of parents who use substances.

There is particular concern for the risks associated with these children, and the lack of effective interventions, which could prevent intergenerational involvement in problematic substance use. There is a further need to coordinate support from local services for children who do have substance-abusing parents, based on their individual needs. The impact on children of familial substance misuse is often under identified and unacknowledged, despite its long-term impacts.

**How Can I help?**



To achieve the aim of this research, we need your help to provide us with your opinions in an interview asking 6 questions regarding what you feel the needs are for children with a parent who uses a substance, what helps in caring for these child(ren), what hinders in caring for these child(ren), what the service gaps are, and what works well in the services.

**When will it take place?**

The interview will take place October-December 2016, organized by the research committee on a date and time that suits you.

**How can I take part?**

If you are interested in taking part, you can contact the researcher directly. You will be provided with a consent form in addition to this information sheet. You will then be given 7-10 days to decide whether or not to participate, using this information leaflet, and the consent form and by asking the service manager and/or the researcher from Trinity College, any queries you may have about the study during this time.

**What are my rights:**

You may decide to stop being a part of the research study at any time without explanation. You have the right to ask that any data you have supplied to that point be withdrawn/destroyed. You have the right to omit or refuse to answer or respond to any question that is asked of you. If you have any questions as a result of reading this information sheet, you should contact the research team directly before the study begins. Data will be retained securely for 5 years in a secure password protected folder in a secure folder on the TCD server.

**Benefits of participation:**

A potential benefit to taking part in this study is that key stakeholders have the chance to give valuable input in relation to the needs of children of parental substance misuse. These findings will help inform policy at both the HSE Tusla child and family level and the Drug Service provision level through publication of findings and through goals identified from this study for the Drugs Strategy.

**Confidentiality/ Anonymity:**

A participant study number will be issued for each participant. Potentially identifiable information such as contact details are required for study purposes such as to schedule interview times and will be kept in one document. Contact details will be linked to the study number and stored in a password-protected folder on a secure TCD server.

Access to this folder will be restricted to the TCD researchers on this project. This folder will be separate to the study data with study number only. If a participant wishes to withdraw from the study at any point, it will be possible for the researcher to trace the relevant information and subsequently delete as per request. Any hard copies of data will be brought from the point of collection to the School of Nursing and Midwifery will be stored securely in a locked fire proof filing cabinet, with access strictly restricted to personnel

working on the study. *No identifying information will be made available at any stage in the reporting of this study.* However, the research team cannot guarantee absolute confidentiality to the participants as they are duty bound to report any disclosures of professional misconduct.

All views shared by you will be treated confidentially and all comments will be reported anonymously. You have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, you or the researcher has the right to terminate

**Contact details if further assistance is required for participation:**

**Title:** Ms. Karen Galligan, PhD Candidate and researcher, School of Nursing and Midwifery, Trinity College Dublin, University of Dublin, The Gas Building, 24 D'Olier Street, Dublin 2 *Tel :* XXXXXXXXX  
*E-mail:* XXXXXX@tcd.ie

## Appendix 2: Interview Schedule/Questionnaires

### Appendix 2a: Focus Group Questions for Family Member

#### **Section A Demographic Details**

1. Age: \_\_\_\_\_
2. Gender: Male  Female
3. Relation of Service User to the Family Member:  
Husband  Wife  Mother  Father   
Grandfather   
Grandmother  Other (please state) .....
4. Main Drug of use that service user is attending the service for \_\_\_\_\_

#### **Section B Meeting the Needs of Children**

- 1) *What do you feel are the needs of children where a parent is attending a service for substance use?*
- 2) *What do you think helps in the care of these children in relation to the groups below?*
- 3) *What do you think hinders in the care of these children?*
- 4) *What gaps are there in the service provided for these children?*
- 5) *How can services collaborate with families to improve the situation?*
- 6) *What is successful in current services?*
- 7) *What are the main differences between current services?*

*Appendix 2b: Focus Group/Interview Questions for Service Providers*

**Section A Demographic Details**

1. Age: \_\_\_\_\_

2. Gender: Male  Female

3. Name of Service: \_\_\_\_\_

4. Function of Service: \_\_\_\_\_

5. Who are the client groups that attend your service? \_\_\_\_\_

**Section B Meeting the Needs of Children**

- 1) *What are the risks of children who have parental substance misuse?*
- 2) *What are the protective factors of children who have parental substance misuse?*
- 3) *What are the enablers to providing a suitable response to children of parental substance misuse?*
- 4) *Which of these factors do you feel your service addresses well?*
- 5) *Which of these factors do you feel your service does not address well?*
- 6) *What if any systemic issues are there which cannot be avoided in this situation?*

*Appendix 2c: Focus Group Questions for Service Users*

**Section A Demographic Details**

1. Age: \_\_\_\_\_

2. Gender: Male  Female

3. Number of Children: \_\_\_\_\_

5. Age(s) of Children: \_\_\_\_\_

6. Main Drug of use that you are attending the service for \_\_\_\_\_

**Section B Meeting the Needs of Children**

- 1) *What do you feel are the needs of children with a parent who uses a substance?*
- 2) *What do you feel would help you better care for your children?*
- 3) *What do you feel hinders you from caring for your children?*
- 4) *What are the services gaps at present for you and your children?*
- 5) *What works well in the services for you and your children?*
- 6) *What are your needs as a drug-using parent?*
- 7) *Why did you choose to access the service that you did?*

Appendix 3: Consent

*Appendix 3a: Consent Form for Family Member*

**PROJECT TITLE:** Proposal for assessing the numbers, needs, risks, and evidence based interventions for children of parental substance misuse across communities of X Regional Drugs and Alcohol Task Force ( X RDATAF).

**PRINCIPAL INVESTIGATORS:** Prof Catherine Comiskey, Karen Galligan PhD Candidate, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**RESEARCHERS:** Geraldine Prizeman, Michelle Byrne, Emma Atkin, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**BACKGROUND**

This study aims to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the South East Regional Drug & Alcohol Task Force ( X RDATAF). To achieve this, we need your help to provide us your opinions regarding what you feel the needs are for children with a parent who uses a substance, what helps in caring for these child(ren), what hinders in caring for these child(ren), what the service gaps are, and what works well in the services. Participation will involve a focus group with other people who also have a family member who is attending services for drug and or alcohol use and who is a parent. A researcher from Trinity will explore the questions above with the group. The focus group will last 30-40 minutes, or longer if the group wish to continue. Focus groups will take place in a private space in your local drug and alcohol task force service, to ensure confidentiality. The interview will be recorded with your permission using a digital recorder. All transcripts, audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by contributors will be treated confidentially and all comments will be reported anonymously. Participants have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, the participant or researcher has the right to terminate.

**DECLARATION:**

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time, and I have received a copy of this agreement.

**PARTICIPANT'S NAME:** .....

**CONTACT DETAILS:** .....

**PARTICIPANT'S SIGNATURE:** .....

**Date**.....

**Statement of investigator's responsibility:** I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

**INVESTIGATOR'S SIGNATURE**..... **Date**.....

*Appendix 3b: Consent Form for Service Provider Interviews*

**PROJECT TITLE:** Proposal for assessing the numbers, needs, risks, and evidence based interventions for children impacted by parental substance misuse across communities of X Regional Drugs and Alcohol Task Force ( X RDATF).

**PRINCIPAL INVESTIGATORS:** Prof Catherine Comiskey, Karen Galligan PhD Candidate, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**RESEARCHERS:** Geraldine Prizeman, Michelle Byrne, Emma Atkin, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**BACKGROUND**

This study aims to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the South East Regional Drug & Alcohol Task Force ( X RDATF). To achieve this, we need the help of people like you, who are providing services to provide us with your opinion. Your input at this stage in the process is invaluable to us. Participation will involve a one-to-one interview with you and a researcher from Trinity college Dublin, exploring your opinion of the needs and risk and protective factors for children of parental substance misuse. Also, your opinion is sought regarding the enablers and barriers to providing a suitable response to children of parental substance misuse. The interview will take place in a private space at your local workplace to ensure confidentiality.

The interview will last 30-40 minutes, or longer if you wish to continue. The interview will be recorded with your permission using a digital recorder. All audio recordings will be stored securely on the researcher's password protected computer and then transcribed. Participants have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, the participant or researcher has the right to terminate. All views shared by contributors will be treated confidentially and all comments will be reported anonymously.

**DECLARATION:**

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time, and I have received a copy of this agreement.

**PARTICIPANT'S NAME:** .....

**CONTACT DETAILS:** .....

**PARTICIPANT'S SIGNATURE:** .....



**Date.....**

**Statement of investigator's responsibility:** I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

**INVESTIGATOR'S SIGNATURE..... Date.....**

*Appendix 3c: Consent Form for Parents Who Are Attending Services*

**PROJECT TITLE:** Proposal for assessing the numbers, needs, risks, and evidence-based interventions for children of parental substance misuse across communities of X Regional Drugs and Alcohol Task Force (X RDATE).

**PRINCIPAL INVESTIGATORS:** Prof Catherine Comiskey, Karen Galligan PhD Candidate, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**RESEARCHERS:** Geraldine Prizeman, Michelle Byrne, Emma Atkin, School of Nursing & Midwifery, D'Olier Street, Trinity College, Dublin 2

**BACKGROUND**

This study aims to explore numbers, needs, risk and protective factors, and appropriate evidence-based interventions for children/young people of parental substance misuse across the areas of the South East Regional Drug & Alcohol Task Force ( X RDATE). To achieve this, we need your help to provide us your opinions regarding what you feel the needs are for children with a parent who uses a substance, what helps in caring for these child(ren), what hinders in caring for these child(ren), what the service gaps are, and what works well in the services. Participation will involve a focus group with other service users and a researcher from Trinity who will explore the questions above with the group. The focus group will last 30-40 minutes, or longer if the group wish to continue. Focus groups will take place in a private space in your local drug and alcohol task force service, to ensure confidentiality. The interview will be recorded with your permission using a digital recorder. All transcripts, audio and written, will be anonymised and securely stored for the duration of the research project. All views shared by contributors will be treated confidentially and all comments will be reported anonymously. Participants have access to relevant transcripts, and any information deemed to be revealing about personal information or otherwise may be omitted. At any point during this process, the participant or researcher has the right to terminate.

**DECLARATION:**

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time, and I have received a copy of this agreement.

**PARTICIPANT'S NAME:** .....

**CONTACT DETAILS:** .....

**PARTICIPANT'S SIGNATURE:** .....

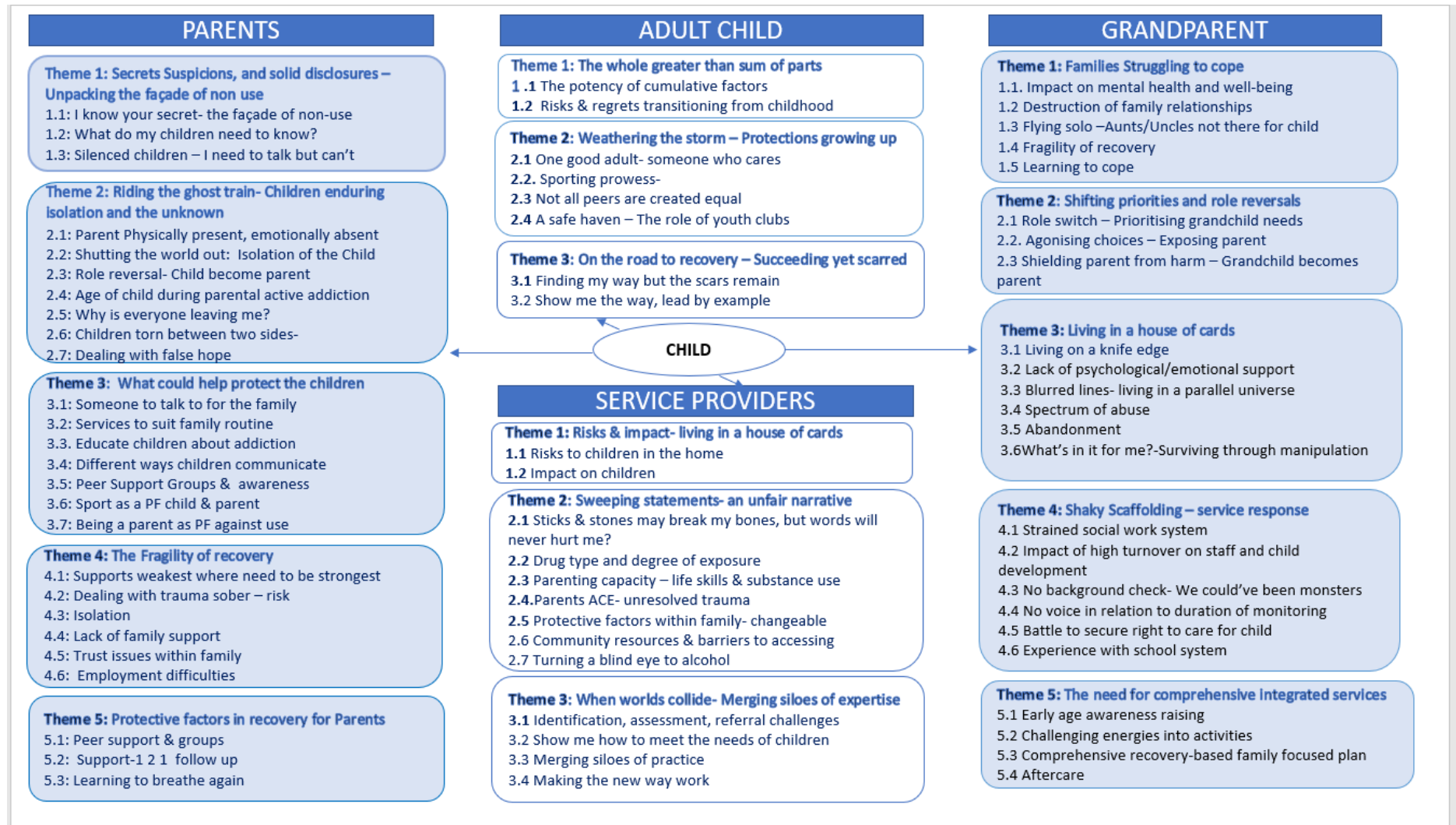
**Date**.....

**Statement of investigator's responsibility:** I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have

offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

**INVESTIGATOR'S SIGNATURE..... Date.....**

Appendix 4a: Summary of Themes and Subthemes: Figure 4: Overall Visual Summary of Themes and Subthemes



Appendix 4b Mapping of Themes: *Figure 5: Map of Themes across stakeholders-Bronfenbrenner Ecological Systems Theory*

