

Everyone Has a Story

Component 4

What the evidence tells us

"She is not using as much, as far as I can tell. We do more together at the weekends than we used to."

*shared story

Young Person (aged 8 - 11)

This is component 4 and forms part of the Everyone Has a Story action learning project.

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Summary

This component offers a comprehensive evidence review with the aim to support the wider action learning approach of Everyone Has a Story.

The definition of recovery is adapted from the Scottish Government's 'Road to Recovery' strategy (2008) as a person who is progressing towards a substance free life and looking to make positive changes in all areas of their life; family, health, work and community.

This evidence review recognises the reality for people in recovery will often mean that parents are known to services, will be engaging with some form of support and making attempts to change things in their lives.

Through a critical analysis of the empirical evidence, this review seeks to explore the ways parental recovery from problematic drug and alcohol use may affect children and young people.

This review consults literature that illustrates the ways parental problematic drug and alcohol use can impact family life and the support needs of children and young people. Close analysis of the evidence helps to identify the protective factors that may facilitate child well-being and positive outcomes, e.g. the role of positive family relationships and opportunity for respite. In addition, the literature illustrates the potential risks and vulnerabilities of children and young people affected by parental problematic drug and alcohol use e.g. emotional neglect and trauma.

Evidence illustrated within childhood trauma and neglect studies provides scope to understand the ways negative events in childhood can be the source of irreversible damage that can shape outcomes in adulthood. Finally, the review consults evidence that demonstrates the diverse and at times unstable living arrangements children and young people may experience as a result of parental problematic drug and alcohol use and recovery.

Key messages:

This evidence review is not a conclusive analysis of children and young people's needs during their parent's recovery from problematic drug and alcohol use. It aims to demonstrate the need to recognise children and young people's experiences in recovery by illustrating the complexity of their family life and the different factors associated with their own well-being and development.

- It is important not to overlook the contextual factors that may shape how a child or young person is affected by problematic drug or alcohol use and recovery. For instance, where a child is living, the availability of support and the quality of family relationships.
- Understanding how children and young people experience change is important. The transitions associated with an adult recovery as well as the complexity of different family circumstances need close consideration when supporting a child or young person.
- Greater emphasis on hearing from the experiences and views of children and young people to support qualitative research. This would further develop our understanding of children and young people's needs.
- Consulting studies childhood development in the context of trauma, attachment and resilience provide a useful framework of how early childhood experiences may impact adulthood outcomes. Capturing narratives from young people affected by trauma or significant change would help to further validate the quantitative data.
- An awareness of potential thematic gaps in existing social research, particularly around the changing of family dynamics. Greater exploration is needed around children and young people's experiences of kinship care as well as reuniting care experienced children and young people with their parents during recovery.

Background

This component, 'What the evidence tells us', provides a comprehensive summary of the evidence, including formal literature, giving an overview of what we know are the potential protective and risk factors for children and young people. Its aim is to provide an understanding of the existing research and potential gaps that could help us have a better understanding of the support needs for children and young people whose parents are in recovery from drugs and alcohol.

Introduction

Over recent years, there has been increasing recognition of the impact parental substance issues have on children and young people. This is reflected within social research and policy. Implementing a robust and consistent approach to improving the lives of children and young people in Scotland has been a central focus of Getting it Right for Every Child (GIRFEC) (2012) along with the Getting our Priorities Right (GOPR) (2013) strategy. According to the Scottish Government, approximately 40,000 - 60,000 children and young people are affected by parents with a substance problem in Scotland (GOPR, 2013). However, helping children to cope with their parent's problematic substance use is only part of the story. Social research that directly investigates the ways a parent's recovery from problem drug or alcohol use affects a child or young person is sparse. There is no data available that capture the number of children and young people whose parents are in recovery from substances in Scotland. Although, the Scottish Drugs Misuse Report (2010) estimated over 10,000 adults receiving treatment for their illegal drug use had dependent children.

We learn from existing research that children and young people may develop various emotional responses and coping mechanisms to deal with the chaos of parental problematic drug or alcohol use in their family (See Bancroft et al. 2004; Hogan and Higgins, 2001; Barnard and Barlow, 2003). However, these coping strategies may become redundant if parents recover from their substance issues and children may need to devise an entirely new approach to family life. Consider, for example Kroll and Taylor's (2003) suggestion that parent-child role reversal is a common response from young people who take it upon themselves to try and implement household structure or become the primary source of care and responsibility in the home. The extent this can be relinquished and normal parent-child roles restored as a result of recovery from substances will be an important element of this review. In addition, we should consider the extent parental recovery may appease or exacerbate a child or young person's anxieties that may have been commonplace during the turmoil of their parent's problematic drug or alcohol use. Exploring evidence on the impact of trauma, neglect and damaged attachments will lay the foundations to help us understand the needs of children and young people affected by parental problem substance use and recovery. This review aims to highlight the need to acknowledge parental recovery from substances from the perspective of a child or young person.

Recovery and Relapse

Although formal definitions vary, the dominant rhetoric for recovery from problematic drug and alcohol use focusses on the needs of the individual user. The personal circumstances that underpin recovery processes and experiences form the basis for much of the evidence on substance recovery (Road to Recovery, 2008: 23).

'A process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.' (Road to Recovery, 2008).

Similar notions of recovery can be found within The Betty Ford Institute's (2007: 223) study of recovery concepts, which concluded recovery is a person-led process supported by networks, kin and community. These definitions often focus on the ways an individual with problematic drug and alcohol use may negotiate through the stages of recovery and experience identity transformations (Betty Ford Institute, 2007: 223; Road to Recovery, 2008). It is evident that these person-centred explanations leave little scope for to consider children or young people of parents recovering from problematic drug and alcohol use. Furthermore, although these definitions offer an insight into an individual's recovery journey, it is worth challenging the assumption that recovery is a linear process, defined by an individual achieving a life completely free from drugs and alcohol. The complexity of the recovery process is highlighted throughout this review.

As extensive research has come to demonstrate, problematic parental drug and alcohol use can adversely affect a child in numerous ways. The entire balance of a family can be weighted on the needs of the user resulting in children becoming well-adjusted to the chaos of family life. With that in mind, if the impact of problematic drug and alcohol use so evidently extends beyond the user we must apply the same approach when we consider the impact recovery can have on a child or young person. Research that explores the roles of the family as a facilitator of recovery is useful in challenging assumptions that this is only experienced by the individual user. Analysis on recovery capital is a relevant premise here. Capital refers to the possession or development of social networks or resources which support one's advance in status or well-being (Bourdieu, 1986). In the context of recovery from problematic drug and alcohol use, recovery capital could be defined as an individual's skills, aspirations, values and family relationships (Cloud and Garfield, 2004; Best and Laudet, 2010). By drawing on the wider social influences of the recovery process, Cloud and Garfield, (2009; Best and Laudet, 2010) demonstrate the importance of considering the broader picture of recovery and the key components that may foster recovery success.

Family members, as described by Copello et al. (2010) is an integral part of the recovery process not only as supportive agents, but also as experiencing a recovery in their own right. Whitfield (1997) asserts that the immediate family can become so attuned to meeting the needs of the people with problematic drug and alcohol use that they can struggle to articulate their own needs and identity. **Recognising the needs of family members during recovery provides scope to understand the importance of not overlooking children and young people.**

Furthermore, it is important to challenge the assumption that recovery from problematic drug and alcohol use is a liberating process which initiates positive change. Moe (2007) argues the difficulties can commence for children when their parents enter a recovery programme. Children growing up with problematic parental drug and alcohol use may understand their parent's drug and alcohol use as a normal part of life, accepting the family disorder and becoming well-adapted to the chaos (Mackey, 1989). When the entire fabric of family life is built around drug or alcohol issues, the radical changes of recovery could be unsettling for children (Mackey, 1989; Moe, 2007). We learn from the literature that recovery from problematic drug and alcohol use demands significant lifestyle changes. Radcliffe (2011) asserts recovery is a process of identity transformation, whereby the individual learns to reconstruct their role in their family and society. For a parent these transformations could potentially reshape their relationships with their child. A notion Harbin (Harbin, F. and Murphy, M. (eds.) 2006) develops with the Rollercoaster of Change diagram (figure 1), which provides a useful illustration of the ways recovery may impact on a child or young person. Harbin (Harbin, F. and Murphy, M. (eds.) 2006) suggests that the transitions associated with adult recovery, such as contemplation, pre-contemplation (Prochaska, J. and DiClemente, C. 1982; 1983) provoke different emotions and changes for a child. For instance, the maintenance phase of an adult's recovery may prompt feelings of uncertainty for children. In other words, as parents begin to control or reduce their drug or alcohol use children are also learning to renegotiate the relationship they have with their parent. In addition to this, experiences of relapse may hinder attempts to restore the trust between a parent and their child.

The Cycle of Change and the Child's Roller Coaster

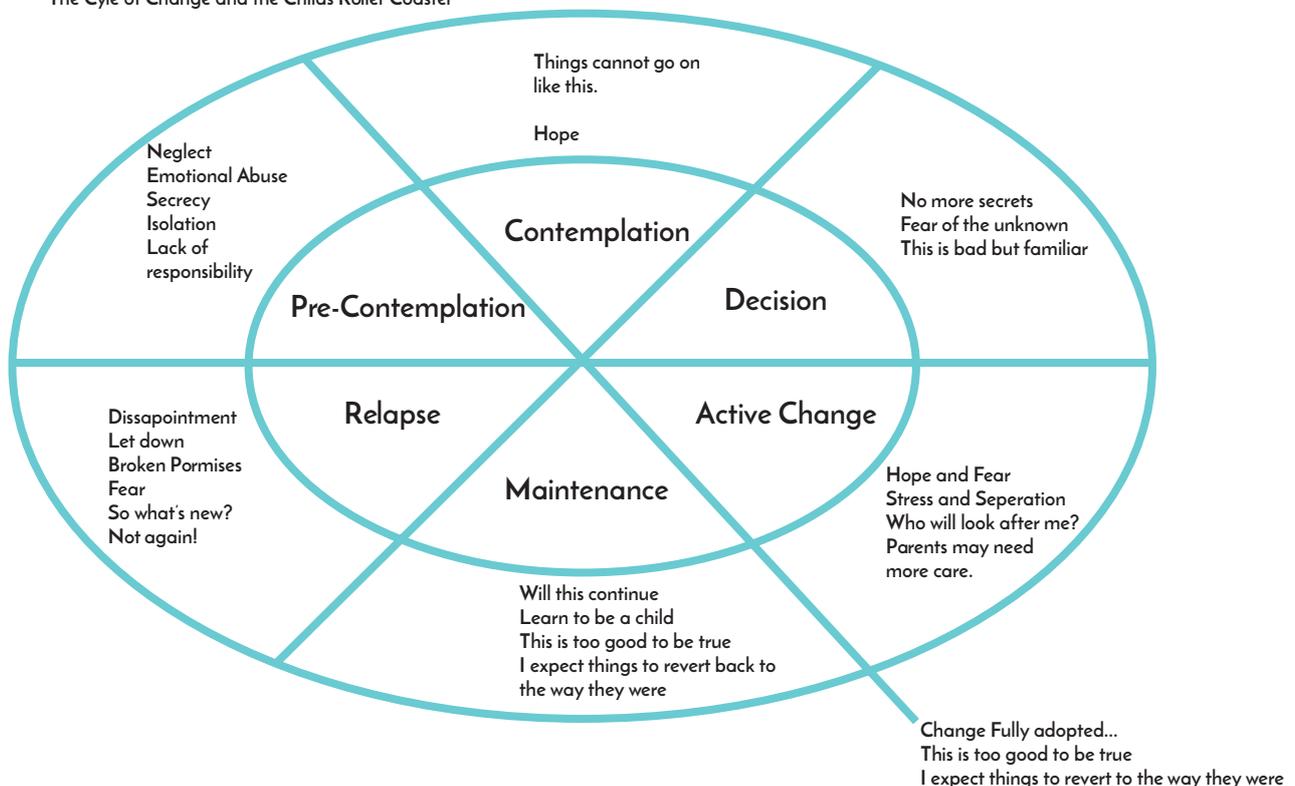


Figure 1: Cycle of Change (adapted from Prochaska and DiClemente 1982 - Fiona Harbin)

Harbin's (Harbin, F. and Murphy, M. (eds.) 2006) illustration of the complex recovery experiences of children, young people and their parents are supported within wider empirical sources. Adfam's (2013) 'whole family recovery' captured the qualitative narratives from young people and their definitions of recovery.

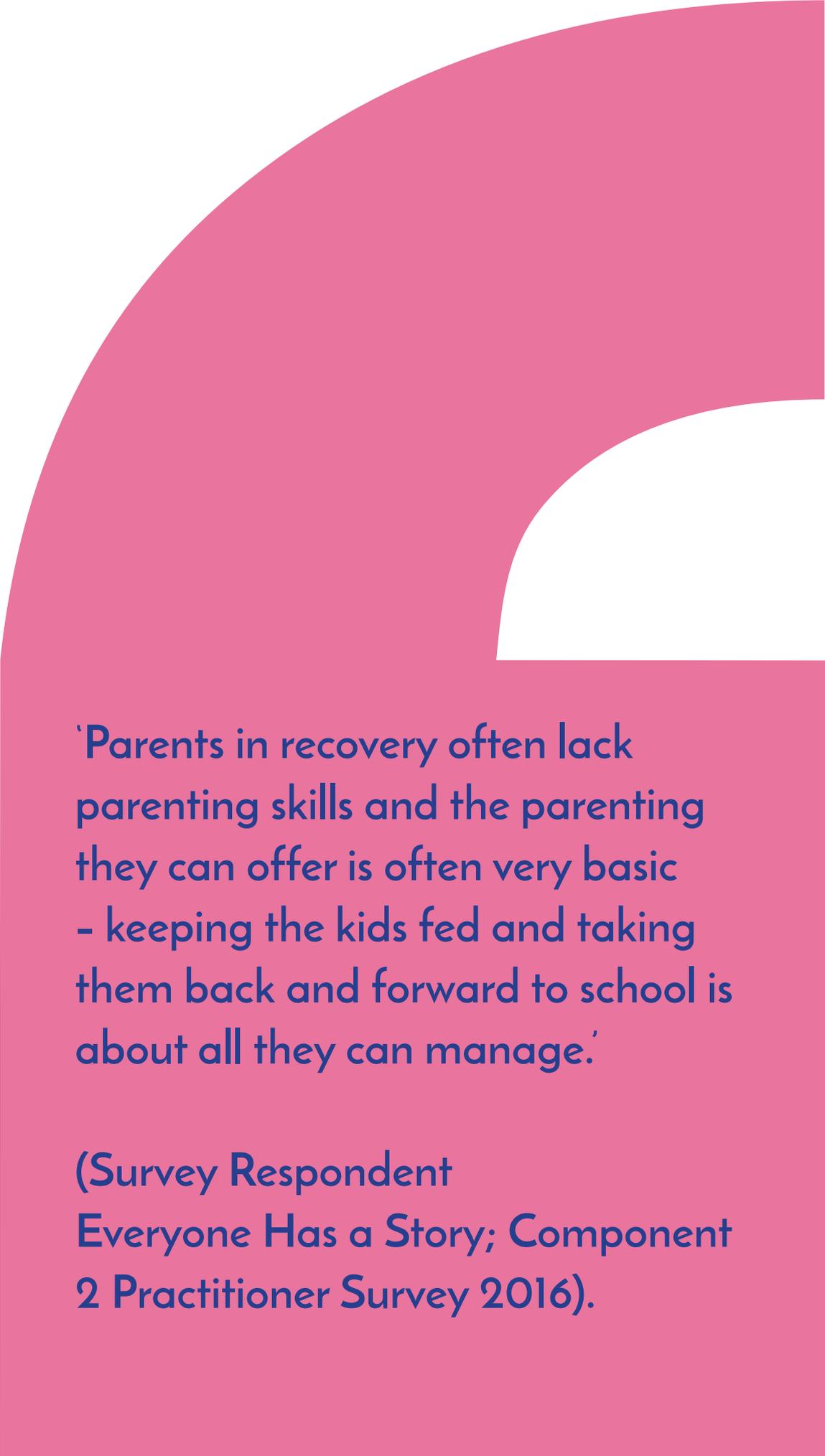
**'When mum first did her detox I used to have sudden panic attacks; sudden anxiety that 'gosh, she could start drinking again tomorrow.'
(Participant in focus group, Adfam, 2013: 6)**

These findings provide a useful glimpse into the recovery experiences of children and young people. Capturing the stories of young people affected by parental problem substance use and recovery provide a new dimension to our understanding. The above narrative demonstrates the ways relapse or the prospect of parental relapse can be a catalyst for emotional turmoil in an already fragile environment (Adfam, 2013: 6). Similar notions were echoed in Everyone Has a Story action learning project, practitioner survey where 46% of practitioners claiming fear of relapse was a common concern for children and young people during their parent's recovery (Everyone Has a story; Component 2 2016).

**'I have had experience of children wishing their parents would go back to using as that is familiar for them and the stress of a possibility of relapse causes the young person increased anxiety.'
(Survey Respondent, Everyone Has a Story; Component 2, 2016)**

This practitioner's account demonstrates that even when parents may be abstaining from drugs or alcohol children may be anxiously anticipating relapse. This also illustrates how unpredictable recovery can be and the importance of supporting the whole family through the key stages. A principle promoted within whole family approaches to support, whereby recognising the needs of individual family members is considered paramount to overcoming the issues associated with problematic drug or alcohol use (Boon and Templeton, 2007). Boon and Templeton (2007) suggest by facilitating a space where children are able to communicate their fears and needs to their parents can be a positive step towards tackling issues and repairing family relationships.

With that in mind, Moos and Billing (1982: 158) found the families that had experienced persistent stints of relapse had the least family cohesion and a greater tendency for the children to experience significant mental or physical health problems. This suggests a sudden decline back into old habits can polarise family relationships and damage optimistic hopes of change for children (Adfam, 2013; Moos and Billing, 1982: 160).



'Parents in recovery often lack parenting skills and the parenting they can offer is often very basic - keeping the kids fed and taking them back and forward to school is about all they can manage.'

(Survey Respondent
Everyone Has a Story; Component
2 Practitioner Survey 2016).

Relationships

Family dynamics and relationships are often central to studies of childhood well-being and development. Empirical evidence continues to emphasise that positive relationships are the route towards mental well-being, resilience and positive life outcomes (Ainsworth, 1964; Hughes, 1998; Rutter, 2007). This evidence can be applied to the context of parental problem drug or alcohol use, as the existence of consistent support, care and nurture can be a crucial protective factor for vulnerable children (GOPR, 2013). Howe (2005) suggests relationships can heal emotional wounds and help individuals overcome challenges.

This interplays with the role of relationships in recovery. Literature suggests wider societal factors and family dynamics can play a key role in facilitating as well as hindering sustainable recovery from drugs or alcohol (Moe, 1989; 2007; Mackey, 1989; Moos and Billings, 1982). Munton et al. (2014) asserts family can be a powerful source of 'recovery capital' to support individuals towards recovery from substances. What is interesting to observe here is that the recovering individual may be reliant on supportive family relationships to achieve their desired outcome, all the while children require support and care from their recovering parent. Component 2 of this resource further brought to light the importance of considering parenting capacity during recovery (Everyone has a Story; Component 2, 2016).

F *'Parents in recovery often lack parenting skills and the parenting they can offer is often very basic - keeping the kids fed and taking them back and forward to school is about all they can manage.'*
(Survey Respondent, Everyone Has a Story Component 2, 2016).

In Harbin's (Harbin, F. and Murphy, M. (eds.) 2006) illustration of recovery experiences for a child and young person, Harbin (Harbin, F. and Murphy, M. (eds.) 2006) suggests that when a parent embarks on their recovery journey a child may worry their own needs may be pushed to the side-lines, As Harbin asserts (2006) 'Parent's will need more care, who will look after me?' Here it becomes evident that parental recovery can cause uncertainty for a child or young person.

This suggests that a parent's availability and engagement with their child may be hindered during their recovery journey. Furthermore, this highlights recovery may prompt an imbalance of need between a parent and child, as both may require the support of a stable nurturing relationship. GOPR (2013: 80) outlines several key outcome measurements to consider when supporting a child or young person during their parent's recovery. Of these outcomes, the availability of a positive adult role model as well as safe and stable home environments were identified as a significant need for children and young people. It is critical that we ensure and recognise that the burden of recovery from problem drug or alcohol use should not lie with the child or young person (Boon and Templeton, 2007). This is supported with the findings from Everyone Has a Story action learning project's practitioner survey where 46% of respondents (n 207) cited children and young people had a fear of parent's relapse and 35% claimed anxiety was as a key concern for children or young people living with their parents during recovery (Everyone Has a Story, Component 2, 2016).

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'Mum looks better, she tells me off now. I have to go to school and mum does normal things like cooking. Dad is more interested in what I am doing at school, there is more money to do nice things as a family.'

(Survey Respondent,
Everyone Has a Story;
Component 2, 2016).

This narrative shared by survey respondent as part of *Everyone Has a Story* (2016) supports the GOPR (2013:80) outcome measurement by illustrating the positive impact the availability of parental care and stability. We learn from the above experience, that recovery has promoted more positive engagement between parent and child. Boon and Templeton (2007) suggest trust can be repaired through a whole family approaches to support, focusing on parenting capacity and empowering young people to communicate their needs with confidence.

Attachment

'Heavy use of alcohol and drugs distort, disrupt and disturb parent-child relationships' (Howe, 2005: 184).

To thoroughly consider the ways family relationships and conditions may adjust through recovery we should visit literature that explores the ways parental problematic drug or alcohol use impact on family life. The literature highlights the ways parental problem drug or alcohol use can provoke chaos within a household and expose children to a multitude of risks (Hidden harm 2013; Kroll and Taylor, 2003; Bancroft et al., 2004). These unstable family conditions may damage the relationship between a parent and child (Caspers et al., 2006; Thomas, 2011). When problematic drug or alcohol use begins to interfere with a parent's capacity to care for a child, Howe (2005: 184) asserts a child's vision of belonging and worth can severely decline.

These notions of self-worth in childhood are associated with theories of attachment. For all children, the availability of a positive 'attachment figure' that appropriately responds to a child's emotional needs is essential (Caspers et al., 2006; Ainsworth, 1970). Drawing on attachment theories developed by Bowlby (1969, 1980), Rutter (2007) describes consistent childhood care and nurture as the 'cornerstones of healthy child development.' In the simplest terms, attachment could be understood as the bond between a parent and a child (Hughes, 1998: 3), a bond that provides a protective haven for children allowing them to flourish and their needs to be met. When parents fail to provide sensitive care, attachment between them is compromised (Ainsworth, 1964; 1970; Oates, 2007).

In other words, a reliable source of protection and warmth are a basic necessity for all children (Hughes, 1998; Oates, 2007; Rutter, 2007). Howe (2005) argues when feeling threatened babies and young children seek the protection of their attachment figure to offer safety and reassurance. Gerhardt (2009: 81) stresses this is particularly important for babies as they lack the ability to self sooth in times of heightened stress. In most cases, parents will become the primary attachment figure by default, and their role is to appease their child's need to be held close and comforted (Ainsworth, 1970; Bowlby, 1969). When this source of comfort is not available and parents or carers fail to respond to a baby's basic emotional needs, anxiety goes unresolved and the consequences can be detrimental to child development (Howe, 2005: 163, Taylor and Lazenbatt, 2014). Acknowledging the significance of attachment is crucial in building our understanding of the ways parental problem drug or alcohol use and recovery impacts on children and young people.

Ainsworth (1970) acknowledged three styles of attachment, secure, ambivalent and avoidant.

Ambivalent attachment can be understood as an unpredictable care giving relationship, This is caused by the attachment figure being inconsistent with the care they provide. One moment the parent may not react to a child's distress or tease them when the infant seeks their attention (Ainsworth, 1964). The next moment the parent may be overly attentive and affectionate. This instability transpires to an uncertain bond between a child and their parent, leaving children unsure as to how their parents will respond and often unsatisfied with the care when offered (Howe, 2005; Oates, 2007). Ainsworth's (1964) study of mother and child responses in unfamiliar settings, observed infants defined as having 'ambivalent' attachments quickly became restless, some actively seeking their mother's attention but appearing unfulfilled with the comfort given. The study highlighted the different ways attachment can impact a child's focus and interactions with their parent. It is interesting to observe that even when parents become responsive to their infant's cries, a child's mistrust and uncertainty may remain (Ainsworth, 1964; Howe, 2005; Hughes, 2009). This raises questions of how children may respond to their parent's behavioural changes during recovery and how this may influence the attachment between them.

One response to an uncertain attachment put forward in the literature is avoidance strategies. Avoidance can be a tactic adopted by children whose desire for attention is continuously rejected (Howe, 2005). By avoiding confronting their anxieties, children may feel able to suppress any signs of fear and weakness (Howe, 2005; Kroll and Taylor, 2003: 179). This provides children with a means of protecting themselves from further harm. This mistrust and reluctance to engage can develop into severe difficulties coping with social interactions and forming new relationships (Bowlby, 1969, 1980; Kroll and Taylor, 2003). This may also create a false illusion of coping with difficult situations, children who adopt avoidance strategies become invisible to potential support (Barnard and Barlow, 2003; Rutter, 2007). This suggests opportunities to support vulnerable children and young people may go unnoticed if they appear to have well developed coping strategies, all the while masking their own support needs. This is important to consider in the context of parental recovery from problem drug or alcohol use, as children and young people may create a façade of coping with their fears and experiences as a response to disorganised attachment. The resilience chapter of this review is useful here to further highlight the complexities of disorganised attachment in childhood and coping strategies, explored later in this review.

Hughes (1998:7) provides some interesting commentary on attachment by exploring the ways avoidant attachment styles can obscure a child's understanding of relationships. Hughes (1998) asserts repairing the damage caused by emotional neglect is not simply a case of replacing the care-giver or teaching parental care, but rather resolving the trauma caused by withdrawn or resentful parents. Children build an idea of self-worth by observing how the significant adults in their life respond to their needs. When care is unpredictable or absent children's vision of worthiness is hindered and children do not learn to trust, interact or belong alongside other individuals (Hughes, 1998; Howe, 2005). This is an important consideration as we explore the changes children may be confronted with during their parent's recovery from problematic drug or alcohol use and how they can be supported to overcome the problematic relationships of the past. Children who have little first-hand experience of organised attachment will in effect be learning how to trust and be cared for, for the first time

(See Hughes, 1998: 3).

The long lasting impact of disorganised attachment styles forms a significant part of the discussion within neglect and child development studies. Gerhardt (2009: 83) asserts babies develop an 'internal working model' which helps them distinguish who their primary carer is, where they will be found and the nature of care they can offer. However, when the offer of care does not satisfy the child's needs children can become agitated and distressed, an affect that some scholars argue has ramifications into adulthood (Gerhardt, 2009; Howe, 2005; Ainsworth et al., 1964).



'Many challenges in adult society - mental health problems, obesity, heart disease, criminality, competence in literacy and numeracy - have their roots in early childhood.'
(World Health Organisation, Gerhardt, 2009: 81).

This is echoed by Howe's (2005) claims that the **impact of early childhood neglect and trauma may not be visible until adulthood**. The recovery journey as experienced by children and young people may bring about significant transitions it is therefore important to understand how experiences in early childhood can shape responses to changes and challenges in later life. Bell (2002 cited in Kroll and Taylor, 2003: 137) asserts children may grow up unable to calm themselves down and demonstrate 'extreme reactions' in day to day situations. This resonates well with literature that suggests children of people with parents with a problematic drug or alcohol use may be considered to have behavioural difficulties through their inability to self-regulate their emotions or articulate their feelings (Evans, 2008; Hogan and Higgins, 2001; Barnard and Barlow, 2003). Kroll and Taylor (2003: 137) describe a pattern of 'negative chain reactions' caused by inconsistent attachment experiences: The drug and alcohol problems disrupts normal family functioning resulting in disorganised attachments. This has negative implications for the child, their low self-esteem and difficulty relating to others manifests in their problematic behaviour, provoking negative reactions from the parent and adults around the child, furthering their isolation.

Trauma

At a broad level, trauma can be defined as experiencing a distressing or painful event which the victim is powerless to prevent (Evans, 2008; Pilnik and Kendall, 2012). A traumatic experience may be a one off incident, or a re-occurring event that becomes a part of day-to-day reality (Levine and Kline, 2007; Taylor et al., 2005). The concept of trauma is used to describe multiple distressing experiences and the impact on the individual may depend on the severity, frequency, age or gender of an individual (Holt et al, 2008; Grimshaw et al,

According to recent figures published by Alcohol Focus Scotland, alcohol was a factor in 50% of murders, 72% of domestic abuse incidents and 76% of assaults (Hope et al., 2013).

2011). In some cases, children may be considered 'poly-victims' who frequently experience several forms of hardship (Pilnik and Kendall, 2012). This is an important premise that highlights the need for continuous support for children and young people who are overcoming multiple adversities, particularly as evidence demonstrates the links between problem drug or alcohol use and the increased likelihood of being exposed to violence, abuse or physical or emotional neglect (Ullman, 2003 cited in Halt et al., 2008).

According to recent figures published by Alcohol Focus Scotland, alcohol was a factor in 50% of murders, 72% of domestic abuse incidents and 76% of assaults (Hope et al., 2013).

 *'When my mum is drunk she calls me horrible names and says she wishes I'd been killed. Usually the neighbours call the police which make it stop.'*

(Young person, aged 8; Everyone Has a Story, Component 1 2016).

The above narrative voices the frightening and uncertain relationship between a child and their mother in relation to problematic drug or alcohol use. Qualitative research that capture the experiences of young people provide an essential glimpse into their world and their needs.

Child psychology studies are useful in demonstrating the long term impact of trauma on a child or young person (See: Gerhardt, 2009; Hughes, 2009). Evans (2008) asserts all humans have a survival instinct that begins developing from babyhood and supports individuals to be able to overcome difficult or frightening circumstances. It is a normal human reaction to feel scared or overwhelmed when faced with an adverse situation and a well-developed 'survival brain' allows us to cope with challenging events (Evans, 2008).

However, for children and young people who are frequently subject to traumatic events child development can be hindered severely. For young children to develop a healthy response to traumatic events they need an attachment figure to offer protection and soothe them back into feeling calm (Gerhardt, 2009; Evans, 2008). In other words, the ability to cope with trauma may be exacerbated if there is a lack of an available positive attachment figure for a child or young person (Evans, 2008; Gerhardt, 2009; Howe, 2005).

Levine and Kline (2007: 3) reaffirms this by arguing there is a common misconception that babies and children will not recall or be affected by traumatic incidents when they are

very young, by drawing on strong empirical evidence asserting young children are the most vulnerable to the effects of trauma as their nervous systems are undeveloped. Furthermore, Gerhardt (2009) suggests we should not overlook the brain's ability to remember traumatic events, similar environments, language or behaviours can provoke a child to re-experience the distress evoked through trauma. Pilnik and Kendall (2012) claim flashbacks and re-experiencing are a common symptom of post-traumatic stress disorder.

The parallels between trauma and attachment theory are helpful to draw upon when considering how children may recover from past experiences. McIntosh (2006) suggests 'absent-minded' parents can intensify and prolong the impact of trauma for a child and young person. McIntosh (2006) suggests before children are able progress past trauma they need to be able to understand it, and the capacity of the parent can be an important factor in supporting trauma recovery. These assertions reiterate Harbin's (2006) notion that children may be experiencing their own recovery alongside that of their parent's.

Several studies have found alcohol to be a major predictor for violence in the home (Ullman, 2003 cited in Halt et al., 2008; Evans et al., 2008; Hope et al., 2013). Where domestic violence is present in the family home, the impact on children goes beyond simply witnessing the abuse (CEDAR, 2011; Halt et al, 2008). Halt et al., (2008) argue domestic abuse rarely occurs without the influence of other 'stressors' such as poor mental health, economic hardship, social exclusion or substance issues. These risk factors further exacerbate the impact on child well-being (Taylor and Lazenbatt, 2014; Pilnik and Kendall, 2012). 'Dual violence families' is a term Farmer and Owen (1995; Halt et al., 2008) describe as violent or abusive parental relationships that increase the likelihood of child maltreatment (McGee 2000 cited in Halt et al., 2008).

Social research exploring the sources of childhood trauma often makes links to an insecure attachment in infancy. For instance, Hammersley and Dalgano's (2013) qualitative study of people who had injected drugs, found a strong connection between the drug use of the participants and their experience of trauma. The study found the drug use had become a coping mechanism for the participants who were struggling to overcome difficult experiences (Hammersley and Dalgano, 2013). This exemplifies the difficulty of undoing the damage caused by disorganised attachment and trauma. Liotti (1999: 300 cited in Howe, 2005: 198) suggests children are all too often labelled as 'problematic' or 'difficult' by teachers, parents or family members overlooking the roots of their behaviour. **Studies of childhood trauma and development often make reference to the way trauma can negatively impact cognitive ability and behaviour.**

 *'The strongest predictor of children's behavioural problems was a climate of chaos and violence in the home environment during the early years.'*
(Sharp and Jones, 2011: CEDAR project).

Crittenden (1992, cited in Howe, 2005) echoes this, asserting children who were victims of neglect or abuse can be more hostile, aggressive and more sensitive to stress than children with non-abusive pasts. Evidence emerging from childhood development studies also suggests a gendered impact of trauma. Humphrey's et al., (2008) argues, that boys and girls can exemplify different emotional or behavioural responses to traumatic experiences.

For instance, boys may demonstrate 'externalised' behaviour, for instance through unruly or aggressive conduct. Whereas girls may show signs of 'internalised' conduct, where they become timid, introverted and express their anxiety through self-harm. Although some scholars reject gendered responses and assess other more contextual factors of trauma to understand the impact (Cummings et al., 1999 cited in Halt et al., 2008), there is evidence to suggest the gendered multigenerational impact of trauma, particularly as a consequence of violent or emotional abuse (See: Atkinson et al., Evans and Dilidilo, 2008; Halt et al., 2008).

Resilience

There is a growing interest in understanding the concept of resilience and the role of protective factors in allowing children to achieve successful life outcomes in the face of adversity (Carle and Chassin, 2004: 577; Lee and Cranford, 2008: 213; CE Waugh et al., 2008: 1013). Resilience is a contentious concept but at a basic level can be defined as overcoming adversity and having the ability to adapt to major life events whilst managing to maintain emotional and physical well-being (C E Waugh et al. 2008: 1031). The notion that a child may be able to develop an ability to 'bounce back' from difficult experiences has unsurprisingly sparked a great deal of interest and debate within studies of child welfare and protection (Brooks and Rice, 1997: 77 cited in Kroll and Taylor, 2003).

The robustness of resilience theory and research is held back by the lack of consensus over definitions and common language (Rutter, 2007). Rutter (2007) highlights the complexity of defining a child as resilient, firstly rejecting notions that resilience is simply a personality trait that one does or does not possess.



*"Resilience is not a one-dimensional, dichotomous attribute that an individual has or doesn't have."
(Rutter, 2007)*

Rutter (2007) suggests resilience should be considered to be a flexible state and warns of the dangers of assuming a child's resilience will not be compromised if they are faced with future adversities. Scholars have pointed out that care should be taken not to attach overly positive or negative labels to children as this may overlook the complexity of their emotions. Brooks (2005) asserts too much emphasis on the harmful experiences of a child's past may further a child's sense of vulnerability and hinder their ability to construct positive outlooks and aspirations. Similarly, child development studies highlight the way some children can adopt avoidance strategies, creating the illusion of coping with adverse experiences (Kroll and Taylor, 2003; Howe, 2005; Barnard and Barlow, 2003). As Barnard and Barlow (2003) describe, children may construct a 'false self' whereby children deny their true feelings as a means of protecting themselves from the dangers they envision from opening up about their personal life. This highlights the importance of not misinterpreting avoidance tactics as resilience. It is clearly challenging to identify the variables of resilience, one condition could provoke a vulnerable response from a child another could strengthen the child's resilience (Zolkoski and Bullock, 2012). Therefore, as Rutter (2007) stresses, we should aim to treat children as individuals with different experiences and needs.

Nonetheless, resilience literature provides a useful analysis of the protective factors that can foster healthy child development despite adverse experiences or conditions. Miller

(2002; cited in Zolkoski and Bullock, 2012) asserts, resilient children are able to learn from difficulties and actively seek out positive opportunities. The cognitive ability of a child has been associated with their ability to critically assess situations and communicate their worries effectively (DuMont et al., 2007). Educational success has been identified as a key protective factor for vulnerable children, where positive progression in school is described as helping enhance self-esteem as well as provide respite from the negative areas of a child or young person's life (Carle and Chassin, 2004).

Several scholars identify self-confidence as a component of resilience (Zolkoski and Bullock, 2012). The development of a positive sense of self is often discussed in the literature as an outcome of secure attachments and stable home life (Howe, 2005; Oates, 2007). With once again, the evidence suggesting that secure attachments underpin positive outcomes the question persists around the extent a child with a disorganised attachment could be considered resilient in the face of adversity. Brooks (2005) asserts having a positive, non-abusive caregiver can provide a child with stability and encouragement. DuMont et al.'s, (2007) study of resilience in neglected and abused children, found resilience could be achieved with the pre-existence of additional protective factors such as safe, secure environments and trustworthy relationships. The availability of positive empathetic relationships appear to be a key component of the development of resilience (DuMont, 2007; Skinner et al., 2008).

In addition, family conditions are said to play an important role in fostering resilience (Zolkoski and Bullock, 2012; DuMont et al., 2007). According to Clauss-Ehlers (2008) authoritative but loving families with consistent care and structure help to maximise competence in children. Similarly, the environment beyond the home can play an important role in the development of positive life outcomes and resilience (Clauss-Ehlers, 2008; Hill et al., 2007). The availability of accessible services such as health care or community recreational activities can help promote positive networks and supportive relations. This is important when considering how contextual factors may hinder or support the development of protective factors. **This reinforces the importance of using resources such as the My World Triangle assessment tool (Scottish Government, GIRFEC, 2012: 17).** The tool has been designed to allow children to consider what is important in their life, their needs and any risks to their wellbeing.

Role Reversal and Recovery

This section explores the ways child and parent roles may become blurred as a result of parental problematic drug and alcohol use and considers the extent these roles can be relinquished during recovery. Kroll and Taylor (2003: 179) assert where parental problem drug or alcohol use is present a child's fear over their parent's safety or the loss of family structure can be the catalyst for taking on significant care responsibilities. The implications of becoming a 'parental child' (Kroll and Taylor, 2003) will be important in understanding the changing family dynamics during recovery.

According to studies of young carers the impact of children taking up considerable household or care duties in their family home can be extensive. For instance, care duties may interfere with the everyday activities associated with childhood such as making friends, playing and socialising as well as going to school (Dearden and Becker, 2000; Aldridge and Becker, 1993). The literature suggests that for children and young people use hypervigilance is common, whereby children may decide to hide substances or keep a close surveillance of their parent's conduct (Barnard, 2007: 81; Kroll and Taylor, 2003: 120).

F *'And just I used to stay off to make sure my ma didn't get drugs and all that... 'cause I hate it...I used to follow her not let her do it...I mean, like, I would make sure she stayed in the house with me'*
(Child of problem drug user Jane, 15 years old; Barnard, 2007; 96).

F *"I'd only be [in school] for a certain amount of time and then I'd have to go home and look after my mum ... I used to come in from school. I would do the dishes. Put, like, all the clothes in the washing machine. My mum would be lying steaming [drunk] on the couch and I'd have to try and cook dinner."*
(Rachel, 17; mother alcohol misuser, Bancroft et al., 2004).

The above narratives illustrate the ways a young person may attempt to become the authority figure in the family. The experience highlights the ways parental problem drug or alcohol use can become the central concern of a young person's life to the extent that the other areas of their life, such as attending school are overlooked. Numerous studies highlight the ways being a young carer can disrupt school life, both through poor attendance and a lack of parental encouragement (Aldridge and Becker, 1993; Cree, 2003: 305; Kroll and Taylor, 2003: 201). Aldridge and Becker (1993) found being a young carer can be the source of isolation and loneliness. It would appear the more immersed a child or young person becomes in their caring role, their interactions with other young people may become limited (Aldridge and Becker, 1993). Cree's (2003) study into the worries and problems of young carers echoes this assertion as it identified having no friends as a key concern for young carers, along with self-harm and bullying. These findings are important as they suggest that young carers may have limited opportunities to access the positive prospects school can provide such as respite and making friends. It is important to reflect on the isolation some children and young people may experience when caring for a parent with problematic drug or alcohol use, and the extent this could be remedied or exacerbated through their parent's recovery from problem substance use.

An additional factor that may exacerbate feelings of seclusion, is the stigma associated with being a young carer as well as the social stigma attached to drug and alcohol issues. Cree (2003) suggests the embarrassment of their caring roles or family circumstances may deter young people from seeking support.

F *'She has no control and falls over all the time. She pees on the settee and me and my brother have to clean up after her.'*
(Debbie, 13; ChildLine cited in Kroll and Taylor, 2003: 179).

F *'The worst things about my childhood? I think it was the fact it was as if she was the child and I was the mum.'*
(Child of drug-using parent: Beth, 19 years, Barnard, 2007: 93)

We learn from the above experiences that young people may find themselves completing inappropriate tasks whilst caring for their parent. What's more, the literature suggests that when caring and household duties become part of the everyday reality for children, releasing children of this burden can be equally challenging (Kroll and Taylor, 2003; Bancroft et al., 2004). Kroll and Taylor (2003) assert that caring roles can result in the loss of childhood making it difficult for children or young people to resume a role that does not require the level of adult responsibility they have acquired through caring. This is important, as we consider the changes that may occur to the dynamics of a family during recovery. For instance, the extent parents and children are able to renegotiate their roles and reshift the power imbalance that may have occurred. This resonates well with Whitfield's (1997) claims that the identities of family members are affected by problematic drug and alcohol users. Thus, children and young people may be learning to differentiate between their own needs and identity from that of their parents during recovery from problematic drug and alcohol use.

With that in mind, handing household responsibilities back to their parents can be a difficult transition for children and young people (Kroll and Taylor, 2003). The literature suggests that for some, being a carer can have a positive impact on the self-esteem of a child and that taking control over the household can give a young person an important status in an otherwise unstable environment (Aldridge and Becker, 1993). Scholars suggest the practical skills developed through caring duties can allow children to become more self-reliant as well as in some cases strengthening the relationship between a child and their parent (Aldridge and Becker, 1993; Dearden and Becker, 2000; Kroll and Taylor, 2003).

F *'When I was looking after my mum I was looked up at. People really did think the world of me because I was young and looking after my mum.'*
(Rachel, 17; Bancroft et al., 2004: 10).

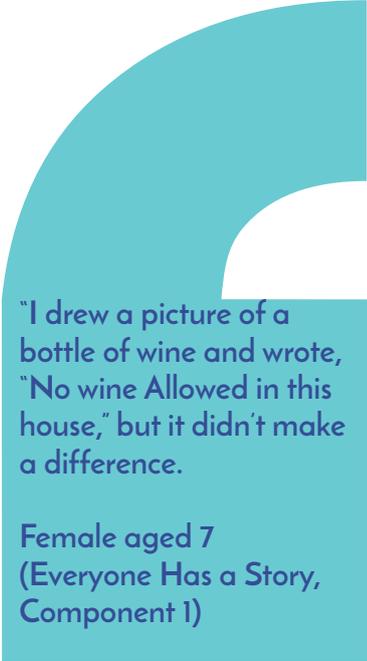
It will be important to acknowledge the ways these positive social representations may shift once their parent is in recovery. Kroll and Taylor (2003) claim children may struggle to adjust to their parent's increased ability to take care of themselves and the household. In other words, losing the role as carer may mean the loss of a positive contribution to the family.

 *'It's like I'm used to daen all the tidying up and the cooking and like telling (siblings) when to be in and who no tae hang about with and where no to go...and my mum's started daen that and...it's like a kind of conflict between us now because she's like saying "You're 17, I'm the mum"*
(Bancroft et al., 2004: 10).

It is clear from this experience that parental recovery has provoked a power imbalance between the young person and their parent. This implies there are challenges around restoring parent and child roles during recovery, a suggestion that resonates within Laybourn et al.'s (1996 cited in Kroll and Taylor, 2003:186) exploration of role confusion. Laybourn et al., (1996 cited in Kroll and Taylor, 2003:186) **suggest after witnessing parent's in a vulnerable state it may be difficult for children to cope with their parent's attempts to restore authority**, in other words 'You behave badly so don't try telling me what to do,'(1996 cited in Kroll and Taylor, 2003:186).

Living Arrangements

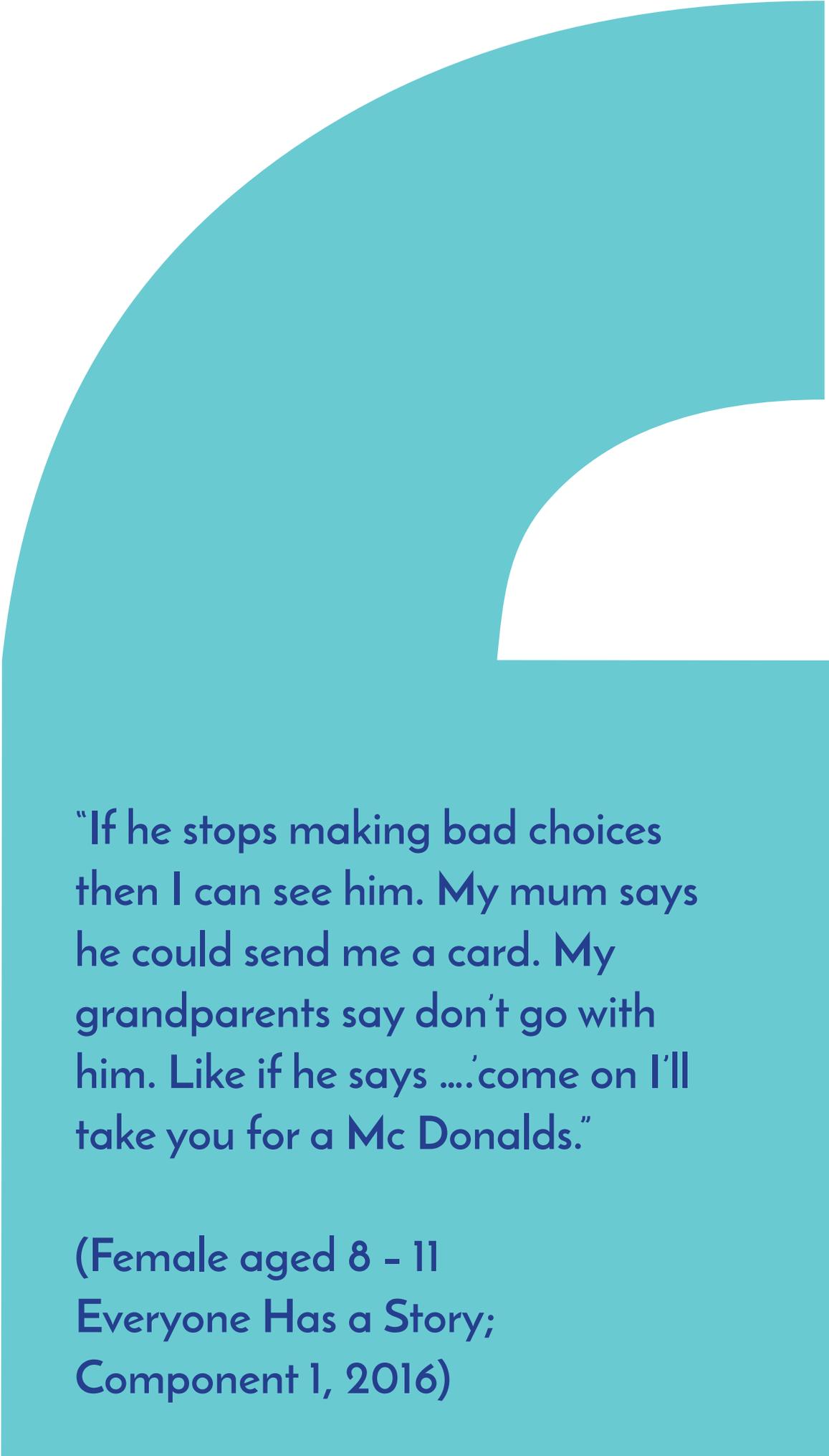
An analysis of the literature around children affected by parental problematic drug and alcohol use demonstrates the diverse living arrangements children may experience. Exploring these living arrangements provides an insight into the needs and experiences of children and young people. The National Treatment Agency in England reviewed evidence collated by the National Drug Treatment Monitoring System (NDTMS) and found the living arrangements can be an important factor in a parent's recovery progress. The report suggested that parents who were living with their own children had stronger motivations to recover from problematic drug or alcohol use than those whose children had alternative living arrangement. Although we should not overlook the complexity of recovery and the multitude of factors that may facilitate positive relationships between a parent and child, these findings hint at the importance of exploring the living arrangements of a child or young person during their parent's recovery.



"I drew a picture of a bottle of wine and wrote, "No wine Allowed in this house," but it didn't make a difference.

**Female aged 7
(Everyone Has a Story, Component 1)**

Simply removing a child from the parental home may prevent immediate exposure to risks but the impact of traumatic experiences can be long-lasting and may manifest in problematic behaviour (Barnard, 2007: 111). A total of 60% of the kinship carers surveyed in Gautier and Wellard's study (2014) claimed the most difficult aspect was coping with the child's anger issues. This is widely reflected throughout the literature of kinship care, as emotional or behavioural problems have been cited as a common trait of children affected by problematic drug or alcohol use (Barnard, 2007; 101; Gautier and Wellard, 2014; Mentor, 2011). This once again re-emphasises the importance of long term support for children and young people. The literature highlights that children and young people are likely to be placed in kinship care because of the serious adversities they face living with their parents. According to Gautier and Wellard's (2014) survey exploring the lives of kinship carers, 51% of the children had been abused or neglected and 47% had been placed in kinship arrangements because of parental problematic drug or alcohol use. As the trauma, and children affected by parental problem substance use literature suggests, negative childhood experiences can have an impact on a child's well-being and behaviour. Kinship arrangements may not be enough to remedy their anxieties and overcome past experiences.



“If he stops making bad choices then I can see him. My mum says he could send me a card. My grandparents say don’t go with him. Like if he says’come on I’ll take you for a Mc Donalds.”

(Female aged 8 - 11
Everyone Has a Story;
Component 1, 2016)

Kinship Care

As previously discussed through this evidence review, stable, nurturing relationships are paramount in fostering positive outcomes for children and young people. Hogan (2007) acknowledges that the needs of children and young people affected by problematic drug or alcohol use can often be met by extended family or friends. Kinship care has long been cited as an option for children and young people of parents with problematic drug or alcohol use. The Children and Young People in Scotland Act (2014) formally acknowledges the role of kinship carers and makes specific provision.

'The assistance which may be specified as kinship care assistance includes -

- (a) the provision of counselling, advice or information about any matter,**
- (b) the provision of financial support (or support in kind) of any description,**
- (c) the provision of any service provided by a local authority on a subsidised basis.'**

The literature describes the ways parenting capacity may be hindered by problematic drug or alcohol use, as a result children and young people may be placed in alternative care arrangements and kinship care is identified as a common response. (Barnard, 2007: 17; Broad et al., 2001; Aldgate and McIntosh, 2006; Nandy et al., 2011).

There is evidence to suggest that feelings of loss or adjustment may be minimised when moving in with a family member compared to children looked after by the local authorities (Aldgate and McIntosh, 2006; 41). This resonates well with the evidence cited within attachment and resilience literature that suggest consistent and stable home environments are paramount in promoting healthy child well-being. Comparative studies suggest kinship care is a more stable and long term placement than alternative care arrangements (Broad et al., 2001). This continuity and nurture suggested in literature may foster the protective factors to help children overcome negative past experiences (Aldgate and McIntosh, 2006).

F *'It's better to be going to school on time. We didn't know it was wrong to be late. It was a big change. It's good to be normal.'*
(Aldgate and McIntosh, 2006: 43).

With that in mind, kinship care may facilitate the structure and routine that may have been previously missing from a child or young person's life (Aldgate and McIntosh, 2006: 43). The practitioner survey responses from Everyone Has a Story found that 32% of practitioners had observed an increase in self-esteem and 32% stated children claimed to feel safer living in kinship care (Everyone Has a Story; Component 2, 2016). In the context of recovery, the findings suggest that kinship care could offer a child or young person much needed stability during a time of significant transitions for their parent.

Nonetheless, the challenges of kinship care should be considered. Kinship care arrangements can cause an entire upheaval of a household, for instance overcrowding in the family homes and a strain on household resources such as increasing utility bills and food costs (Mentor UK, 2011; Gautier et al, 2013).

'Not having my own room- I don't get to sleep right for my baby sister waking up.' (Aldgate and McIntosh, 2006: 41).

Aldgate and McIntosh's (2006) study gathered children and young people's views of kinship care. One of the main transitions referenced in the literature of children's experiences of kinship care was getting used to new routines and lifestyles. This was often discussed in the context of children coming from homes where there may have been little or no boundaries or discipline (Aldgate and McIntosh, 2006; Selwyn et al, 2013; Barnard, 2007: 101). The kinship children in Aldgate and McIntosh's (2006: 41) study spoke of the difficulty getting used to new homes, different family dynamics or being away from friends.



'She doesn't understand life for a teenager today. She wants to go to bed earlier so you end up going to bed earlier as well.'
(Aldgate and McIntosh, 2006; 42).

This is further reiterated in the findings from the practitioner survey responses; 24% of practitioners said adjusting to new routines and lifestyles was difficult for children living in informal kinship care arrangements (Everyone has a Story; Component 2 2016).

Although, existing literature on kinship care emphasises the challenges and benefits of kinship arrangements the complexity of extended family relationship is often overlooked. Aldgate and McIntosh's (2006) study challenged the assumption that kinship carers have an established positive relationship with the child or young person, with some participants reporting prior to the living arrangements their kinship carer was relatively unknown to them. Greater analysis is needed to understand the intricacy of kinship care relationships.

Furthermore, it is important not to overlook the ongoing trauma children may experience. Simply removing a child from the direct risk caused by problem parental drug or alcohol use may not be enough to prevent a child's anxieties or fears. Emotional and behavioural difficulties of kinship children and young people is reflected as key theme in the literature. Managing a child or young person's troubled past whilst adjusting to their new responsibilities is identified as a key concern in the literature of kinship cares (See Gautier et al, 2013; Nandy et al, 2011). In Nandy et al., (2011) study 34% of children and young people had significant mental health problems. This further highlights the importance of exploring children's experiences of change and the need for ongoing support.

The presence of the parent is significant in understanding the **dynamics of kinship care arrangements and children's experiences and is also often overlooked in social research.** Nandy et al., (2011) found that 67% of parents were unable to provide sufficient care for their children because of problem substance use, resulting in their child living in kinship care. Further exploration is needed around the impact kinship care arrangements have on the dynamics of a family. For instance, the implications on the relationship between the kinship carer and the parent or the presence of the parent while a child lives in kinship care. Nandy et al., (2011) suggest ongoing presence of a parent can be the source of distress for a child particularly when promises of visits are broken. These are important factors to consider whilst analysing the quality and the complexity of the relationships available to a child during their parent's recovery.

As previously explored through the role reversal literature the dynamics within a family can alter during recovery (See Kroll and Taylor, 2003; Bancroft et al., 2004). This line of thought is useful when considering the adjustments children and young people may experience during their parent's recovery and transition between kinship and parental care. Moreover, for some children and young people the transition to kinship care may become a permanent arrangement. The difference between informal or formal kinship care arrangements may have a significant impact on the continuity and perceptions of permanence available for a child as well as the financial support available for carers (Selwyn et al., 2013; Nandy et al., 2011).

Looked after children

 *'At least when my mum was drunk we sometimes got sweets. My mum dumped us with social work, I don't know where she is now and never see my brother and sister.'*
(Young person aged 14, *PDI Everyone has a story, Component 1 2016*).

For some children, parental problematic drug or alcohol use may reach crisis point and in an effort to safeguard them from further harm they may be removed from the home temporarily or permanently (McConnell et al., 2001; Munro, 2011). Empirical evidence of children's experience of residential care was closely consulted for this section. Exploring literature on looked after children is an important premise for this review for several reasons. Firstly, according to social work statistics between 2013 and 2014, 39% of child protection concerns were related to parental problematic drug or alcohol use, 29% were referred to child protection cases due to emotional abuse and 37% were referred due to domestic abuse in the home (Children Social Work Statistics, 2013-2014). The evidence suggests that among other risk factors substance related issues can be a reason for child protection referrals. These are important findings as it demonstrates children are not only experiencing a major change in care arrangements but they may be overcoming trauma (Henderson et al., 2011).

In addition to this, we can identify a significant gap in the literature concerning the impact of returning home from residential care. Henderson et al. (2011) reviewed the **complex factors around parental contact and reunification for looked after children**, such as lack of trust, broken promises and parenting capacity. The report found that for the majority of looked after children, it took over two years for a child to be placed in a permanent, stable care arrangement either through adoption or parental responsibilities order (Henderson, et al., 2011: 5). This provides an insight to the insecure care environments looked after children may experience, and as per the attachment literature, the damaging effects this may have on the well-being and outcomes of children and young people. To provide a fuller understanding of how children adjust to significant family change, **greater analysis is needed to explore children's experiences and impact of returning home from residential care.**

As revealed in the attachment literature, stable family and positive relationships can be an important resource for children and young people (Munton et al., 2014; Boddy, 2013). For instance, families can be source of protection and nurture and the availability of family care can be indicative to a child's self-worth (Hughes, 2009). For children and young people who have been removed from the family unit into residential care, the sudden loss of the private family space could be detrimental to their self-esteem and intensify feelings of rejection (Boddy, 2013). The fear of being removed from the family home may prevent a child from speaking out about their parent's problematic drug or alcohol use (Barnard and Barlow, 2003). Barnard and Barlow (2003: 189) suggests confiding in someone over family circumstances is often burdened with worry, uncertainty and feelings of disloyalty towards their parents. This reiterates that the pressure of keeping secrets as well as the stigma associated with drugs and alcohol should not be overlooked when exploring children's experiences of parental drug or alcohol issues (Barnard and Barlow, 2003: 189; Barnard, 2005; Kroll and Taylor, 2003; Golding 2010). This also resonates well with earlier suggestions in the literature that vulnerable children and young people may adopt avoidance

tactics as mechanisms of coping. This illustrates the uncertainty and worry children may experience when being looked after by the local authorities. It also demonstrates the need to support and effectively communicate with children during this transition from their parent's care into residential care.

With that in mind, the concept of 'corporate parenting' is discussed within recent evidence and refers to the collective responsibility of all statutory organisations to meet the needs of young people in residential care (Children and Young people (Scotland) Act, 2014; Who? Cares Scotland, 2014). This is particularly important in ensuring children feel listened to and are knowledgeable of their rights (Who Cares Scotland, 2014; Cossar et al., 2011).

 *'I was denied contact with my parents because I didn't go to school. I knew I had the right to see my parents...'* (Who Cares Scotland, 2014).

Allowing children to be a part of the decision making process is highlighted as key to ensuring their individual needs are met (Who? Cares Scotland, 2014; Cossar et al., 2011). What is also implied in the above narrative and an important consideration in the context of recovery, is the contact between a parent and a child when they are placed in residential care. Beihal (2006) suggests that regular parental contact when a child is looked after, along with additional protective factors such as positive attachment, may support children to successfully return home. There is a lack of exploration into the factors and impact of returning home; however, it is useful to consider the extent to which contact between a child and parent may affect how well children are able to cope with the transition back home and the changes recovery may cause.

With that in mind, there are studies pointing to the length of time spent in residential care as being closely linked to the likelihood of returning home, the longer a child spends in care the probability of them returning home decreases significantly. (Bullock, 1998: Bullock et al., 1993 cited in Biehal, 2006). However Beihal (2006) warns this should be interpreted with caution as there are numerous factors involved in reunification. Biehal (2006) argues there are significant challenges to consider when children return home, such as the importance of appropriate timings. It is hard to measure the extent it is in the child's best interest to return home, a small body of existing research suggests there is a significant risk of repeated abuse and neglect with approximately one third of children returning to residential care after re-entering the family home (Biehal, 2006). This is supported by The Who? Cares (2014) report that examined the existing evidence of reunification and found abused children have better overall outcomes when contact with abusive parents was cut entirely.

Another significant adjustment for looked after children and young people is sibling separation. The Family Rights Group (FRG) found almost half (49%) of sibling groups in local authority care had been separated. The Family Rights groups argue the presence of a familiar family member to confide in can provide a vulnerable looked after child with the nurture and love that appears otherwise unavailable (FRG, 2015). McAuley and Davies assert being a sibling can be a positive role for a child or young person, providing them with an outlet to strengthen their relationship skills (McAuley and Davies, 2009). However, separation from a sibling can exacerbate feeling of isolation (McAuley and Davis, 2009; FRG, 2015). This resonates well with the ways positive attachment figures appears embedded

in childhood well-being (Hughes, 1998; Ainsworth, 1964). This is therefore a significant transition for children placed in residential or foster care as they may be required to renegotiate their understanding of family relationships and belonging (Hughes, 1998: 3).

As Hughes' (1998) analysis of attachment demonstrated, it can be an upward struggle to find a loving home for children who have experienced a disorganised attachment with their parent. Hughes (1998) suggests children's homes or foster carers that are not equipped to deal with emotionally fragile children will only further a vulnerable child's difficulty coping with positive relationships.

F *"(Foster carers) may have no previous knowledge of what food they like, what are the things that scare them and whether they have a particular soft toy at bedtime," while some children's homes, "Can seem scary or overwhelming." (FRG, 2015)*

This further reinforces the complexity of the relationship between a child and a caregiver. Whether a child returns home from residential care, this literature provides a useful insight to how recovering parents or new caregivers need to develop an understanding of their child's needs, restoring trust and ultimately facilitating a space where the traumas of the past can be soothed.

"I am not in touch with her. I don't care about her. I am feeling better without her."

**Young Person
aged 12 - 15
Everyone Has a Story,
Component 1 2016**

Conclusions

Through an exploration of the existing literature, this paper aimed to identify the key experiences and transitions that children and young people may be confronted with during their parent's recovery from problematic drug or alcohol use. There was a particular emphasis on the role of relationships and living conditions as a facilitator for positive outcomes and resilience. Current evidence of recovery highlights the ways individuals will begin to re-evaluate their identity and lifestyle as they progress towards a substance free life (Betty Ford Institute, 2007; White, 2007; Carten, 1996). However, the impact of these changes on children remains widely overlooked in empirical evidence.

Changing family dynamics is inevitable during recovery, this is reflected in the role reversal literature which suggests the difficulty adjusting to parents assuming a carer role that had been previously occupied by the child (Boon and Templeton, 2007; Kroll and Taylor, 2003). Family conditions are integral as we learn from attachment literature, the importance of consistent care and nurture can be key in overcoming trauma and resolving the anxieties of the past (Bowlby, 1969: 1980, Hughes, 1998: Howe, 2005). It is perhaps no surprise to learn that children of parents with problematic drug or alcohol issues may experience various upheavals to their living arrangements, disrupting a child's sense of belonging and facing them with new households and routines to become accustomed to (Chassin et al., 2015; Aldgate and McIntosh, 2006).

The literature provides the evidence of the need for ongoing support for children and young people who face traumatic change in their lives. There are increasingly many approaches to what constitutes a whole family approach to support. Reflecting on the literature review and the wider action learning programme it is recognised that a whole family approach is a model of practical and therapeutic support for child, parent/guardian and extended family. The whole family approach and understanding the implications of recovery on the child should be central to any family model, with space for the child to feel listened to, understand and manage the changing dynamics and feelings associated with parental recovery from problematic drug or alcohol use.



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This project was supported by



The Action Learning Set and Blueprint was facilitated by



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