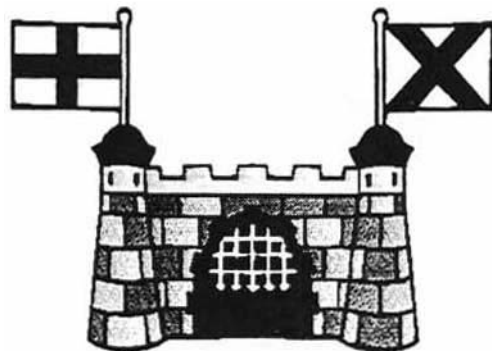


The Social and Psychological Needs  
Of Children of Drug Users

Report on Exploratory Study

**Diane M. Hogan**

The Children's Research Centre



Trinity College Dublin

The Social and Psychological Needs of Children of Drug Users:  
Report on Exploratory Study

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Published by

The Children's Research Centre  
University of Dublin  
Trinity College

ISBN 1 902230 00 0

This research report was supported by funding from *Forbairt*, under the *Science and Technology Against Drugs Initiative*.

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## Acknowledgments

A number of persons made this study possible by participating in interviews. Many of these we have chosen not to name individually for reasons of confidentiality. They include:

the parents and carers who participated in the study and gave their consent to interviews with other informants;

the teachers and home-school liaison worker at the five participating schools:

the social workers, workers at drug treatment centres, residential care worker, and probation and welfare officer who were interviewed as key workers for the study.

The following persons and agencies also provided invaluable assistance in conducting the study and in the preparation of this report:

The members of the *advisory group* for the study who helped with the design and provided constructive comments on this report: Dr. Joe Barry, chairperson (Eastern Health Board and Department of Community Health and General Practice, TCD), Tony McCarthaigh (Rialto Community Drug Team), Shane Butler and Marguerite Woods (Addiction Studies Programme, Department of Social Studies, Trinity College), Mary O'Shea (senior social worker, Drug Treatment Centre, Trinity Court), and Dr. Fergus O'Kelly (general medical practitioner);

The following *community agencies and personnel* who facilitated the study by identifying participants and providing rooms for interviews: Tony McCarthaigh and Joanie Whyte of The Rialto Community Drug Team;

Marguerite Woods and Jacinta Deignan of The Ana Liffey Drug Project; and Joe Donoghue of The Blakestown and Mountview Neighbourhood Youth Project;

The *Eastern Health Board*, which supported The Children's Centre in gaining access to participants for the study, and especially Brid Clarke, Programme Manager for Children, Families and Child Care, and Aine McGuirk, Social Work Team Leader, Community Care Area 3;

Personnel at *The Children's Centre* who were instrumental in the design of the study and who provided helpful comments on this report: Dr. Sheila Greene, Robbie Gilligan, Barry Cullen and Louise Higgins.

We also wish to again thank *Forbairt* for providing funding to support this research.

### *The Children's Centre, Trinity College Dublin*

The Children's Centre was established at Trinity College as a research centre by the Departments of Psychology and Social Studies in 1995. It is now based in a new premises in Aras an Phiarsaigh on Pearse Street. This research was conducted as part of the Centre's commitment to investigating the risks to which Irish children are exposed in a context of social and economic change.

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# **Chapter One: Introduction**

## **Summary of Findings**

### **Impact on Children's Life Experiences**

Children in the study experienced exposure to parental opiate use in different ways. Half had been prenatally exposed to opiates, according to parents. All had experienced the effects indirectly, however, either through changes evident in parental behaviour and/or through separation from and loss of parents.

Many had been exposed at an early age to the legal system, having experienced their parent being incarcerated and in some cases witnessing the arrest and visiting a parent in prison. The majority of the children had experienced separations from parents, due to parental incarceration, hospitalization, and/or inability to provide care.

Few of the children showed evidence of social-emotional problems relating to parental drug use, with only one child having received treatment for psychological or behavioural problems.

### **Impact on Children's School Progress**

The majority of children were experiencing difficulties at school. These problems were related to poor attendance, concentration difficulties, poor work completion, and low levels of parental involvement with their education.

### **Parental Concerns about Drugs Use and Parenting**

Drug-using parents had three primary areas of concern about the impact of their problem drug use on their parenting. The first was that preoccupation with acquiring drugs distracted them from giving adequate attention to their children. The second concern was that their drug use affected their social interactions with their children, making them irritable and short-tempered. The third area of concern was that their involvement with drugs created an atmosphere of secrecy in the home and distrustful relationships between parents and children.

### **Key-Worker Concerns about Drug Use and Parenting**

Key workers also had three primary areas of concern about the ability of drug-using parents to provide adequate caregiving to their children. First, they were concerned that some drug-using parents appeared to be unable to provide consistently good quality caregiving to their children. Second, there were concerns that some drug-using parents may have neglected the physical needs of their children. Third, they were concerned that some children may have witnessed drug-use and drug paraphernalia in their homes. It appeared that parents who were receiving treatment for their problem drug use were less likely to experience such parenting difficulties. There were a number of parents about whom no concerns were raised, and whose competence as parents was emphasized.

## **Background to Study**

There is evidence that increasing numbers of children, particularly in the Dublin area, are being exposed to parental drug addiction. 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.

Little is known about the social and psychological effects on children of parental drug use, particularly in the Irish context. International studies of the care provided to children of heroin users have been largely inconclusive, but studies of children's psycho-social development indicate that such children are at an elevated risk for poor school progress and for drug dependence. These issues have not previously been studied in the Irish context, where the focus has been mainly on the physical effects of prenatal exposure to drugs rather than on social and psychological effects.

**The Children's Centre at Trinity College Dublin** decided in 1996 to undertake a cross-disciplinary empirical research project with the purpose of assessing the effects on children of parental drug use, and the social and psychological needs of children arising from these effects. The study was designed to take place in two stages. This document reports on the first of a two stage study of children of opiate users in the Dublin area. Stage One was a qualitative study involving 10 families in which one or both parents were opiate users. Stage two of the study, which will be undertaken over the course of the next year, will involve comparing a larger number of children of drug users to a group of children from a similar socio-economic background whose parents do not use drugs.



## **Objectives of Study**

Drug use by parents may affect children in a number of ways—physically, socially, and psychologically. Our primary interest was on the social and psychological dimensions. two areas of children’s development that are closely linked. The aims of the project as a whole are to:

### ***Increase knowledge base about children of drug users***

- identify patterns of psychological development, both social and cognitive, in children of drug users;
- explore the social/family contexts in which children of drug users are being raised;
- identify needs in terms of care and parenting, psychological intervention and education on the basis of these findings;
- identify the reasons why children of drug users are more likely to use drugs themselves than other children.

### ***Make policy recommendations regarding services and interventions***

- make recommendations on appropriate interventions to counteract the negative social and psychological effects on children;
- make recommendations on appropriate steps to be taken to prevent children of drug users from becoming drug users themselves.

## **Aims of Stage One**

The aims of Stage One were to obtain baseline information, through exploratory research, on the difficulties experienced by a small group of children in the Dublin area whose parents are opiate users. Specifically, we aimed to identify areas of need experienced by children of opiate users in terms of the care and welfare provided to them, and in terms of their psychological development. On the basis of the findings of this stage the larger study will be conducted.

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## Chapter Two: Literature and Conceptual Framework

This chapter reviews the literature on the social and psychological effects of parental drug use on children. It then outlines the nature and progress of the drug problem, and especially the opiate problem, in Ireland, and describes the conceptual model in which the present study was framed. Finally, it outlines the research questions explored at Stage One.

### Children of Drug Users: Psycho-social Effects

The issue of the effects on children of parental drug use has received little attention in the Irish context, and has largely been limited to medical studies of the effects of *prenatal chemical exposure* rather than on *postnatal social exposure* (Keenan, Dorman, & O'Connor, 1993; O'Connor, Stafford-Johnson, & Kelly, 1988; Ryan, Magee, Stafford-Johnson, Griffin, & Kelly, 1983).

Internationally, the issue has also received relatively little attention, particularly in comparison with research on children of alcoholics (Johnson, 1991). The literature on children of drug addicts is widely dispersed across a number of disciplines. It addresses such topics as adequacy of parenting, child social and psychological outcomes, and inter-generational continuity of drug use (Deren, 1986). To date, this literature has produced largely inconclusive and frequently contradictory findings, and fails to address the question of how parental drug use is linked to child development (Hogan, under review).

### Parenting and Care

The small number of studies on parenting concentrates primarily on mothers, particularly those receiving treatment for drug use. They reveal few or no differences in parenting style between addicted and non-addicted mothers (Bauman & Dougherty, 1983; Colten, 1980) but differences within families, with drug use by mothers associated with negative parenting, and drug use by fathers with positive parenting (Kandel, 1990). Studies of the incidence of child abuse perpetrated by drug-using parents suggests that such children may be at a higher risk for maltreatment (Murphy, Jellinek, Quinn, Smith, Poitras & Gosko, 1991; Mayer & Black, 1977; Sowder & Burt, 1980; Wasserman & Levant, 1993). It is possible, however, that poverty may explain these findings, since similarly high rates of child abuse were found in comparison families from similar neighbourhoods and socio-economic status (Sowder & Burt, 1980). Furthermore, child maltreatment appears to be linked to use of specific types of substances. Famularo, Kinsherrff and Fenton (1992) found that parental cocaine use was associated with child sexual maltreatment and alcohol use with physical maltreatment, but opiate use was not significantly linked to any form of child maltreatment.

Although little research has been carried out on the issue of children of drug users in Ireland, recently the issue has captured a good deal of media attention and the portrayal of parents, particularly mothers, who are addicted to heroin is profoundly negative and suggestive of abuse and neglect. On the other hand there is a perception that negative stereotyping of drug-using parents has *not* been practiced by those providing services heroin using parents and their children, such as social workers (Butler, 1995). Clarke (1994) argues that in practice an assumption of child abuse or neglect does not follow automatically from the knowledge that a parent is a drug user. The international literature on children of drug users suggests that such assumptions would indeed be unwarranted, since findings reflect considerable variation in the adequacy of the

parenting provided by drug users. The literature is, however, fraught with difficulties, as described below.

### **Psychological Effects on Children**

Studies of child psychological outcomes are also scarce. Children of drug users have been found to experience more social-emotional and behavioural problems than other children (Wilens, Biederman, Kiely, Bredin, & Spencer, 1995) but it is not clear whether the effects of mothers' and father's drug use the same (Kandel, 1990). Such children have also been found to experience more problems with peer relations than other children (Kumpfer & DeMarsh, 1986) but this relationship may be attributable to parental alcohol use as these were confounded. Children of drug users in care outside the home have been found to experience difficulties relating to others, but to have relatively fewer psychological difficulties than children in care for other reasons, perhaps because they tend to enter care at a younger age (Fanshel, 1975; Nichtem, 1973).

Research on the cognitive consequences for children of parental drug use provides more comprehensive and compelling information about the risks to children. Children have been found to adjust poorly to school (Fanshel, 1975; Sowder & Burt, 1980), to be at risk for speech and language difficulties (Nichtem, 1973) and to perform poorer on cognitive/intelligence tests (Bauman & Dougherty, 1983, Bauman & Levine, 1986; Herjanic, Barredo, Herjanic, & Tomelleri, 1979; Sowder & Burt, 1980). They are also at risk for behavioural problems at school and tend to miss more school days (Sowder & Burt, 1980). It is important, however, to distinguish between children exposed to drug prenatally and those who are not, since prenatal exposure is linked to greater cognitive problems, although the childrearing environment also produces significant effects (Wilson, McCreary, Kean, & Baxter, 1979).

### **Problems in the Literature**

This small number of studies on parenting and child outcomes is limited by almost exclusive use of retrospective data obtained from pre-selected samples such as parents receiving treatment and parents who have been reported for suspected child abuse or neglect. Most studies fail to include the experiences and outcomes of children who have not come to the attention of child welfare authorities or whose parents have not received treatment for drug dependence. It is necessary to include the experiences of children whose parents are not receiving treatment and who may be leading more chaotic lifestyles.

These studies also fail to adequately explore the *process* by which parenting is affected by drug use, and in particular, the meaning that parental drug use has for children in their everyday lives and activities. The literature does not address such issues as bereavement experienced by children who have lost a parent due to drugs-related illness or separation from parents due to illness or imprisonment. Neither does it address the implications for children's prosocial development of exposure to criminal activity, the risk to children of isolation within their communities due to social condemnation of drug use, or indeed the isolation of children within their own families due to parental efforts to conceal their drugs-related behaviours. It does not describe the material process by which dependence on illicit drugs interferes with a parent's ability or motivation to provide adequate physical and emotional care to their children. As such, this literature does not identify the specific areas in which children of drug users and their parents are in need of support on a day-to-day basis.

Furthermore, the literature does not make explicit use of a theoretical framework to guide the research design or to interpret the meaning of findings. As a consequence, the literature is quite fragmented. The role of social context, for example, has not been explored in this literature in a systematic way.

In the following section, the background to the Irish drugs problem is outlined and the rationale and conceptual framework for a study of children of opiate users are described.

## **Irish Children of Drug Users**

### **Opiate Use in Ireland**

The illicit use of opiates in Ireland dates back to at least 1979 (Dean, O'Hare, O'Connor, Kelly & Kelly, 1985). In the late 1970s and early 1980s the use of opiates, particularly heroin, in Ireland became a recognised social problem. Prior to 1979 the primary illicit drugs used were cannabis and LSD, the scale of this usage was small, and intravenous drug use was uncommon. In the early 1980s numbers seeking treatment for heroin addiction grew dramatically and unexpectedly (Butler, 1991; Dean et al., 1985; O'Mahony, 1997). Apart from a brief hiatus in 1983 numbers seeking treatment consistently increased in epidemic proportions throughout the 1980s and 1990s.

The actual prevalence of heroin addiction is unknown but statistics are available for the numbers of treated cases, which includes all medical and non-medical interventions for problem drug use. Health Research Board statistics are available for numbers of treated cases in the greater Dublin area between 1990 and 1995. In 1990, the estimated number of treated cases was 1,752 and in 1995, 3,593 cases. Throughout that period the primary drug of misuse has been an opiate, primarily heroin, and this increased from 80% in 1990 to 87% in 1995 (O'Hare & O'Brien, 1992; O'Higgins, 1996; O'Higgins & Duff, 1997). These statistics do not capture all cases of illicit drug use, however, and the magnitude of the problem is likely to be much greater than the suggest. It has been estimated that between 5000 and 7000 individuals in Dublin are dependent on opiates, including heroin and synthetic substitutes such as methadone (Physeptone) (O'Mahony, 1997).

Heroin is either smoked or injected. Both routes of drug-taking are on the increase, at least among those receiving treatment and there is evidence that the latter has become more popular among both males and females. (O'Higgins & Duff, 1997).

### **Social Context of Drug Problem**

The problem of opiate addiction, from the 1980s to the present, has largely been confined to the greater Dublin area, where it is the drug cited most frequently by those attending drug treatment facilities in recent years as their drug of primary use. Information about the prevalence of opiate dependence is presently available for that section of the population seeking treatment, either in the form of counselling, advice, or medical information and is published annually by The Health Research Board. Until this year, that information was also restricted to the treatment of cases in the greater Dublin area, but has now been extended to include other regions of the country. These recent statistics support anecdotal evidence that opiate addiction is a problem confined largely, though not exclusively to the Greater Dublin area. Of a total of 803 cases treated outside Dublin in 1995, 20% cited opiates as the primary drug of misuse for which treatment was being sought.

The heroin problem is even more context-specific however. It is located primarily in the North and South inner city and some suburbs, those areas affected most profoundly by unemployment in Dublin (Cullen, 1992, 1994; Dean, Bradshaw, & Lavelle, 1983; McKeown, Fitzgerald & Deegan, 1993; O'Hare et. al., 1992; O'Higgins, 1996, O'Higgins & Duff, 1997).

## **Individual Characteristics and Drug Use**

Heroin use is also related to individual characteristics, and particularly to age. Heroin users are typically aged between 15 and 35, with the age of first drug use falling annually (O'Higgins, 1996; O'Higgins & Duff, 1997). A substantial proportion of childbearing years are captured by this age range and anecdotal evidence suggests that many drug users are parents, although prevalence statistics are not available on the numbers of children affected. Gender is also a factor in heroin use in that most heroin users are male. However, there are also many female heroin users. They are more likely than male drug users to have a partner with whom they are living, and to have a partner who uses drugs. It appears that female drug users are less likely to seek treatment than males due, at least in part, to fears of being judged an unfit parent and having their children taken into care by the State (Butler & Woods, 1992). Mothers who are heroin users seem more likely than fathers to be "invisible" to service providers.

The role of individual factors in children has not been explored substantially in the literature, and therefore the impact of such factors as the age and gender of a child on the nature and extent of psychological effects is unknown.

## **Rationale for Study**

It is clear that a substantial number of children in Dublin, living in areas characterised by extreme social deprivation, are being raised with the additional potentially negative experience of parental heroin dependence. The risk of exposure to parental heroin addiction is influenced by socio-contextual factors such as geographical and socio-economic environment and by individual parental factors such as age and gender. The question inspiring this study was whether exposure to the lifestyle of a heroin using parent has deleterious effects on the social and psychological development of children, and if so, in what ways.

The present study was undertaken due to specific several concerns regarding the welfare and development of children of drug users. The overarching concern was the potential for illicit drug use to disrupt parenting and to negatively affect the social and psychological development of children. This captures several specific areas of concern, which include: first, the established link between heroin use and crime and in Ireland (O'Dea, 1996; O'Mahony, 1996, 1997), which may result in children's exposure to criminal activities and discourse; second, the risk to children of drug users of bereavement linked with the separation from or loss of parents due to imprisonment and/or drugs-related illness; third, the close association between opiate dependence and social deprivation in Ireland (O'Mahony, 1997) and the potential for greater poverty for children of parental opiate use; and fourth, the evidence of inter-generational continuity in drug dependence (Fawzy, Coombs & Gerber., 1983; Gfroerer, 1987; Kumpfer and DeMarsh, 1986; Sowder & Burt, 1980).

## **Conceptual Framing**

This study uses Bronfenbrenner's Ecological Model (1979, 1993) 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.

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, 1993).

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 (Green, 1994; Tudge, Gray & Hogan, 1996). 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.

The following research questions were selected for exploration at Stage One:

### **Research Questions**

1. What are the socio-demographic characteristics of drug using parents?
2. What is the nature of the drug problem—in terms of degree, routes of drug taking, duration, treatment?
3. What impact does parental opiate use have on daily lives of their children?
4. What impact does parental opiate use have on children's school progress?
5. What concerns do drug using parents have about their ability to provide adequate care for their children?
6. What concerns do keyworkers have about the adequacy of parenting by drug users?

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## **Chapter Three: Methodology**

The first stage of the study involved using qualitative methodology. Since no baseline information was available about children of drug users in Dublin and very limited data from other contexts, Stage One was an exploratory step to generate specific research questions and hypotheses. It was envisaged that approximately 10 to 12 children from different families would be recruited for this stage of the study.

This chapter describes the development of the project with the help of an advisory committee, the development of instruments, the participants, and the procedures used for gaining access to and interviewing participants.

### **Development of Study**

#### **Advisory Committee**

An advisory committee was established to help guide the design and implementation of the study. The committee was comprised of the programme director and two academic directors of the Children's Centre, a medical doctor with experiences of treating drug users and an interest in drugs issues, representatives from the Rialto Community Drug Team and the Ana Liffey Drug project, and the coordinator of the Addiction Studies Diploma course at Trinity College Dublin.

A meeting with the committee was convened to discuss the objectives of the proposed research study, available resources, potential access to participants, and research questions. It was decided at this forum to conduct a two stage study, starting with an in-depth qualitative study with a relatively small number of children using multiple informants. It was agreed that such an approach was necessary given the lack of research on this topic previously conducted in Ireland and the inconclusive nature of the findings of international literature on children of drug users.

On the basis of this meeting a research proposal was drafted and circulated to committee members for comments. Further individual consultation followed with members of the advisory committee on such issues as criteria for selection of participants, interview questions, and information and consent forms for parents. The instruments were then prepared for piloting.

#### **Research Instruments**

Separate interview questionnaires were constructed by the researcher for each of the four main categories of informant; parent, teacher, professional worker, and non-parental caregiver. Questions were based on a list of salient variables agreed on with the advisory committee. Parental interview questionnaires were longer than the other forms, since parents were asked a number of specific questions about their socio-demographic status and for a detailed description of their drug-taking behaviour and treatment.

Questionnaires were circulated to members of the advisory committee for comments and were then revised and piloted. Participants in the piloting of the instruments for Stage One were identified through the Ana Liffey Drug Project (ALDP), The Rialto Community Drug Team, a social worker in the south inner city of Dublin. Three of the interviews took place at the participating drug treatment agencies and two at The Children's Centre.

One drug-using mother and one drug-using father, two professional workers and one primary carer (a grandmother) were interviewed. Participants were informed that the purpose of the interview was to pilot other measures and were asked to make comments and suggestions about the questionnaires throughout the interview.

This process resulted in the revision of a number of questions and particularly the re-wording of questions that participants thought likely to cause confusion or offense. It also resulted in some re-structuring of the order of questions to allow for better continuity and less repetition across questions. Piloting proved to be a useful method of checking the validity for questions for participants with direct experience of the difficulties of drug-using parents and their children. It was also an important step in facilitating the researcher's familiarity with drug-using parents and the professionals with whom they have contact, with the issues of concern for this group, and with the day-to-day language used by drug-users about drugs and drug-related criminal activity.

## **Participants**

### **Children & Family**

Children themselves were not directly studied. Instead, a number of key adult informants were asked to participate in interviews about children's care and development. It was decided that children of drug users should not be exposed to the research process until clear and specific research questions had been generated. This was thought to be particularly important given that resources were not available to provide follow-up support for children who may become distressed as a result of discussing parental drug use. It was envisaged, however, that children would participate shortly in the second stage of the study.

It was not intended that participants at Stage One of the study would continue a representative sample of the population of children in which we are interested. It was argued that by including children living in a range of circumstances at Stage One it would be possible to identify the categories that should receive attention at Stage Two of the study and that should be included in the sample.

Children of drug users do not constitute a homogenous population. Although available statistics indicate that such children have a good deal in common in terms of socio-economic status and associated conditions of life in that their parents are relatively young, unemployed, and have low levels of education, they also differ in some other important respects. For example, some are living at home with their parents, others live with relatives or friends, and still others are in foster or residential care for reasons related to the drug use of one or both their parents. Such children also represent a wide age range, and their parents' drug using behaviour may vary substantially—some parents are stabilised on methadone, while others live more chaotic lives. The following participants were targeted for inclusion at Stage One.

- ***primary school-aged children (aged 6-11)***. Given the small sample the age range of participating children was restricted to allow for gathering of sufficient information to create a reliable profile. It was decided to focus on children of primary-school age since this is the group about which least is known in relation to drugs. In addition, by including school-aged children, the experiences of younger children such as preschoolers can also be included retrospectively.
- ***one or both parents dependent on opiates***. It was expected that difficulties would arise in selecting participants who were solely taking methadone and did not ever smoke or inject heroin or use drugs. At Stage One, therefore, the study was not restricted in this way. Parents who were dependent on opiates were invited

to participate, and were asked to describe their drug behaviour, indicating whether this involved methadone treatment.

- ***children prenatally and/or post-natally exposed to drugs in utero.*** It was expected that difficulties would arise in identifying mothers who had used no drugs during pregnancy, for two reasons. First, given the age range of targeted children, mothers were asked to recall their behaviour going back several years which may have reduced accuracy. Second, mothers who used drugs may conceal their prenatal drug use due to a perceived danger of having their child taken into care.
- ***children with each of drug using mothers, fathers or both.*** In this study both mothers and fathers were interviewed, where possible since parent gender is an important variable that is often unexplored. It is also important to distinguish between children of *one* drug using parent and those who have *two* parents who are drug users. If one parent is addicted the possibility still remains that the child has access to care from a drug-free parent. Where both parents are addicted the implications for child care and development may be quite different
- ***children with the following care arrangements: living at home with mother or father or both, living with relatives or friends, living in foster or residential.*** The social needs and psychological development of children with different residential status may be unique and should be investigated.

These criteria were used initially in attempts to obtain a sample. It was not possible, however, to obtain an equal distribution of children in each of these categories. All of the children were within the age range of 6 to 11 and had either a mother or father or both who was addicted to opiates. Five mothers said that they had used drugs prenatally. Although the objective was to have an equal balance of children with a drug-using mother, father, or two parents who used drugs, eight of the ten children who participated had two drug-using parents. In addition, none of the children had a drug-using mother but not father, and lived at home with her and none had a drug-using mother but not father and were in foster or residential care. Similarly, none of the children had a drug using father but not mother, and lived either with relatives or friends, or was in foster or residential care

**Table 1. Child participant profiles; Parental drug use and child residential status**

<b><i>child A</i></b>	both parents drug-users (father deceased), living with mother
<b><i>child B</i></b>	father drug-user, child living at home
<b><i>child C</i></b>	both parents drug-users, child in foster care
<b><i>child D</i></b>	both parents drug-users, child living at home
<b><i>child E</i></b>	both parents drug-users(father deceased), child living with relatives
<b><i>child F</i></b>	both parents drug-users, child in residential care
<b><i>child G</i></b>	both parents drug-users, child living at home
<b><i>child H</i></b>	both parents drug-users, child living at home
<b><i>child I</i></b>	both parents drug-users, child living with mother and new partner
<b><i>child J</i></b>	mother drug-user, child living with relatives

## **Adult Informants**

Where possible, the following informants were contacted and asked to participate in an interview about the target child's care and development: mother, father, other primary care giver, if relevant (such as grandparent, residential care worker, key worker, foster parent), school teacher, and professional worker with frequent contact with the family (such as social worker, counsellor at Drug Treatment Agency, other community workers).

A total of 30 informants were interviewed, as described in Table 2 below. Informants included eight mothers and four fathers, all of whom were drug users, six teachers, ten professional workers (of whom seven were counsellors at drug treatment centre one a social worker with the Eastern Health Board, one a probation and welfare officer formerly attached to Mountjoy women's prison and one a community worker in a neighbourhood youth project) and two carers (a grandmother and a residential care key worker). A third child was also in the care of relatives but these could not be contacted.

### ***Mothers***

8 mothers were interviewed, all of whom were drug-users (child A, D, E, F, G, H, I, J). One mother, who was not a drug-user, did not wish to participate in the study (child B). Another mother was not traceable as she was homeless at the time of the study and had not made contact with the participating father for several months (child C).

### ***Fathers***

Four fathers were interviewed, all of whom were drug-users (child B, C, D & G). One of those interviewed died approximately two months after the interview due to AIDS-related illness. Two of the fathers had been deceased for several years, also due to drugs-related illness (child A and E). It was not possible to obtain consent to participate for four of the fathers, three of whom were drug-users (child F, H, and I). Of these three, one was estranged from the mother and child and the participating mother did not wish to contact him, while two were not informed about the study of their partner's participation in it due to concerns that these fathers might react negatively (child H). Finally, one father (child J) was not a heroin user and had sole custody of the child. He was estranged from the child's mother and she was unwilling to contact him about the study because she had previously experienced difficulties with him in connection with her efforts to gain custody of the children.

### ***Teachers***

Six teachers were interviewed (child A, D, E, F, G, H). Of the remaining four, it was not known in one case whether the child was attending school, since both mother and child were homeless (child C). In three cases (child B, I and J) the schools were not contacted due to parental fears that teachers might discover the purpose of the study and that this might have had negative consequences for the children.

### ***Key Workers***

Ten professional workers were interviewed. Seven of these were counsellors of key workers from drug treatment centres, one a social worker with the Eastern Health Board, one a probation and welfare officer formerly attached to Mountjoy women's prison and one a community worker in a youth project.

Parents in each family were asked to nominate a professional worker whom they would consent to being interviewed about their drug problem and its impact on their children. There was social work (child protection) involvement in six of the ten families, as confirmed by the professional workers who were interviewed. In eight cases (drug treatment agency workers and probation and welfare officer) the keyworkers nominated worked on an individual basis with the parent or parents rather than providing a direct service to the child, but all had previous contact with the child in question and had worked with the parent in a counselling capacity on issues related to parenting. In two

cases the child was the professional worker's primary focus, but there was substantial involvement with the family as a whole (child F and H).

**Carers**

Two primary carers of children were interviewed (child E and F). Three of the ten children were confirmed by professional workers to be in care outside the home (child E, F and J). Child C was also suspected to be in care but this could not be confirmed since it was not possible to trace the child or mother.

Of the three children in care outside the home, one child (child J) was living with her paternal grandmother although her father had custody. It was not possible to interview this carer because the child's mother was unwilling to contact the child's father to seek consent.

**Table 2: Informant Profile by Child**

Child	Mother	Father	Teacher	Key-Worker	Carer	Agency for Access
A	interviewed	deceased	interviewed	interviewed (ALDP)	not applicable	ALDP
B	consent not obtained	interviewed	consent not obtained	interviewed (ALDP)	not applicable	ALDP
C	not traceable	interviewed	not traceable	interviewed (RCDT)	not traceable	RCDT
D	interviewed	interviewed (later deceased)	interviewed	interviewed (RCDT)	not applicable	RCDT
E	interviewed	deceased	interviewed	interviewed (RCDT)	interviewed grandmother	RCDT
F	interviewed	consent not obtained	interviewed	interviewed (EHB)	interviewed residential care worker	RCDT
G	interviewed	interviewed	interviewed	interviewed (RCDT)	not applicable	RCDT
H	interviewed	consent not obtained	interviewed	interviewed	not applicable	NYP
I	interviewed	consent not obtained	consent not obtained	interviewed (RCDT)	not applicable	RCDT
J	interviewed	consent not obtained	consent not obtained	interviewed (PWO)	not applicable	ALDP

**Key:**

- ALDP = Ana Liffey Drug Project
- EHB = Eastern Health Board
- NYP = Blakestown and Mountview Neighbourhood Youth Project
- PWO = Probation and Welfare Officer
- RCDT = Rialto Community Drugs Team

## **Access to Participants**

### **Access Procedure**

Drug-using parents were approached by workers at the relevant agencies and asked if they would be willing to participate in a study about the social and psychological needs of children of drug-users. It was emphasized that participation was voluntary and that interviews with each informant would be confidential. Agencies were provided with a short written summary of the aims and procedure of the study which they made available to potential participants. When parents agreed to take part they were introduced to the researcher, who again explained the purpose and procedure of the study. Once it had been established that parents understood the nature of the study they were asked to sign a parental consent form stating that they gave permission for the researcher to contact and interview other relevant informants and that they themselves agreed to be interviewed for the study. Parents were given the option of refusing to give consent to categories of informants to which they objected and were assured that their family's identity would not be revealed. Each parent who was interviewed signed a consent form.

Where parents did not have custody of their child they signed the consent form to state that they gave permission for the study to include their child, but their consent alone was not sufficient in these cases. For this study, consent to contact informants about children who were in the care of the State was obtained through consultation with the Eastern Health Board on a case by case basis. The Health Board was supportive of the study and gave consent where requested.

Nine families were identified through the ALDP and RCDT (three and five respectively). In addition, one child became involved through contact with the Blakestown and Mountview Neighbourhood Youth Project.

### **Access Difficulties**

Difficulties were experienced in gaining access to participants to this study in two respects; first in finding families who fitted into the initial categories for a sample, and second in maintaining the involvement in the study of a parent once they had initially agreed to participate. A number of parents broke appointments to be interviewed.

The serious access difficulties experienced in recruiting participating families where either mother or father, but not both, were drug users may be a reflection of the lower incidence of those families in the population. Health Research Board statistics suggest that it is more unusual for a female to be a drug-user and not to have a drug-using partner than it is for males—they reported that “females were always proportionately far more likely than males to be living with a drug-using partner” (O’ Higgins, 1996, p. x).

This may explain the difficulty in gaining access to families where the mother but not the father is a drug-user, but does not explain why difficulties were experienced recruiting families where fathers but not mothers used drugs. This latter access difficulty may reflect a reluctance of fathers to engage in a study that focuses on the care and welfare of children, since they may be less likely to perceive themselves as being engaged in the role of parenting. Indeed, in the eight cases where both parents were drug users, of which six fathers were potential interviewees, in all but one case the mother expressed initial interest, gave consent for participation, and was interviewed first.

A second issue was the maintenance of parental involvement in the study following their initial agreement to participate. In a number of cases parents agreed to be interviewed when approached initially, and arranged an appointment with the researcher either by telephone or in person, but subsequently failed to keep appointments. There

are a number of potential explanations for this pattern. Although parents were assured that participation was voluntary there may have been a tendency for some parents to agree to participate in order to “please” the drug treatment agency worker by being cooperative. They may subsequently have realised that they did not wish to take part. for several reasons.

First, parents may have had fears regarding confidentiality. They may have fears of being judged to be an unfit parent and that this evaluation would be passed on to the health board. Second, parents may have been prevented from attending appointments due to arrest or imprisonment. When drug use is unstable or chaotic parents may be actively involved in criminal activity to obtain money for drugs, such as shoplifting, robbing, selling drugs, and prostitution, and therefore be at a high risk for being arrested. In some cases where an appointment was missed the parent in question was arrested immediately prior to the scheduled interview. Third, where drug use is active there is also a likelihood that drug users are either preoccupied with looking for drugs or money for drugs, or they are too ill as a result of withdrawal from drugs to be able to attend for interview. Several participants who had previously been active users but were stable at the time of interview described the period of active drug use as a time when they moved between frantically chasing after drugs to reduce the pain of withdrawal, or were intoxicated by drugs.<sup>1</sup>

The failure of some parents to follow through with participation in the study may also be attributable to factors unconnected to drug use, particularly in cases where parents were stable on a treatment programme. They may simply have experienced such difficulties as lack of child care, non-drugs related illness, and so on, that prevented their attendance.

The problem of non-attendance was exacerbated by the fact that contact was made with parents through the drug treatment agencies rather than directly. Parents’ addresses and home telephone numbers were not given to the researcher in order to protect the confidentiality of the clients of drug treatment agencies.

### **Reliability of Data**

Interviewing multiple informants about each child/family provided one form of reliability check on the information gathered. Although this was not checked in a quantitative fashion there were notably few points on which there was disagreement between relevant informants.

Parents appeared to engage in the research process in an open and honest way. This is likely to be due to the facilitation of the research by community-based agencies. The ethos of participating agencies was to engage with clients in an accepting and non-judgmental manner in relation to drug use. The agencies were mandated to report suspected child abuse or neglect, however. Parents who agreed to participate appeared to view the researcher sharing the ethos of the agencies, and certainly to understand that the researcher was independent and not an agent of the State. They appeared to perceive the researcher as an objective, as somebody who did not have an agenda for change of the parents’ behaviour, and as conducting the research in the best interest of the families. The majority of parents volunteered information freely about their drug-taking behaviour, including violation of treatment programmes. They also described their involvement in criminal activity, including robberies and drug selling. The latter of

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<sup>1</sup> In connection with this point, it should be noted that illness was common among participants. One father had been in hospital frequently for treatment for AIDS and was visibly ill during the interview. and one mother who was actively using drugs was in her ninth month of pregnancy and was also quite ill. In both cases some questions were dropped in order to shorten the interview process.

these is currently a widely condemned activity in Dublin, and the willingness of some parents to discuss this behaviour suggests that they were being honest.

Some topics, however, were not as freely discussed as others. Some parents were more willing to volunteer information on their HIV status than others, while information about their hepatitis status appeared to be offered more freely<sup>2</sup> Some mothers seemed reluctant to discuss their drug use during pregnancy. There was evidence that mothers' fears of having their children taken into care were quite pronounced. One mother had been using drugs for approximately sixteen years, and another for seventeen years prior to getting treatment. In both cases this failure to seek treatment was explained by the mothers as being due solely to such fears.

Another issue relating to the reliability of data relates to parents' level of intoxication at the time of interview. Two of the fathers were clearly intoxicated during the interview, but according to workers at the drug treatment agencies this behaviour was typical of these clients. The issues is whether the information provided during the interviews was less accurate as a result of having taken substantial amounts of heroin and other substances. However, none of the parents interviewed were drug-free and therefore could be considered to be under the influence of psychoactive substance. It would be extremely difficult to differentiate between those who were more or less likely to be reliable informants on the basis of amount of drugs taken.

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<sup>2</sup> Parents were not asked to describe their HIV status but a number volunteered that information unprompted.



## Chapter Four: Findings

### ***Socio-Demographic Characteristics of Parents*** **(Research Question 1)**

The ***education*** level of interviewed parents was extremely low. Only three parents had completed state examinations. Of these, one father had completed the Intermediate Certificate and one mother had passed the Junior Certificate examination, both while institutionalised on criminal charges. The average school-leaving age was 14.08 years and the age range of school leaving 12 to 17.

In terms of ***employment***, none of the parents who were interviewed were employed and all were dependent on State welfare.

***Housing*** was also poor. All but three parents were renting local authority accommodation. Three parents, two fathers and one mother, reported being currently homeless and awaiting housing by the local authority. The parent did not have care of the target child in any of these three cases. The average ***age*** of participating parents was 33.9, ranging from 29 to 40.

### ***Drug-Using Profile of Parent*** **(Research Question 2)**

In accordance with the study design, the ***primary drugs*** for which all parents were receiving treatment in this group were opiates, usually heroin or methadone (mostly the brand Physeptone). Many also reported using morphine sulphate tablets (also synthetic opiates), popularly known as “Napp’s” or MST’s”. All, however, had injected heroin as their main drug.

Parents also reported use benzodiazepines, especially anti-anxiety drugs such as Diazepam (Valium), as well as cannabis. Many of the parents interviewed were quite stable, with ten receiving medical treatment in the form of Physeptone. Three parents reported current active drug-using (two of whom were also receiving some form of medical treatment) and a chaotic lifestyle.

The majority of participating parents were long-term drug users. The average ***age of first drug use*** for interviewed parents was 18 and the range was 13 to 37. This was inflated by the case of one mother who had started, untypically, to use heroin for the first time at age 37, and excluding this one individual the average age of first drug use was 17. Parents in the study had been dependent on opiates for an average ***duration*** of 16 years and ranging from 3 to 26 years.

### ***Impact on Children's Daily Life Experiences*** **(Research Question 3)**

Information gathered from parents about the experiences of children in the study that related to their parents' use of drugs is summarised in Table 3. This table gives information about the number of children reported by parents to have experienced a particular life event, the number of children reported by parents to not have experienced such an event, and the number of children for whom information is not available. In the cases where information is not shown, parents were unable or unwilling to provide the information, or the relevant parent was not interviewed.

#### **Exposure to Drugs**

Of the ten children included in this study, only one had a father and another a mother who was not dependent on opiates. Five of the children were reported to have been exposed prenatally to opiates and four to have experienced withdrawal. Seven of the children had a mother and five a father who had used or currently used heroin intravenously.. According to parents, none of the children had witnessed parental drug use or seen drug using equipment such as syringes in the home.

#### **Exposure to Legal System**

Five children had a mother and seven a father who had been or was currently incarcerated. Five children had visited a parent in jail, while three had witnessed their father being arrested and taken into custody by the Gardai.

#### **Separation from Parents**

Separation from parents was a striking feature of the children's lives, as can be seen in Table 3. The majority of children had experienced separation from their parents due to parental drug use; seven had been separated from their mother and nine from their father, for varying lengths of time. Separations ranged from permanent placement in the care of the State with limited visits to parents to shorter periods in the care of relatives or friends while parents were unable to cope with child care. It also included separations due to parental imprisonment and death. If the children had not already suffered major separations and bereavements, they were likely to in the future as most of the parents who were still living at the time of the study had serious and potentially fatal illnesses.

#### Separation due to drugs-related death and illnesses

Two children had already suffered major bereavements through the death of a parent. The fathers of child A and E were deceased prior to the interviews, when the target children were preschoolers, due to drugs-related illness and the father of a third child (child D) in the study died shortly afterwards. Parents were not asked whether they had any drugs-related illness, such as HTV and Hepatitis, but several volunteered this information. Six mothers had a drugs-related illness, including five who said they were HP/ positive. Six fathers also had been or was currently HIV positive. One mother and one father tested negative for HIV, and the HIV status of the remaining parents was unknown. Several parents reported having contracted hepatitis B, C or both. Several children had also experienced separation from parents due to parental hospitalisation for detoxification from drugs, or for treatment for drugs-related illnesses.

#### Separation due to imprisonment

Children were also separated from parents due to their imprisonment. It was common for parents, especially fathers, to have spent considerable periods of time in prison for crimes related to their drug dependence during the lifetime of the target child. Seven of the ten fathers had been imprisoned on multiple occasions since the target child was born. One spent the first three years of his child's life in jail. Two fathers were in jail during the study period. Fathers were imprisoned more often than mothers. Three

mothers had been in jail on drugs-related charges. In two cases this occurred following the death of their husbands (it appeared to be a common pattern for husbands to supply their partners with drugs), while in the third case the father was not a heroin user and ‘ the parents were separated.

All of the children in the study had at least one parent who had been incarcerated. Only one child (H) had not experienced parental imprisonment for drugs-related activities during their lifetime. As mentioned earlier, many children had visited a parent in jail. Parents reported concealing the reason for these separations from children. Some mothers reported having told younger children that their father was in hospital, but that this no longer worked as they got older. One mother said that her 10 year old son becomes very withdrawn when his father goes into jail, which occurs frequently, and refuses to visit him, at least for the first few months. A mother who served several long prison sentences did not have custody of her children, but they made regular supervised visits to her over a two year period.

Separation due to parental inability to cope

At the time of data collection, three of the ten children were formally in care outside the home, one each in the care of a grandmother, in foster care, and in residential care. In addition, one child was in the sole custody of her father, who was not a drug user, and was living with a grandparent. In total, however, seven of the children had experienced one or more periods in care outside the home due to parental drug use. These episodes were sometimes informal arrangements whereby grandparents or friends took the children into their home, and some were formally arranged through the Eastern Health Board. Although many parents, especially mothers, voiced fears that their children would be taken into care, in reality this occurred in only a small number of cases and was typically on a voluntary basis.

**Table 3: Child Life Experiences (Parent Reports)**

<b>Child Experience</b>	<b>Yes</b>	<b>No</b>	<b>Not Known</b>
<b>Prenatal Parental Drug Use</b>			
Prenatal exposure to drugs	5	5	0
Treated for withdrawal	3	3	0
Experienced withdrawal	4	4	0
<b>Postnatal Parental Drug Use</b>			
Mother drug user	9	1	0
Father drug user	9	1	0
Mother IV drug user	7	3	0
Father IV drug user	5	4	1
Mother poly drug user	4	5	1
Father poly drug user	4	1	5
Mother on medical treatment	7	2	1
Father on medical treatment	5	4	1
Witnessed mother’s drug use	0	9	1
Witnessed father’s drug use	0	9	1

<b>Child's Current Living Circumstances</b>			
Lives with one drug-using parent	4	6	0
Lives with two drug-using parents	2	8	0
Lives with non-drug-using parent	2	8	0
In care with relatives	1	9	0
In foster/residential	2	7	0
<b>Parental Involvement with the Law</b>			
Mother ever incarcerated	5	4	1
Father ever incarcerated	7	0	3
Mother current legal involve	3	6	1
Father current legal involve	3	4	3
Child visited mother in jail	2	7	1
Child visited father in jail	3	2	5
Witnessed mother arrest	0	9	1
Witnessed father arrest	3	2	5
<b>Separation from Parents</b>			
Father deceased	2	8	0
Mother deceased	0	10	0
Ever separated from mother due to drugs	7	3	0
Ever separated from father due to drugs	9	1	0
Ever in care due to parental drug use	7	3	0
<b>Parental Illness</b>			
Mother had/has drugs-related illness	6	1	3
Father had/has drugs-related illness	6	1	3
<b>School Experiences</b>			
Frequently misses school days	2	5	3
Involvement in bullying	1	6	3
Other social problems at school	0	7	3
<b>Social-Emotional Experiences</b>			
Has social worker currently	4	5	1
Referred for psych, assessment	5	3	2
Treated for social-emotional problems	1	7	2

## Factors Influencing Life Experiences of Children

There was remarkable variation across families in the circumstances of their lives and parental drug behaviour, indicating a complexity of factors that must be considered in assessing the risk status of the children;

- ***Who is the child living with?***  
The daily routines of children in care were notably different from those of children living with drug-using parents, in that there was evidence of greater regularity and consistency in school attendance and in caregiving provided. It also made a difference whether older siblings were also living in the home who were able to take over child care responsibilities.
- ***What social support is available?***  
Are family members supportive? Is the community giving the family hassle or being supportive? Is there an agency to which drug users have relatively easy access? Those families most profoundly and negatively affected by parental drug use appeared to be those who were cut off from their families, isolated from their communities (perhaps due to pressure from neighbours) and had little recourse to support from counsellors in drug treatment agencies.
- ***Are the drug users on treatment and if so for how long?***  
There were notable differences between the reported caregiving abilities of parents receiving treatment and those who continued to actively use drugs, especially in consistency and in the degree of attention given to children, as described in more detail below.
- ***How old was the child when parents first became drug users and when drug use was chaotic?***  
The age of the child when parents started to use heroin may have implications for the disruption caused to parenting and the impact on the child. In this study, the majority of parents were dependent on opiates for a substantial number of years prior to the birth of the child. Two of the 10 children (child G and I) had been born when their mothers first became heroin users. Perhaps of greater significance is the age of the child when parents were chaotic users. There appeared to be substantial variation across families in this.
- ***What is the parents' history of drug use and treatment?***  
Parents differed quite dramatically in this group in their history of drug use and treatment, as did the effects of their drug use on their families. Factors which could affect children's response include whether the drug use was chaotic, whether treatment was received and if so whether it was consistent and brought stability to the family.
- ***Are one or both parents using drugs?***  
In this study the majority of target children had two parents who were drug users. However, the impact on the children may be quite different when only one parent is using drugs (usually the father in such cases). This may lead to children being buffered from the problem by their non-drug using parent and to minimal interference with the care they receive. However, it might also result in greater disharmony between the parents, since their lifestyles are substantially different.

Given the multitude of factors that influence how parents themselves cope with their dependence on drugs, and the context in which they do so, it is clear that the effects on children of parental drug use is a complex issue, without simple answers that can be generalised across all families and situations.

***Impact on Children's School Progress***  
**(Research Question 4)**

Information about children's school experiences was obtained primarily from school teachers. Out of the possible 10 cases only six teachers were interviewed, due to the fact that three parents did not give consent for contacting the teacher and one child could not be traced at the time of the study. Each teacher was asked questions on the following key areas : school attendance, academic progress, social adjustment/peer relations, parental involvement, and the child's psychological well-being. Significant problems relating to the child's school experiences were evident from the teacher's reports. The results, which apply to five female and one male child, are summarised in Table 4 below.

**Table 4: Children's School Experiences (teacher reports)**

<b>Children's School Experiences</b>	<b>A</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>G</b>	<b>H</b>	<b>Total</b>
<b>Class at school</b>	<b>2nd</b>	<b>6th</b>	<b>4th</b>	<b>3rd</b>	<b>senior infants</b>	<b>4th</b>	
<b>Age</b>	8	11	8	8	6	10	
<b>Gender</b>	female	female	female	female	female	male	
Poor attendance	yes	no	no	no	yes	yes	3
Often late for school	yes	no	no	no	yes	yes	3
Poor presentation	yes	no	no	no	yes	yes	3
Remedial teaching	yes	yes	yes	yes	no	yes	5
Problems with mathematics	no	no	yes	yes	no	yes	3
Problems with reading and comprehension	no	yes	yes	no	no	yes	3
Problems with writing	yes	yes	yes	yes	yes	yes	6
Language difficulties	no	yes	yes	yes	no	yes	4
Homework difficulties	no	no	no	yes	yes	yes	3
Concerns about child's cognitive development	no	yes	yes	yes	no	yes	4
Concentration problems	no	yes	yes	yes	yes	no	4
Lack of motivation/ interest	no	no	yes	yes	yes	yes	4
Peer relationship problems	no	no	yes	no	no	yes	->
Child receiving counselling	yes	no	yes	no	no	no	2
Concerns about child's emotional development	no	yes	yes	yes	yes	yes	5
Concerns about low parental involvement in child's schooling	yes	no	yes	yes	yes	yes	5

**Attendance**

Three of the children (child A, G, & H) were reported by teachers to have very poor attendance, and particularly child A and H, each of whom missed several days a week in the term prior to the interview. Child H had missed two months of school at the end

of the previous year. Lateness was also a problem with these children, and resulted in the need for remedial education to compensate for time missed. Two of these children (G and H) were in the care of active drug users, which may explain the inconsistency of attendance. These three children were also mentioned as having poor physical presentation at school. Teachers reported that these children were sometimes untidy and unclean.

### Academic Performance

Teachers were asked to describe children’s academic progress given their age and ability, and compared to other children of the same age. It appeared from the results that five of the children were currently attending or had previously attended remedial teaching.

All teachers reported at least one problem in the area of academic progress. A range of problems were reported, but some were more common. Teachers were asked to provide a rating of target children in comparison to other children of the same age and gender on six dimensions; mathematics, reading and comprehension, writing, artistic/creative activities, communication and sports. These ratings provide an overview of how target children were perceived to be performing at school in these core areas. It can be seen from Table 5 that children were more likely to be rated as below average on these dimensions than average or above average, and especially in the academic areas of writing, reading and comprehension, and mathematics.

Five teachers reported serious problems with academic progress, with children falling behind their age level in *writing* and *mathematics* (D, E, F, G, H). Child A had an extremely poor attendance record and her progress was contingent on this continuing to improve. *Language* skills, especially written, were of particular concern for four of the six teachers and it was felt that this might become more problematic as children grew older and moved through the education system.

**Table 5: Teachers’ reports of children’s progress compared to other children of same age and gender**

SUBJECT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Mathematics		3 (A,D,G)	3 (E,F,H)
Reading and comprehension		3 (A,F,G)	3 (D,E,H)
Writing			6 (A,E,D,F.G.H)
Artistic/creative	2 (A,G)	2 (H,F)	2 (E,D)
Communication	1 (D)	4 (A,E,F,G)	1 (H)
Sports***	2 (D,H)		1 (E)

\*\*\* Three of the teachers did not comment on the child’s sports performance.

**Homework** was reported as a problem for three of the children, in terms of quality, completion and presentation. As a result their teachers had serious concerns over the child's academic progress and cognitive development. In the three cases where children's homework was being well done, teachers mentioned that they believed family members (brother, grandmother, one drug-using mother) were helping the child.

### **Parental Involvement**

Parental involvement (including parental involvement in child's education and schooling, commitment to ensuring the child's attendance at school, and completion of homework) was generally reported as being poor. Five of the six teachers reported lack of parental involvement as a serious concern. In all five cases, neither of the child's parents had ever been to the school. In most cases the teachers had not met the child's parents and believed that they were not committed to ensuring their children attended school and completed their homework. In two cases the children were brought to school by siblings, who themselves had dropped out of school early. In one case, however, the child's mother was very involved with her child's education, and in another, the child's grandmother had obtained custody of the child and was committed to supporting the child's education.

### **Social Adjustment at School**

Teachers were also asked to describe the child's social adjustment in the classroom including peer relationships, bullying, the child's behaviour in the classroom (e.g. concentration, interest, and participation) and problem behaviours (see Table 4). It was reported that four of the children had concentration problems, and four children had a lack of motivation and interest in learning and in their schooling in general. It appeared that two of the children had difficulties mixing with their peers, and both of these children were also reported by their teachers as having problem behaviours (e.g. one child was described as being anxious, impulsive, insecure and full of anger, the other child was described as being withdrawn and lacking in confidence).

Bullying was not described as a significant problem by these teachers, although one child had been involved in the encouragement of bullying another child, and another had herself been bullied when in a previous class. Three teachers mentioned having serious concerns about a child's emotional development (e.g. concerns about the child's inability to express their emotions and low confidence), two of the teachers had minor concerns, and one teacher reported no concerns.

### **Children's School Needs**

Teachers were asked to report any needs (cognitive and emotional) that they could identify specifically for the child. In four cases they reported that the child needed more attention, supervision, and special help such as more one to one teaching. The teacher of a younger child, who was in senior infants class, believed that it was necessary for the parents to become more involved with the child's education and to provide more encouragement to the child. Another teacher felt that the child's greatest need was parental encouragement to attend school regularly. Four teachers reported specific emotional needs. Two of these believed that the child needed counselling, while the other teachers believed the children to have more general needs such as stability, and feeling comfortable within oneself.

### Teacher Vs. Parent Reports

Some information on the child's school experiences was obtained from the interviews with the child's parents. Parents were asked questions about the child's school attendance, progress, and help with their child's homework. Some of the parents were unable to answer questions pertaining to the child's progress due to a lack of contact with their child, mainly as a result of the child being in residential care, or in 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 where academic problems and a number of concerns were identified. This illustrates the importance of interviewing teachers as well as parents about the child's academic and socio-emotional behaviour.

In the four cases where the teachers were not interviewed, the only information that could be obtained about the child's school progress was from their parents. In two of the cases the parents could not answer questions in relation to the child's schooling as the child was not living with them. In two of the cases where the child was living with the parents they reported no problems or concern over the child's schooling.

## ***Parents' Concerns about Caregiving (Research Question 5)***

There was considerable variation across families in the circumstances of their lives and their drug use, and in the complexity of factors that must be considered in assessing the risk status of the children. The following three themes were identified among the concerns raised by parents. Most parents were reasonably stable and receiving treatment. Their concerns were retrospective as well as current. Three themes (defined as concerns raised by more than one parent) emerged.

### ***1: Lessened Involvement with Children***

This was the most common concern of parents. Several said that they either missed time with their children completely (e.g. in prison) or more commonly, that they were so preoccupied with drugs that they did not give their children enough attention. The mother of child C described her experience as follows:

“Your whole life revolves around the gear. When you get up in the morning you are thinking that you have to get the money together, then where are you going to score, that’s your main thought.”

The mother of child J captured the feelings of a number of parents as follows:

“It affected me in the way I know I am not able to give one hundred percent to my children. When I got up in the morning I had to have my fix or my “Phy” (Physeptone) before I could do anything for them, even their breakfast. I lost out a lot on their childhood, even when they were with me. The most important thing they missed out on is their mother. I was a junkie first and a mother second, I was selfish in that way...I gave them everything except one hundred percent of me.”

These parents appeared to be preoccupied, not with their own pleasure, but with the goal of pain avoidance or reduction. Every parent worried about withdrawal pain and was preoccupied with avoiding it at all costs. The concerns voiced by parents about the adverse effects of drug dependence indicate that one impact of drugs use is to lower levels of parental involvement with their children on a day-to day basis.

### ***2: Irritability with Children***

Parents talked about how drugs made them react to and interact with their children on a daily basis. Four mentioned that they would often feel “sick”, that is, unless they were just after getting some of the drug they would feel physically very ill, and this made them short-tempered with the children. One mother (child G) said

“The drugs make you think you are more relaxed but in fact you are more snappy. There could have been an atmosphere in the flat...my oldest told me I don’t roar as much anymore now I am off drugs.”

Her father had a similar experience:

“I’d be cranky and frustrated. I hated being back on drugs. And I was worse when I was sick.”

The following remarks were made by the mothers of child H, I, and J, respectively:

“In the mornings I’d be roaring at them and really cranky and giving out to them if they were making noise. I wouldn’t go back to that life for anything. I want to go off methadone too--I wouldn’t want to stay on it too long, my kids are too important to me.” “I might be feeling bad but you still have to get up when you have kids. But I’d be irritable and just off form, so the kids would know there was something.”

“When I was on drugs I’d be very narky, very worn out....would get my mother to mind them and go to get money for a Fix....I remember one time hitting (older child) across the Face when she ripped the wallpaper and bit her sister. I remember I was roaring and crying and later on ( tried to make it up to her.

These concerns indicate that the relationships between parents and children may be negatively altered by parental involvement with illicit drugs, and specifically, that parents may interact with their children in harsher ways that they believe appropriate. Parents’ descriptions of this negative interaction pattern were restricted to verbal interactions, and there was no evidence that this harshness was manifested in inappropriate physical punishment.

### **3: *Family Secrecy***

Parents of three children said that being on drugs created an atmosphere of secrecy in the home, that they made every effort to hide what they were doing from their children, and that the children appeared to be worried about what was going on. The parents create a picture of their active drug use as involving them spending a lot of time in the bedroom or bathroom, shouting at the children when they tried to come in, having locked doors, and this being upsetting for the children. One mother felt the secrecy was a form of mental abuse and that one of her children seemed to think she was getting ready to leave them.

Another concern was that children became very secretive themselves—being afraid to repeat anything that was said to them, but that they generalised this beyond drug use and it was difficult to get them to talk about anything. This was very different from the naive way that young children typically tell “tales.” Another mother said that her older daughter didn’t trust her parents, that she was always suspicious they were going out to buy drugs, even when they were no longer taking drugs.

This appears to indicate that parental use of illicit drugs, and their concealment of their drug-related activities, gives rise to problems in parent-child relationships, and particularly in the levels of trust between parents and children.

### ***Parenting and Social Support***

Support for drug-using parents in the provision of care to their children was provided primarily by close family members and particularly by their own parents. This occurred in five of the families. Mothers and sisters in these families provided a range of care for the children, from short-term child minding while parents attended drug treatment centres, to longer term arrangements for days of weeks when parents were unable to cope with childcare themselves. The mother of child I, for example, reported the following:

“My family has also been very supportive. I have two brother and two sisters on drugs...my parents have been very supportive of all of us, they gave us all a chance and brought us back home.”

In the case of five families parents reported receiving little or no support from their families, primarily because contact with them was either negative or had been broken off. In some cases this was attributed to their involvement with drugs. The father of Child C, for example, said

“At the moment my family don’t want to know me because of the drugs.”  
The mother of child G, similarly, said “My family cut me off. I’d never had a close relationship with them but it was worse since the drugs. They would never take the kids.”

The child's father shared this perception, saying

“we both have big families but we didn't see them except for my brother. They shunned us. When we were straight it was different.”

The majority of the parents said that, apart from family support, their main source of social support as parents as well as individuals, was through the drug treatment centre. Others mentioned receiving support in the community, but that this had decreased or turned to “hassle” when they were actively using and/or selling drugs. The mother of child I remarked

“I got some hassle in (the flats] because I was bringing people into my flat to use drugs, but that was my own fault.”

There was also one parent who felt that she did not receive any form of social support. It was clear from all parents that social support was perceived as vital to their functioning as good parents. A number of parents mentioned, however, that drug users who were parents should receive more advice and information about the potential negative effects of their drug use of their children and the ways in which they could protect their children from future involvement in drug use themselves.

## ***Keyworkers' Concerns about Parenting*** **(Research Question 6)**

On the whole there was a good deal of variation in the level of concern voiced by keyworkers about the adequacy of care provided by drugs-using parents. In a few cases there were simply no concerns beyond the bounds of everyday parenting difficulties. Concerns were more likely to be about parents who were currently or previously using heroin actively and not receiving treatment. Three themes emerged:

### ***1: Inconsistency***

A strong theme emerging from interviews with professional workers was that parents, when actively using drugs, appeared to be unable to engage with their children in a stable way, even when the children had difficulties. In one case (father of child C) this was perceived to be so problematic as to preclude even access visits to the child:

“His commitment to seeing his son is sporadic. I wouldn’t see him as being a good parent. He’s way too chaotic. Even access visits would be a problem—he’d show up a few times and then stop. He’s been homeless a few times and is now. A lot would have to change.

One professional worker perceived the mother of child J as potentially unable to provide consistent care to her children:

“..she was....chaotic, erratic, and I would have feared for her ability to take care of her children’s needs once she was outside the structure of the prison. The children were getting to see their mother consistently when she was in prison, but not when she left....She had been very chaotic, was really not getting it together to visit her children on a regular basis...The children often said that she hadn’t come to see them regularly, that Mammy said she was coming and then she didn’t come.”

The parents of child G were perceived to be unable to provide consistent care when their drug use reached its most chaotic levels prior to their receiving treatment:

“The parents were out of control. Then there were major concerns that [target child] had been interfered with..... Social workers got involved but the parents would not engage. They didn’t keep appointments for the child at Child Guidance.”

This keyworker concern echoes, 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.

### ***2: Neglect***

There were serious concerns about the physical neglect of three of the children and in all cases there was social work involvement. In the case of child F, following several occasions when the children had been voluntarily placed in care, a permanent care order was obtained. In the view of the social worker, these parents had neglected their children over time:

“The kids were neglected. The way they ensured their kids were fed was by dumping them on the Health Board.”

In the other two cases, neglect was suspected when parents were actively involved in drug use. The parents of child G were perceived as unable to provide basic physical care such as food:

“I am sure it affected the kids—we had major concerns about them. I was aware that the kids were constantly going to neighbours for money because they were out of food. The neighbours were worried that the kids were hungry so they gave them food.”

The mother of child I was described in similar terms:

“She used to be very clean and I heard her flat was filthy (when on drugs) which was out of character for her. The kids didn’t go to school at all and they were hungry.....The kids would be looking for somewhere to sleep at night....It was basically neglect, forgetting to feed them. staying in bed all day, leaving the kids and herself not washed or clean.”

Neglect of children’s basic physical needs was a serious concern, but one which applied to less than one third of the children involved in the study.

### **3: *Exposure to Drug Use***

A major concern about three of the target children was that their parents invited drug users in the area into their homes to take drugs and that children were exposed to this behaviour. The parents of child G were described as follows:

“When active they were very chaotic, there was a lot of activity in their flat and it got progressively worse. They were allowing their place to be used as a shooting place-I think it got them free drugs. Whatever discretion they showed earlier stopped. You could see them out poaching for drugs. There were a lot of drug addicts hanging out in their flat, both to buy and sell.”

It was also suspected that Child I was exposed to drug taking because of his mother’s behaviour:

“When she was using she got very chaotic and let people use her flat. The place was a shooting gallery—God knows what those kids saw.”

There were concerns that child H was exposed to drug use when his father was in prison, as this decreased the stability of the child’s mother because she was obliged to seek out drugs herself:

“The husband supports the mother’s habit and there is more stability when he’s there. When he’s in jail it gets chaotic—she has no-one to score for her so she lets other drugs users in the area use her house to shoot up in exchange for drugs.”

This final category of keyworker concern indicates that children of drug using parents may witness the use of illicit drugs by parents, other relatives, and by friends or even strangers, in the family home. This may have negative implications for children’s moral development and for their future choices about whether to use drugs themselves.

### ***Parenting Strengths Perceived by Keyworkers***

Professional workers were also asked to describe the strengths of each parent. It was evident that the main strengths emerged when parents were on treatment than when they were actively using drugs since this was linked to a more chaotic and inconsistent lifestyle. The parents of child G, for example, about whom there were some concerns about parental neglect, were viewed as competent parents once they had settled into a treatment programme:

“At the moment the main strength is that they have their dignity back, and that now they are there for their kids. Since they started on treatment I can see the improvement in their quality of life. They are planning, responsible, behaving differently, talking about their responsibilities to their children.”

Similarly, there had been serious concerns about the adequacy of care provided to child I and about the child’s exposure to drug use while his mother was actively using heroin. Her professional worker said that she was more stable now that she was receiving treatment, and was taking care of her children’s physical needs competently. Even parents who were still judged to be leading quite a chaotic lifestyle and to be unable to care for their children on a day to day basis, professional workers could identify strengths. About the a parents of child F, for example, a social worker commented:

“They have engendered a strong sense of family identity. The child has a good sense of who she is. The children love them and there’s no doubt that they love the children.”

There were also parents in this group about whom no concerns were raised, and indeed their strengths as parents were emphasized. This was particularly true of the parents of child D:

“I honestly feel they are the same as any other ordinary parents, and that is not something I’d say of all drug users. I am not aware of any weakness due to them being on drugs. When the father had relapses lately the kids were a bit upset and withdrawn because he wouldn’t be there for them as much. But the mother in particular always made sure the kids were all right....They are willing to talk about the potential effects on the kids. And they have a great sense of protection of their children and a great pride in them.”

Similarly, the mother of child A was described as follows:

“In relative terms I would see her as a good parent, a very concerned parent. She is very consistent in terms of delivering physical care and she was extremely good around talking to the child about her father’s death.”

### ***Support to Parents***

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. In two cases the child’s grandmother was raising the child on a full time basis, and in three cases, grandmothers regularly took care of the child. The mother of child I emphasised the importance for her of here parents’ support:

“My family has been very supportive...they gave us all a chance and brought us back home.”

The mother of child J said that she relied on her mother for help with her new baby:

“My mother...will take care of [baby] when I need to come into town for treatment or something like that.”

However, in four cases relationships with the parents families were poor. primarily due to grandparents cutting parents off because of their involvement with drugs. For example, the mother of child G described her relationship with her family as follows:

“My family cut me off. I’d never had a close relationship with them, but it was worse since the drugs. They would never take the kids. We had no support from [father’s] family either.”

Seven parents also pointed to the support they received from the drug treatment centres. and only one parent said that she felt that she did not receive support from this source. The mother of child I said

“..the main help I got was from here [drug treatment centre]. I find them great, to have someone to talk to about it, get yourself sorted out.”

The father of child D, similarly, said :

“I got great support from [keyworker at drug treatment centre]....”

In the case of two families, parents mentioned that they received less support and indeed some negative pressure from the local community during the period in which they were actively involved in using heroin. One said that she got “hassle” because she was bringing people in to her flat to use drugs, and she felt that this was her own fault.

In summary, some parents who used drugs were perceived by keyworkers to experienced parenting difficulties, while others were viewed as coping competently with childrearing. This suggests that parenting should be assessed on a family-by-family basis for the purposes of intervention.



## Chapter Five: Conclusions and Implications

This study takes an in-depth look at the social and psychological effects on young children of parental heroin use in a time of rapid social and economic change in Ireland. In this chapter the findings are discussed in the light of the contextual/ecological conceptual framework. The implications for children's development are then outlined. The areas of need on which Stage Two of the study will focus are highlighted throughout the chapter.

### Discussion of Findings

#### *Broader context*

At the level of the community and broader socio-economic context there was a strong relation between parental drug use and social deprivation. Parents were chronically unemployed and had low levels of education. They lived either in local authority housing in areas of pronounced social disadvantage with high rates of local drug dependence or were homeless. In the absence of a comparison group, however, it was not possible to separate the effects of parental drug use from the effects of social deprivation on children's development. At Stage Two the inclusion of a comparison group of children from similar communities and socio-economic backgrounds whose parents do not use drugs will allow for separation of the effects of drug dependence and social deprivation.

At the level of community and family it was clear that support made a substantial difference to the ability of parents to cope with childrearing. This took the form of help with short and/or longer term care of children, advice, and simply having somebody to talk to. In particular, grandmothers and other family members appeared to play a crucial role in providing care for children.

#### *Family Environment*

At the level of the family environment the primary finding of this study was of substantial variation in the effects on children of parental drug use, depending on a number of inter-related factors. Some children appeared to receive good quality care from their parents in spite of drug dependence. Others experienced periods of inconsistent care when their emotional and physical needs were not satisfactorily met. These periods appeared to be associated with variation in the nature and history of each parent's drug problem and treatment.

The greatest parenting difficulties appeared to be associated with active drug use, when parents were preoccupied with warding off withdrawal and led chaotic lifestyles centred around the pursuit of drugs. Parents who were receiving treatment on a consistent basis on the other hand, had greater and more consistent involvement with the provision of physical and emotional care to their children. Children under the care of active drug users in this study were more likely to be exposed to drug-taking and drugs paraphernalia, according to professional workers.

Parents themselves were concerned that their behaviour during periods of intense drug taking was unfocused, under-attentive, and irritable. Some were concerned that their children might be emotionally damaged by the atmosphere of concealment surrounding their drug behaviours.

This study also suggests that children of drug users are at risk for separation from their parents, due primarily to the high incidence of imprisonment of heroin users (especially fathers) and to the risks of drugs-related illnesses such as the HIV and Hepatitis

viruses. These issues, relating to the quality and consistency of parenting, have implications for children's social and emotional development.

At Stage Two the consistency and adequacy of care provided to children of drug users will be a focus of investigation. The frequency with which such children are separated from their parents due to drugs-related crime, illness, death, and inability to provide basic care, will be documented. The nature of the care provided to children during these periods, and particularly by whom it is provided, will be studied. Parents will be asked to describe drugs-related factors that interfere with their ability to provide care to their children on a daily basis, and/or the factors that allow them to continue to provide good quality care to their children in spite of their dependence on drugs. Children's care needs will be assessed on this basis. As well as exploring the processes by which parental drug use impinges in children's lives. Stage Two will also take a more in-depth look at the psychological effects on children.

Stage Two will also investigate the extent to which children are exposed to the drug culture, through witnessing of drug taking and drugs paraphernalia and overhearing conversations about drugs will be investigated further. Their exposure to the criminal justice system will also be studied.

### ***Home-School Relationship***

Context was also related to children's cognitive development, in terms of the relationship between the home and school. Children in this study had notable difficulties with school progress. Several children were in need of remedial teaching and performed below average compared to other children of the same age, particularly in writing, reading and mathematics. For number of children school attendance was poor, as was their homework completion and their physical presentation at school. Teachers related these problems to poor relationships between the school and home contexts and there was a distinct pattern of very low levels of involvement by parents with the school and with their children's education.

### ***Individual Factors***

There was also some variation in children's resilience to parenting difficulties, suggesting that individual factors, such as children's age at the time when parents were most actively involved in the drug culture, should be investigated further. Another source of variation in children's response to parental drug use indicated by this study was the support available from families, relatives, and the community in general, and the ability of both children and parents to make use of this support.

### **Implications for Children's Development**

Children in this study appeared to be exposed to a number of difficulties arising from their parents' use of opiates. These included higher levels of separation from and loss of parents and lessened parental involvement in their lives, in some cases raising concerns of neglect. They also appeared to experience a good deal of tension in the home and to be subject to harsh discipline in some cases. Furthermore, they were exposed, to varying degrees, to the lifestyle associated with opiate dependence, including drug-taking activity and crime. What are the implications of these findings for children's development?

First, separation from and loss of parents was a particular problem in the lives of the ten children studied. Other research has found that disruptions to parental care, especially early disruption of maternal care, is linked to children themselves having long-term difficulties in parenting their own children (Rutter, 1995). It has also been linked with

depression (Amato, 1991), and in the shorter term, with problems with peer relationships (Tizard & Hodges, 1978).

The effects on children of being separated from their parents due to their incarceration has been studied by Gabel (1992a, b; 1993). He found it to be associated with increased incidence of delinquency and depression in boys and with attention problems in girls, he suggests that the seventy of these problems may be influenced by the ability of the remaining parent to cope alone.

Low levels of involvement by parents who are present in the home, such as low levels of supervision and monitoring and infrequent communication with children, has been linked to a range of problem behaviours in children, and especially to fighting, non-compliance, and delinquency (Larzelere & Patterson, 1990; Loeber & Stouthamer-Loeber, 1986; Simons, Whitbeck, Beaman & Conger, 1994). It has also been linked with depression, irritability and somatic problems in some children (Simons et al., 1994). In its extreme form, low parental involvement implies neglect of children's basic physical care, which has serious health as well as psychological implications.

Low levels of parental involvement in children's schooling, such as poor attendance at school functions, has been found to have negative implications for children's performance at school (Paulson, 1994; Steinberg, Lamborn, Dombusch, & Darling, 1992) and with poor school attendance by children, also leading to them falling behind at school (Simons, Johnson, & Conger, 1994). Children in the present study appear to be experiencing similar problems associated with their parents' low levels of involvement in their education.

Low levels of emotional involvement by parents, or a lack of closeness and supportiveness, also appears to have negative implications for children's well-being. It has been identified as factor in delinquency in adolescents (Loeber & Stouthamer-Loeber, 1986). Supportive parenting, on the other hand, in the form of affection, nurturance and interest shown towards children, is associated with such positive attributes in children as greater self-esteem, life satisfaction, and both social and cognitive competence (Wenk, Hardesty, Morgan, & Blair, 1994).

Parenting that is characterised by irritability and harsh verbal criticism has been found to affect children negatively also, leading to social withdrawal and wariness (Rubin, Stewart & Chen, 1995).

Finally, the exposure of children to drug-taking activities and to criminal activities associated with drug-taking by their parents has not previously received attention from research, and therefore its implications are largely unknown. Future research needs to focus in particular at the implications of such exposure for children's own choices regarding involvement with drugs.

In spite of these potentially negative implications for children, it should be noted that the problems listed above were not experienced to the same degree by all families. Furthermore, there was evidence that families coped differently when such problems did arise, 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. In addition, individual children appeared to cope differently with problems in the home associated with parental drug use, showing different levels of resilience. It would be incorrect, therefore, to assume that all children are at risk for the range of problems described here.

## **Summary**

Stage One of this study has identified a number of specific factors, both contextual and individual, which may place children of drug users at risk for inadequate care and for psychological difficulties, as outlined above. These factors will be examined extensively at the second stage of the study in order to identify children's needs and make policy recommendations.

Although these particular children were not studied longitudinally, it is clear that, although Ireland is currently enjoying unprecedented economic advance, growing numbers of children in Dublin's most socially deprived areas are experiencing social and psychological difficulties. Among those particularly at risk are children of heroin users. It is urgent that the experiences and needs of this group of Irish children are better understood.

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