Drug misusing parents: key points for health professionals

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Drug misuse is common, and users of illicit drugs tend to be young. Many have children. A serious drug misuse problem in the parents can be devastating for the lives of their children.¹ Addiction to opiates, most commonly heroin, is one of the forms of drug misuse that is potentially most damaging to the child's home environment. Recent figures produced by the European Commission suggest that about 0.2–0.3% of European adults fulfil diagnostic criteria for heroin addiction at any given time,² and higher rates exist in inner city areas. Department of Health figures suggest that heroin use is the form of drug misuse most commonly presented to treatment services in the United Kingdom.³

The financial pressure of obtaining large sums of money (typically £10–100 a day) to buy heroin can lock a person into a daily cycle of seeking out, buying, and using heroin, which can lead to poverty, criminal activity, and imprisonment.⁴ Chaotic lifestyles may preclude attention being given to basics such as nutrition and attending appointments, and may lead to the presence of unsafe persons in the home, unsuitable carers, and frequent parental absences. Dependent heroin users are also at greatly increased risk of death from overdose, infectious diseases, and other causes.⁴ Addiction to stimulants such as amphetamines and crack cocaine may also produce adverse home circumstances, although anonymous testing of pregnant women suggests that there does not yet appear to be the misuse of these drugs in epidemic proportions in the United Kingdom that is reported in the United States.⁵

It is difficult to obtain clear figures about the scale of parental drug use and the numbers of children affected. Each NHS region has a regional drug misuse database containing details of all new drug users presenting for treatment and those returning to treatment. Details of the user's age, sex, number of dependent children cohabiting, as well as drug use, are recorded. This will significantly underestimate the numbers of parents with children affected, as there is likely to be underreporting by agencies. Furthermore, parents not presenting to treatment agencies at all will not be registered. More locally, maternity units may collect numbers of pregnant women who misuse drugs, but this relies on parental disclosure.

Local audits may also identify numbers of children affected by parental substance misuse who are placed on the child protection register, fostered, or adopted. Audits of child deaths subject to Part 8 reviews may identify particular problems of substance misuse, which can then inform child protection procedures and training. Overall, the incidence of heroin addiction among adults in inner cities is thought to approximate to 1%.⁴

Effects of parental addiction on the children

Studies of the children of drug misusers have tended to concentrate on two areas: developmental outcomes for children of addicted parents and possible teratogenic effects of in utero exposure to the various drugs of abuse. The former group of studies is well summarised in a comprehensive review by Eyer and Behnke.⁶ This suggests that, for opiates in particular, there is still a large measure of doubt as to whether early development is affected by prenatal exposure. The authors also draw attention to the often underemphasised antenatal effects of legal substances, in particular tobacco.

In general, however, it seems that, for whatever reason, children of addicted parents as a group perform less well academically and in terms of social adjustment than controls,^{7,8} and are many times more likely to suffer child abuse in various forms⁹ and to be taken into care.^{10,11} All types of abuse have been associated with drug misuse, including physical abuse, sexual abuse, and neglect,¹² which has been identified as the most common type of abuse.⁹ Although it has proved very difficult for researchers to disentangle the effects of a poor environment from effects of antenatal drug exposure, it does appear that the adopted children of addicted parents can close the gap in functioning between themselves and their peers given an improved environment.¹³

With regard to specific antenatal effects, babies born to opiate users tend to be of a lower birth weight and there is an increased incidence of antepartum haemorrhage and intrauterine death.¹⁴ However, it is unclear whether these effects are specific or caused by the poor health

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and nutritional status of many opiate dependent women. The evidence from some studies^{15 16} seems to suggest that adequacy of antenatal care for drug dependent women may be an important factor in determining outcome and that, with appropriately targeted services, opiate users can expect outcomes similar to those experienced by non-drug-users matched for social circumstances. Women maintained on methadone in pregnancy appear to have better outcomes than untreated heroin users, which once again may be due to improved stability and medical care.¹⁷ Cocaine is known to have a powerful vasoconstricting effect on placental vessels and is associated with increased risk of maternal hypertension, spontaneous abortion and abruptio,¹⁴ and longer term neurobehavioral abnormalities.¹⁸ There are no known specific teratogenic effects of the commonly used illicit drugs, with the possible exception of first trimester use of benzodiazepines, which, although not illegal, are often abused, whether alone or in conjunction with other drugs, and which may be associated with an excess of cleft deformities.¹⁴ However, it seems likely that other environmental effects in utero, notably poor maternal nutrition as the result of poverty and the financial pressures of drug misuse, may be as important as or more important than drug specific effects.

Studies of drug abusing parents show that many of them have received poor parenting,¹⁹ and, as a group, they have high rates of all kinds of childhood abuse themselves.¹ They may therefore lack good models for parenting their own children. The specific postnatal treatment of neonatal abstinence syndrome is outside the scope of this paper. Although the evidence base for the treatment of this syndrome remains relatively poorly developed²⁰ and there are still wide variations in management,²¹ a number of authors have attempted to derive evidence based management strategies.²²⁻²⁴

The evidence base for formal intervention

There are remarkably few good studies of the effect of interventions on the children of drug users, and especially on the effect of providing their parents with the routine evidence based treatments for their drug problems. There is, however, a mass of evidence that interventions aimed at treating the parental drug problem can have a dramatically stabilising effect in terms of harm reduction to the individual, which by extrapolation might be expected to improve family functioning. Methadone maintenance treatment, in which street drugs are replaced by the prescribed opioid methadone, has been widely studied and found to reduce mortality,²⁵ decrease risk taking behaviour such as injecting,²⁶ and reduce criminal activity and time spent in prison.²⁷ Patients receiving methadone maintenance treatment rapidly show substantial increases in the time spent with their family and in time spent attending to the home.²⁸

Furthermore it appears that some specialist interventions including specially designed

methadone regimens and residential programmes may prove successful in stabilising families and improving the childcare skills of addicted parents^{29 30} and in preventing removal of children into care.³¹ To date there is a lack of comparability between these studies, which tends to reflect small samples, and this makes the validity of the results hard to assess. It should, however, be borne in mind that drug addiction is often a chronic relapsing condition which not infrequently resolves spontaneously after many years if the person can be helped to stay alive, but which is often refractory to treatment approaches based on abstinence rather than long term maintenance.³² This means that maintenance can be very protracted, with some people being maintained successfully for many years, which may be one reason for the relative unpopularity of this approach with service planners and commissioners for whom long term financial commitment is less attractive than a "magic bullet". Certainly there is a chronic shortage of places on methadone maintenance programmes in spite of the fact that methadone is relatively inexpensive and its success is well documented.

The response of the health professional

Taken overall, there can be no doubt that parental drug misuse is a very important factor in preventing many children from achieving physical, mental, and emotional health. The new Department of Health *Clinical guidelines on the treatment of drug misuse*³³ make it clear that doctors and other health professionals in all areas of patient care, but especially in primary care, must be able to recognise and provide informed treatment for drug related problems and this must surely include the physical and social problems of the children of drug misusers. How then should health professionals respond when faced with, or suspecting, a drug related problem in a parent?

Many health professionals may be involved with the drug using families, including general practitioners and health visitors, obstetricians and midwives, neonatologists, hospital and community paediatricians, and those working within the mental health services, including psychiatrists specialising in treatment of substance misuse. Other professionals involved include social services and family support teams, police, probation, education, and housing authorities, as well as voluntary drug workers. All need to be aware of the limitations of their own roles, and recognise the complementary role of others. For example, drug treatment workers have expertise in the management of the adult, but may not have the skills to recognise child abuse and neglect; and similarly the paediatrician will need to liaise with treatment centres about management of the parent. There needs to be close collaboration and liaison between such services, and sharing of information to safeguard a child from significant harm. The designated doctor and/or nurse for child protection can help to provide advice, especially where there are issues of confidentiality.³⁴

Services need to be properly coordinated to avoid providing a confusing array of services and appointments to families. This is particularly the case for the pregnant drug user, and comprehensive models of care can improve maternal and neonatal outcomes.³⁵ Equally important is the need to ensure that services do not slip away after the infant is discharged, at a time when he or she may be most vulnerable. There should be a smooth transition of services between pregnancy, delivery, and beyond.

Risk assessment in families of drug users is complex, and attempts to compile risk inventories have tended to reflect the treatment biases of the compilers.³⁶ The Standing Conference on Drug Abuse has produced useful practical guidelines for professionals working with drug using parents for assessing risk to children.³⁷ These guidelines provide a framework for assessing the degree to which parental drug use may be adversely affecting the child. Important among these are the need to be sure that the family has sufficient funds to provide adequately for the child's physical needs, and that the child is not being left alone while the parent is out procuring drugs. When there is concern that neglect or abuse may be occurring or may be a serious possibility, the health professional should take immediate appropriate action according to the local child protection guidelines.

When parents request harm minimisation treatment for a long standing heroin problem, general practitioners may decide that, in line with recommendations in the Department of Health clinical guidelines, they will start some opiate addicted parents on a maintenance prescription themselves. For many addicted parents, this evidence based intervention may be a lifeline,⁴ restoring financial and emotional stability and freeing them up to undertake parenting rather than being constantly involved in drug seeking activities. The lack of access for addicted parents to maintenance prescribing services is likely to be a major factor in the poor environment experienced by some children.

Whatever is felt to be the appropriate intervention, good local shared care protocols and structured interagency working are the key to successful work with this group, as set out in the clinical guidelines.³³

In all situations it is essential to offer the following support to parents and children.

HARM MINIMISATION

- Advice for the parent(s) on where to access drug treatment services and appropriate referral where necessary
- Advice on testing and vaccination for blood borne viral infections and referral for parent and child where necessary
- Advice about injecting and safer sex in order to protect parent and child from contracting transmissible infections.

PARENTING

- General advice on parenting as the parent may have only very poor role models and few support networks
- Advice on nutrition for parent and child, and consideration of parental drug problems

as a possible contributing factor when children fail to thrive

- Advice on the safe storage of drugs away from children, especially methadone mixture, which is attractive in appearance and has been responsible for a number of child deaths³⁸
- Enquiries to ensure that the child has not missed the routine childhood health checks and vaccinations and developmental surveillance
- Attention to ensuring that children are not lost to follow up
- Liaison with other professionals who may be involved with the family so that information may be shared in cases of concern
- When children are in the care of the local authority or adopted, guidance should be offered about testing for blood borne viral infections. This may raise questions about consent and who has parental responsibility to give consent.^{39 40} Parents who do not have parental responsibility may have a right to participate in the decision process under the Human Rights Act, and, if in doubt, legal advice should be sought. There are also important confidentiality matters.^{39 40} Health professionals need training in safety precautions with regard to blood borne virus transmission.⁴⁰

PRECONCEPTION COUNSELLING

- Enquiries to ascertain whether a further pregnancy is planned, and contraceptive advice where appropriate. This is especially important at the inception of a methadone maintenance programme
- Where a pregnancy is planned or is a possibility, preconception counselling focusing on nutrition and the need to reduce or stop injecting and to keep all illicit drug use to a minimum; referral to drugs services at this stage if appropriate
- Should a further pregnancy occur, early diagnosis and referral to specialist services
- Early counselling and testing for blood borne virus (Hep B,C, HIV) status in pregnant woman and neonate and appropriate referral.

Coordination of health professionals and child protection services

Area child protection committees (ACPCs) play a key role in ensuring that appropriate procedures, arrangements, and training are in place to ensure that children are properly assessed when substance misuse by parents is a possibility. This should encompass both children in potential danger and those who have broader needs. ACPCs also need to link with drug and alcohol misuse services and adult mental health services, as well as contributing to plans of local authority children's services, to provide coordinated action for children affected by substance misuse. Regional drug action teams (DATs), which have representation from health, social, police, probation, and education services, are responsible for guiding local strategy depending on local needs and statistics, but tend to be adult focused,

concentrating on key problems around crime and treatment. DATs and ACPs should work together locally at the strategic level.

Many drug misusing parents are already consumed with guilt about the effect their drug use may be having on their child, and it is important to maintain a non-judgmental approach while being firm and precise about the limits of adequate childcare. Positive reinforcement from professionals for good child rearing practices and development of confidence in the parents' own abilities can feed back into a more positive self image for parents, which can help them to take greater control over other aspects of their lives. This cannot take place, however, outside a framework where high quality shared care and interagency working is offered to all drug users.

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