

## LESSONS FROM RESEARCH August 2010

### Introduction

9.1 Our knowledge and understanding of children's welfare – and how to respond in the best interests of a child to concerns about maltreatment (abuse and neglect) – develops over time, informed by research, experience and the critical scrutiny of practice. Sound professional practice involves making judgements supported by evidence: evidence derived from research and experience about the nature and impact of maltreatment, and when and how to intervene to improve outcomes for children; and evidence derived from a thorough assessment of a specific child's health, development and welfare, and his or her family circumstances.

9.2 This chapter summarises what is known about the impact of maltreatment on children's health and development, and sources of stress in families that may also have an impact on children's developmental progress (see also *The Developing World of the Child*, 2006). Further information on findings from the joint Department for Children, Schools and Families and Department of Health Safeguarding Children Research Initiative and other related research can be found on the NSDU research website<sup>153</sup>.

### The impact of maltreatment on children

9.3 The maltreatment of children – physically, emotionally, sexually or through neglect – can have major long-term effects on all aspects of a child's health, development and wellbeing. **The immediate and longer-term impact can include anxiety, depression, substance misuse, eating disorders and self-destructive behaviours, offending and anti-social behaviour.** Maltreatment is likely to have a deep impact on the child's self-image and self-esteem, and on his or her future life.

Difficulties may extend into adulthood: the experience of long-term abuse may lead to difficulties in forming or sustaining close relationships, establishing oneself in work, and to extra difficulties in developing the attitudes and skills necessary to be an effective parent.

9.4 It is not only the stressful events of maltreatment that have an impact, but also the context in which they take place. Any potentially abusive incident has to be seen in context to assess the extent of harm to a child and decide on the most appropriate intervention. Often, it is the interaction between a number of factors that increases the likelihood or level of significant harm.

9.5 For every child and family, there may be factors that aggravate the harm caused to the child, and those that protect against harm. Relevant factors include the individual child's means of coping and adapting, support from a family and social network, and the impact of any interventions. The effects on a child are also influenced by the quality of the family environment at the time of maltreatment, and by subsequent life events. The way in which professionals respond also has a significant bearing on subsequent outcomes.

9.6 Serious Case Reviews<sup>154</sup>, together with other research findings, show that children under one year of age and in particular very young babies are extremely vulnerable to being seriously injured or to dying as a result of abuse or neglect. Young people aged 11 and over also have a heightened level of vulnerability and likelihood of suffering harm, yet their needs and distress are often missed or deemed too challenging for services.

9.7 Some children may be living in families that are considered resistant to change. A knowledge review on effective practice to protect children living in such families, undertaken by C4EO, has identified practices which can enable practitioners to engage with these types of families and improve outcomes for children (see [www.c4eo.org.uk/themes/safeguarding/default.aspx?themeid=11&accesstypeid=1](http://www.c4eo.org.uk/themes/safeguarding/default.aspx?themeid=11&accesstypeid=1)).

### **Physical abuse**

9.8 Physical abuse can lead directly to neurological damage, physical injuries, disability or, at the extreme, death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression, including inappropriate or inexperienced use of physical restraint. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic violence<sup>155</sup>.

### **Emotional abuse**

9.9 There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying<sup>156</sup>. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, as other more visible forms of abuse in terms of its impact on the child. Domestic violence is abusive in itself. Adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

### **Sexual abuse**

9.10 Disturbed behaviour – including self-harm, inappropriate sexualised behaviour, sexually abusive behaviour, depression and a loss of self-esteem – has been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection. The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and on his or her feelings of self worth. (For further information see *Child Sexual Abuse: Informing Practice from Research*)<sup>157</sup>.

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154 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

155 Montgomery, P., Ramchandani, P., Gardner, F. and Bjornstad, G. (2009) *Systematic reviews of interventions following physical abuse: helping practitioners and expert witnesses improve the outcomes of child abuse*. London: Department for Children, Schools and Families.

156 Barlow, J and Schrader-MacMillan, A. (2009) *Safeguarding Children From Emotional Abuse – What Works?*. London: Department for Education and Skills. DCSF-RBX-09-09.

157 Jones, D.P.H. and Ramchandani, P. (1999) *Child Sexual Abuse. Informing Practice from Research*. Abingdon: Radcliffe Medical Press Ltd.

9.11 A proportion of adults and children and young people who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic violence and discontinuity of care. However, it would be quite wrong to suggest that most children who are sexually abused inevitably go on to become abusers themselves.

## **Neglect**

9.12 Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, and feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing<sup>158,159</sup>.

## **Sources of stress for children and families**

9.13 Many families under great stress succeed in bringing up their children in a warm, loving and supportive environment in which each child's needs are met. Sources of stress within families may, however, have a negative impact on a child's health, development and wellbeing, either directly, or because when experienced during pregnancy they may result in delays in the physical and mental development of infants, or because they affect the capacity of parents to respond to their child's needs<sup>160</sup>. This is particularly so when there is no other significant adult who is able to respond to the child's needs, for example where children experience a parent in prison as a result of offending behaviour.

9.14 Undertaking assessments of children and families requires a thorough understanding of the factors that influence children's development: the developmental needs of children; the capacities of parents or caregivers to respond appropriately to those needs; and the impact of wider family and environmental factors on both children's development and parenting capacity. An analysis of how these three domains of children's lives interact enables practitioners to understand the child's developmental needs within the context of the family and to provide appropriate services to respond to those needs. (See the *Framework for the Assessment of Children in Need and their Families 2000*.)

9.15 The following sections summarise some of the key research findings on parental mental illness, learning disability, substance misuse and domestic violence<sup>161</sup>. The information should be drawn on when assessing children and families, providing services to meet their identified needs and reviewing whether the planned outcomes for each child have been achieved.

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158 Daniel, B. Taylor, J. and Scott, J. (2009) *Noticing and helping the neglected child*. London: Department for Children, Schools and Families. DCSF-RBX-09-03.

159 Stein, M. Rees, G. Hicks, L. and Gorin, S. (2009) *Neglected adolescents: a review of the research and the preparation of guidance for multi-disciplinary teams and a guide for young people*. London: Department for Children, Schools and Families. DCSF-RBX-09-04.

160 Chapter 6 of the Government's strategy document *Carers at the heart of 21<sup>st</sup> Century families and communities* (2008) addresses the needs of young carers.

161 Cleaver, H. Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2<sup>nd</sup> Edition. London: The Stationery Office.

In each section the issue is defined, information on its prevalence given, and the likely impact on the child identified.

The research findings are explored in relation to four stages of childhood: the unborn child, babies and infants (under 5 years), middle childhood (5 to 10 years) and adolescence (11 to 16 plus years).

## **Social exclusion**

9.16 Many of the families who seek help for their children, or about whom others raise concerns in respect of a child's welfare, are multiply disadvantaged. These families may face chronic poverty, social isolation, racism, and the problems associated with living in disadvantaged areas, such as high crime rates, poor housing, childcare, transport and education services, and limited employment opportunities. Many lack a wage earner. Poverty may mean that children live in crowded or unsuitable accommodation, have poor diets, health problems or disability, are vulnerable to accidents, and lack ready access to good educational and leisure opportunities. When children themselves become parents this exacerbates disadvantage and the potential for social exclusion. Racism and racial harassment are an additional source of stress for some families and children, as is violence in the communities in which they live. Social exclusion can also have an indirect effect on children, through its association with parental substance misuse, depression, learning disability, and long-term physical health problems.

## **Domestic violence**

9.17 The Home Office<sup>162</sup> defines domestic violence as 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'. Nearly a quarter of adults in England are victims of domestic violence. Although both men and women can be victimised in this way, a greater proportion of women experience all forms of domestic violence, and are more likely to be seriously injured or killed by their partner, ex-partner or lover.

9.18 Domestic violence affects both adults and children within the family. Some 200,000 children (1.8%) in England live in households where there is a known risk of domestic violence or violence<sup>163</sup>. Prolonged and/or regular exposure to domestic violence can have a serious impact on children's safety and welfare, despite the best efforts of parents to protect them. An analysis of Serious Case Reviews found evidence of past or present domestic violence present in over half (53%) of cases<sup>164</sup>.

9.19 Domestic violence rarely exists in isolation. Many parents also misuse drugs or alcohol, experience poor physical and mental ill health and have a history of poor childhood experiences themselves. The co-morbidity of issues compounds the difficulties parents experience in meeting the needs of their children, and increases the likelihood that the child will experience abuse and/or neglect.

9.20 Domestic violence has an impact on children in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in anti-social or criminal behaviour.

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162 Home Office (2009) *What is Domestic Violence?* London: Home Office.

163 Lord Laming (2009) *The Protection of Children in England: Progress Report*. London: The Stationery Office.

164 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

Although separating from a violent partner should result in women and children being safe from harm, the danger does not automatically end. Moreover, the point of leaving an abusive relationship is the time of highest risk for a victim. Contact arrangements can be used by violent men not only to continue their controlling, manipulative and violent behaviour but also as a way of establishing the whereabouts of the victim(s).

9.21 Domestic violence also affects children because it impacts on parenting capacity. A parent (in most families, the mother) may have difficulty in looking after the children when domestic violence results in injuries, or in extreme cases, death. The impact on parenting, however, is often more subtle. Exposure to psychological and emotional abuse has profound negative effects on women's mental health resulting in a loss of confidence, depression, feelings of degradation, problems with sleep, isolation, and increased use of medication and alcohol. These are all factors that can restrict the mother's capacity to meet the developmental needs of her child.

Moreover, belittling and insulting a mother in front of her children undermines not only her respect for herself, but also the authority she needs to parent confidently.

A mother's relationship with her children may also be affected because, in attempts to avoid further outbursts of violence, she prioritises her partner's needs over those of her children.

9.22 The impact of domestic violence on children increases when directly abused, witnessing the abuse of a parent, or colluding (willingly or otherwise) in the concealment of assaults. Other relevant factors include the chronicity and degree of violence, and its co-existence with other issues such as substance misuse. No age group is particularly protected from or damaged by the impact of domestic violence. Children's ability to cope with parental adversity is related to their age, gender and individual personality. However, regardless of age, support from siblings, wider family, friends, school and community can act as protective factors.

Key to the safety of women and children subjected to violence and the threat of violence is an alternative, safe and supportive residence<sup>165</sup>.

9.23 An exploration of the possible impact on the unborn child shows the foetus is at risk of injury because violence towards women increases both in severity and frequency during pregnancy, and often involves punches or kicks directed at the women's abdomen. Such assaults can result in a greater rate of miscarriage, still or premature birth, foetal brain injury and fractures. Domestic violence is also associated with women's irregular or late attendance for ante-natal care. Poor attendance may be the result of low self esteem and depression or due to an abusive partner controlling and restricting women's use of medical services. Once born, the baby continues to be at risk of injury. For example, the infant may be in his or her mother's arms when an assault occurs. A young child's health and development may also be compromised when violence results in the mother having difficulty in concentrating, becoming depressed, or self medicating. When domestic violence undermines the mother's capacity to provide her infant with a sense of safety and security it can impact on the attachment process. Finally, domestic violence may influence a young child's social relationships, increasing their outbursts of anger, peer aggression and other behaviour problems.

9.24 Children in middle childhood, who live with domestic violence, continue to be at risk of being physically injured. Injuries may occur when the child is caught in the cross-fire or when trying to intervene to protect his or her mother. There is also evidence to link domestic violence with elevated levels of child sexual abuse<sup>166,167</sup>.

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165 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

166 Humphreys, C. and Stanley, N. (eds) (2006) *Domestic Violence and Child Protection*. London: Jessica Kingsley Publishers.

167 Hester, M., Pearson, C. and Harwin, N. with Abrahams, H. (2007). *Making an impact: children and domestic violence. A reader. 2nd Edition*. London: Jessica Kingsley Publishers.

Witnessing domestic violence affects children's emotions and behaviour and can lead to temper tantrums and aggression which are directed at family and peers, and cruelty towards animals. Exposure to domestic violence is also associated with children being more anxious, sad, worried, fearful and withdrawn, than children who are not exposed<sup>168</sup>. Some children cope with the stress and fear of violence by seeking to escape. During middle childhood this may be through fantasy and make-believe, or by withdrawing into themselves, or seeking a place of safety.

Experiencing domestic violence and seeing parents unable to control themselves or their circumstances may result in feelings of helplessness and confusion. Children may blame themselves for their parent's violence and feel inadequate and guilty when unable to stop the violent episode or prevent its reoccurrence.

9.25 Adolescents exposed to domestic violence may live in constant fear of violent arguments, being threatened, or actual physical violence being directed at a parent (usually the mother) or themselves. The likelihood of being physically injured continues. Furthermore, in a recent survey of 13 to 17-year-old girls in intimate relationships, one in six girls said they had been hit by their boyfriends (4% regularly)<sup>169</sup> and one in sixteen said they had been raped<sup>170</sup>. Experiencing domestic violence has a serious emotional impact: feelings can include fear, sadness, loneliness, helplessness and despair, and anger. In the home teenagers may focus their anger on both parents, towards the abuser for inflicting the violence and towards the victim for accepting the behaviour. Witnessing the abuse of a parent or experiencing intimate partner violence may result in adolescents exhibiting behavioural problems, both at home and in school, which have an impact on friendships and educational progress. Education can suffer when adolescents stay home to protect their parent or themselves from an abusive partner. Friends are highly valued by teenagers as confidants and sources of support, but behavioural difficulties may jeopardise friendships. Many adolescents cope with the stress of domestic violence by distancing themselves from their family or friends. They may withdraw emotionally through music, reading or participating in on-line virtual worlds, or physically by spending long periods out of the home, or running away.

9.26 Assessments, judgements and plans for children living with domestic or intimate partner violence benefit from the expertise of practitioners working in services for domestic violence. Services for children and families and young people need to take a proactive, collaborative approach to identifying and responding appropriately to domestic and intimate partner violence. Children and families and adolescents experiencing domestic and intimate partner violence are likely to need well targeted support from a range of different agencies. Mothers and children need safe places to stay and children and adolescents need mentors to ensure their needs are identified and met and their welfare is safeguarded and promoted.

### **Mental illness of a parent or carer**

9.27 A wide range of mental ill health can affect parents and their families. This includes depression and anxiety, and psychotic illnesses such as schizophrenia or bipolar disorder. Depression and anxiety are common. At any one time one in six adults in Great Britain may be affected. Psychotic disorders are much less common with about one in two hundred individuals being affected. Mental illness may also be associated with alcohol or drug use, personality disorder and significant physical illness.

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168 Onyskiw, J. E. (2003) 'Domestic Violence and Children's Adjustment: A Review of Research.' *Journal of Emotional Abuse* 3, 1/2, 11-45.

169 Body Shop YouGov survey (2004).

170 NSPCC and University of Bristol (2009) *Partner exploitation and violence in teenage intimate relationships*. London: NPSCC.

Approximately 30% of adults with mental ill health have dependent children<sup>171</sup>, mothers being more at risk than fathers.

9.28 Appropriate treatment and support usually means that mental illness can be managed effectively and as a result parents are able to care successfully for their children<sup>172</sup>. Mental ill health in a parent or carer does not necessarily have an adverse impact on a child's development. Just as there is a range in severity of illness, so there is a range of potential impact on families. The consequent likelihood of harm being suffered by a child will range from a minimal effect to significant one.

It is essential to assess the implications of parental ill health for each child in the family. This would include assessment of the impact on the family members of the social, physical ill health or substance use difficulties that a parent with mental illness may also be experiencing. After assessment appropriate additional support should be provided where needed<sup>173</sup>.

9.29 Given the wide range of mental ill health, the effect on parents and the potential impact on their capacity to meet the needs of their children is varied. Depression can result in the individual experiencing feelings of worthlessness and hopelessness which may lead to everyday activities being left undone. Parents may neglect their own and their children's physical and emotional needs. In psychotic disorders such as schizophrenia, when the person is actively psychotic, they can lose contact with reality, experiencing hallucinations and delusions with consequent inability to understand and respond to their children's needs. In some people with chronic psychotic illness self-neglect in a range of areas of life may be an issue and this may have an impact on their capacity to care for their children. Overall children with mothers who have mental ill health are five times more likely to have mental health problems themselves. Parental mental illness, particularly in the mother, is also associated with poor birth outcomes<sup>174</sup>, increased risk of sudden infant death<sup>175</sup> and increased mortality in offspring<sup>176</sup> – probably through complex interaction of sociological, biological and risk behaviours such as smoking. This research indicates that these vulnerable families need additional support and help.

9.30 The majority of parents with a history of mental ill health present no risk to their children. However, in rare cases a child may sustain severe injury, profound neglect, or even die. Very serious risks may arise if the parent's illness incorporates delusional beliefs about the child, and/or incorporates the child in a suicide plan. Information from the National Confidential Inquiry into Suicides and Homicides suggests that there are about 30 convictions a year where a parent or step parent kills a child (this excludes those cases where the parent then goes on to commit suicide). In 37% of these cases the parent was found to have a mental disorder including depressive illness or bipolar affective disorder, personality disorder, schizophrenia, and/or substance or alcohol dependence<sup>177</sup>.

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171 Meltzer, D. (2003) 'Inequalities in mental health: A systematic review.' *The research findings register, Summary No. 1063*. London: Department of Health.

172 Reupert, A. and Maybery, D. (2007) 'Families Affected by Parental Mental Illness; A Multiperspective Account of Issues and Interventions.' *American Journal of Orthopsychiatry* 77, 3, 362-369.

173 New Horizons: A Shared Vision for Mental Health (2009). London: Department of Health. <http://www.newhorizons.dh.gov.uk>

174 King-Hele S, Webb R, Mortensen PB, Appleby L, Pickles A, Abel KM. Risk of stillbirth and neonatal death linked with maternal mental illness: a national cohort study. *Archives of Disease in Childhood Fetal & Neonatal Edition* 2009; 94: F105-F110.

175 Webb RT, Wicks S, Dalman C, Pickles AR, Appleby L, Mortensen PB, Haglund B, Abel KM. Influence of environmental factors in higher risk of sudden infant death syndrome linked with parental mental illness. *Archives of General Psychiatry* 2010; 67: 69-77.

176 Webb RT, Abel KM, Pickles AR, Appleby L, King-Hele SA, Mortensen PB. Mortality risk among offspring of psychiatric inpatients: a population-based follow-up to early adulthood. *American Journal of Psychiatry* 2006; 163: 2170-7.

177 NPSA Alert. Preventing harm to children from parents with mental health needs. NPSA, 2009.

In a review of Serious Case Review reports where children had either died or been seriously harmed, current or past mental illness was found in two thirds of cases<sup>178</sup>.

9.31 The potential impact of a parental mental illness and the child's ability to cope with it is related to age, gender and individual personality.

9.32 For babies and infants post natal depression may hamper the mother's capacity to empathise with, and respond appropriately to, her baby's needs. A consistent lack of warmth and negative responses increases the likelihood that the infant will become insecurely attached. Depression may also reduce the level of interaction and engagement between mother and child. Parents in these circumstances may have greater difficulty in listening to their children and offering praise and encouragement. Mothers who experience psychotic symptoms after giving birth, and those who continue to be depressed at six months after the birth, are more likely than other mothers to regard their babies negatively and ignore cries for warmth and comfort<sup>179</sup>. Women with a history of severe mental illness are at particular risk of relapse post partum and should be under the care of a psychiatrist, as should any mother who develops psychotic symptoms post birth<sup>180</sup>. Mood swings, a common feature in mental disorders, can result in inconsistent parenting, emotional unavailability and unexpected and unplanned for separations, which infants find bewildering and frightening. Young children can be supported by the vigilance of primary health care workers, the presence of an alternative caring adult, the support of wider family, and good community facilities.

9.33 Parental mental disorders affect children in middle childhood rather differently. Children react to parenting difficulties which result from mental disorders with an increased level of behavioural problems. Some children experience depression and anxiety disorders<sup>181</sup> while others show high rates of conduct disorder<sup>182</sup>. It is widely accepted that boys are more likely to act out their distress with anti social and aggressive behaviours while girls tend to respond by internalising their worries.

Children of this age can escape into fantasy to cope with disturbing parental behaviour, or use more down to earth methods such as withdrawing into themselves, or escaping to a safe place. Relatives, particularly grandparents, can provide children with the emotional and practical support they need. However, children of this age are acutely aware of the social stigma of mental illness and consequently maybe reluctant to talk about family problems. Relatives and other adults who would be able to offer help and support may be unaware of what the child is experiencing. Same age friendships can also be supportive, although a fear of ridicule could keep children from discussing their circumstances with friends.

Nonetheless, play and the companionship of friends can offer children respite from family concerns.

9.34 The prevalence of mental ill health in children increases with the advent of adolescence. A survey of children's mental health suggests 11% of children aged 11-16 years have a mental disorder<sup>183</sup>.

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178 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

179 Egeland, B. (2009) 'Taking stock: Childhood emotional maltreatment and developmental psychopathology.' *Child Abuse & Neglect* 33, 1, 22-27.

180 NICE (2007) *Guidelines on antenatal and postnatal care*. London: NICE.

181 Tunnard, J. (2004) *Parental Mental Health Problems: Key Messages from Research, Policy and Practice*. Dartington: Research in Practice.

182 Klein, D., Clark, D., Dansky, L. and Margolis, E.T. (1988) 'Dysthymia in the offspring of parents with primary unipolar affective disorder.' *Journal of Abnormal Psychology* 94, 1155-1127.

183 Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004*. London: Office for National Statistics.

Parental mental ill health exacerbates the likelihood of young people experiencing psychological and behavioural symptoms<sup>184</sup>. The volatility of this age group means that the impact of parental mental illness, while similar to that at a young age, maybe more intense. Teenagers whose mothers suffer from depression show more behaviour problems than those whose mothers are well<sup>185</sup>. Conduct disorders, depression and a preoccupation with family problems affect young people's ability to concentrate and education and learning may be impaired. Education may also be interrupted when parental mental health problems become severe and young people stay at home in order to look their parent or younger siblings. Although relationships between parent and child may suffer as a result of parental mental illness, the opposite may also be true. As children reach adolescence, and their understanding and empathy develops, parental mental health problems may strengthen the bond between them.

However, this can also result in accelerating the normal pace of emotional maturity, resulting in a loss of childhood. Young people may not only become responsible for shouldering the burden of practical tasks, but also assume the emotional responsibility for a parent or younger siblings. To do this young people may curtail their leisure time and restrict their friendships. Friendships can be a great source of support, but an acute awareness of the stigma of mental illness may result in young people coping alone. It is essential that the needs of young carers are assessed to ensure they receive the support they need. Many families in these circumstances would benefit from practical and domestic help. Young people value the support of sympathetic and trusted adults with whom they can discuss sensitive issues, a mutual friend and knowing who to contact in the event of a crisis regarding their parent.

9.35 It is important not to assume that all young people will have problems just because they grow up living with a parent who has mental ill health. Research has shown that the adverse effects on children and young people are less likely when parental disorders are mild, last only a short time, are not associated with family disharmony and do not result in the family breaking up. Children may also be protected from harm when the other parent or a family member can respond to the child's needs, and the child or young person has the support of friends and other caring adults<sup>186</sup>.

9.36 Advice to services in responding to the needs of families where there is parental mental ill health is found in the NPSA Alert<sup>187</sup> and in practice guidance produced by SCIE<sup>188</sup>.

### **Parental problem drug use**

9.37 The Government's 2008 Drug Strategy refers to that group of illegal drug misusers who present the greatest problems overall – i.e. those using opiates such as heroin and/or crack cocaine – as 'Problem Drug Users' (PDUs). Whilst the 'PDUs' are a priority group for policy and for access to services, these services are at the same time available for all those with problems with their drug use.

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184 Weissman, M.M., John, K., Merikangas, K.R., Prusoff, B.A., Wickramaratne, P., Gammon, G.D., Angold, A. and Warner, V. (1986) 'Depressed parents and their children: General health, social and psychiatric problems.' *American Journal of Diseases of Children* 140, 801-805.

185 Somers, V. (2007) 'Schizophrenia: The Impact of Parental Illness on Children.' *British Journal of Social Work* 37, 8, 1319-1334.

186 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2<sup>nd</sup> Edition. London: The Stationery Office.

187 National Patient Safety Agency (2009) *Rapid Response Report NPSA/2009/RRR003: Preventing harm to children from parents with mental health needs*. London: National Patient Safety Agency. See [www.npsa.nhs.uk/patientsafety/alerts-and-directives](http://www.npsa.nhs.uk/patientsafety/alerts-and-directives).

188 Social Care Institute for Excellence (2009) *Think child, think parent, think family*. London: SCIE.

9.38 Although as many as one in three adults have used illicit drugs at least once, problem drug users are less than one percent of the population in England<sup>189</sup>.

It is hard to know with any degree of certainty how many children are living with parents who are problem drug users as such behaviour is against the law and characterised by denial and secrecy. In England and Wales it is estimated that one per cent of babies are born each year to women with problem drug use, and that two to three per cent of children under the age of 16 years have parents with problem drug use. Not all these children will be living with their parents and only about a third of fathers and two-thirds of mothers with problem drug use are still living with their own children<sup>190</sup>. It is not only their parents whose drug misuse may place the child at risk of suffering significant harm, but problem drug use of other family members such a parent's new partner, siblings, or other individuals within the household.

9.39 To understand how problem drug use can affect parents' capacity to meet the developmental needs of their children is far from simple and it is important not to generalise or make assumptions about the impact on children of parental drug misuse. Consideration needs to be given to both the type of drug used and its effects on the individual; the same drug may affect different people in different ways. The situation is further complicated because the same drug may have very different consequences for the individual depending on their current mental state, experience and/or tolerance of the drug, expectations, personality, the environment in which it is taken, the amount used and the way it is consumed. When parents, or others in the home, stop taking drugs children can be particularly vulnerable. For example, the withdrawal symptoms both physical and psychological may interfere, at least for a while, with parent's capacity to meet the needs of their children.

Problematic drug use is likely to continue over time, and although treatment may prolong periods of abstinence or controlled use, for some individuals relapse should be expected. Assumptions about the use or abstinence of drugs should not be based on whether or not parents, or others in the home, are engaged with services for their problem drug use.

9.40 Parental problem drug misuse is generally associated with some degree of child neglect and emotional abuse. It can result in parents or carers experiencing difficulty in organising their own and their children's lives, being unable to meet children's needs for safety and basic care, being emotionally unavailable and having difficulty in controlling and disciplining their children<sup>191,192</sup>. Difficulty in organising day to day living means that important events such as birthdays or holidays are disrupted and family rituals and routines such as meal or bed times, which cement family relationships, are difficult to sustain. Problem drug misuse may cause parents to become detached from reality or lose consciousness. When there is no other responsible adult in the home, children are left to fend for themselves. Some problem drug using parents may find it difficult to give priority to the needs of their children. Finding money for drugs may reduce what is available to meet basic needs, or may draw families into criminal activities. Poverty and a need to have easy access to drugs may lead families to live in unsafe communities where children are exposed to harmful anti-social behaviour and environmental dangers such as dirty needles in parks and other public places. At its extreme, parental problem drug misuse can be implicated in the serious injury or death of a child.

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189 Hoare, J. and Flatley, J. (2008) *Drug Misuse Declared: Finding from the 2007/08 British Crime Survey, England and Wales*. London: Home Office Statistical Bulletin.

190 Advisory Council on the Misuse of Drugs (2003) *Hidden harm: Responding to the needs of children of problem drug users*. London: Home Office.

191 Hogan, D. and Higgins L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents*. Dublin: The Children's Research Centre.

192 Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

The study of Serious Case Reviews<sup>193</sup> found that in a third of cases there was a current or past history of parental drug misuse.

9.41 Such negative scenarios are not inevitable. A significant proportion of children who live with parents who are problem drug users will show no long term behavioural or emotional disturbance. Some problem drug users ensure their children are looked after, clean and fed, have all their needs met and that drugs are stored safely.

A caring partner, spouse or relative who does not use drugs can provide essential support and continuity of care for the child. Other protective factors include drug treatment, wider family and primary health care services providing support, the child's attendance at nursery or day care, sufficient income and good physical standards in the home. Many parents, however, who are problem drug users often base their social activities around the procurement and use of the drug and are isolated and rejected by their communities. Drug related debts and angry neighbours may result in unplanned moves which disrupt children's schooling, community links and friendships. The safety, health and development of a considerable number of children are adversely affected by parental problem drug misuse and would benefit from services to meet the needs of both children and parents.

9.42 The impact of parental problem drug misuse will depend on the child's age and stage of development as well as this or her personality and ability to cope. Drug use while pregnant may endanger the unborn child depending on the pharmacological make-up of the drug, the gestation of pregnancy and the route/amount/duration of drug use. Structural damage to the foetus is most likely during 4-12 weeks of gestation; drugs taken later can affect growth or cause intoxication or abstinence syndromes<sup>194</sup>. However, gauging the impact of maternal drug use on the unborn child is complicated when mothers take a combination of substances. Some of the problems associated with maternal problem drug misuse can be ameliorated by good ante-natal care. Unfortunately, some pregnant problem drug users do not seek ante-natal care, either because the drugs affect menstruation and leave women uncertain of dates, or because they fear that revealing their drug use to health professionals will result in judgemental attitudes, the involvement of children's social care services and the possible loss of the baby once it is born. For pregnant drug users in general, irrespective of the substance used, especially where poor social conditions prevail, there is an increased risk of low birth weight, premature delivery, perinatal mortality and cot death<sup>195</sup>. While there is general agreement that problem drug use while pregnant can increase the risk of impairment to the unborn child's development, it is also probable that most women who misuse drugs will give birth to healthy children who suffer from no long term effects<sup>196</sup>.

9.43 Maternal problem drug misuse can impact on the attachment relationship between mother and child in a number of ways. Babies who need treatment for withdrawal symptoms may become sleepy and unresponsive. Mothers who undergo rapid drug reduction or abstinence may find it difficult to respond appropriately to their newborn baby. Problem drug misuse may also affect the parents' ability to empathise with the baby. Research has shown that many parents who misuse drugs, particularly heroin, are often emotionally unavailable to their children<sup>197</sup>.

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193 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

194 Julien, R.M. (1995) *A Primer of Drug Action: A Concise, Non-Technical Guide to the Actions, Uses, and Side Effects of Psychoactive Drugs. 7th Edition*. New York: W.H. Freeman and Co.

195 Standing Conference on Drug Misuse (SCODA) (1997) *Working with Children and Families Affected by Parental Substance Misuse*. London: Local Government Association Publications.

196 Powell, J. and Hart, D. (2001) 'Working with Parents who Use Drugs.' In R. Gordon and E. Harran (eds) *Fragile handle with care: protecting babies from harm: Reader*. Leicester: NSPCC.

197 Hogan, D. and Higgins L. (2001) *When Parents Use Drugs: Key Findings from a Study of Children in the Care of Drug-using Parents*. Dublin: The Children's Research Centre.

A consistent lack of warmth and negative responses may result in the infant becoming insecurely attached. Babies and young children who are exposed to dramatic and sometimes frightening parental mood swings may become unnaturally vigilant as they try to alter their behaviour according to their parent's state of mind. Serious drug dependency may result in parents placing their own needs before the safety and welfare of their children. For example, young children may be left alone at home, or in the care of unsuitable and unsafe people, while the parent prioritises the acquisition of drugs.

9.44 Parental problem drug misuse also affects children during middle childhood. Research suggests that children's education and performance in school may suffer because parental problems dominate the child's thoughts and can affect concentration<sup>198</sup>. Some children feel responsible for their parent's actions, believing they are to blame for their parent's drug taking. This can lead to feelings of inadequacy and guilt when their actions fail to make any impact on their parent's use of drugs. Parental problem drug misuse may have very negative effects on the parent/child relationship. The need for drugs is paramount and children may believe that they take second place in their parent's lives, leaving them with feelings of anger, betrayal and worthlessness. Children may also have to grow up too quickly, as parental problem drug use may result in some children having to assume adult responsibilities. Children may be left to take care of themselves for much of the time, which can lead to school work being neglected, erratic school attendance, curtailment of friendships, and a general loss of childhood. Parental problem drug use is associated with higher levels of aggressive, noncompliant, disruptive, destructive and antisocial behaviours in children<sup>199</sup>. For some children school and friendships offer respite and a safe haven from a troubled home situation. Other protective factors for this age group include: the presence in the home of an alternative, caring adult who does not misuse drugs, a supportive older sibling and/ or members of the wider family, regular school attendance, vigilant and sympathetic teachers, learning different ways of coping and developing the confidence to know what to do when parents are incapacitated.

9.45 As children grow up parental problem drug use affects them in different ways. Adolescence ushers in great physical changes. Parental problem drug misuse may mean parents are unaware of children's worries over their changing body and fail to provide support and advice. Children's health may be affected because parental problem drug use is associated with an increased risk during adolescence, of children experimenting with drugs. Some young people learn to mirror their parents coping strategies and come to depend on drugs to deal with difficult situations and negative feelings<sup>200</sup>. The relationship, however is complex and most children of parents with drug problems do not themselves become problem drug users. The likelihood that children's education is affected continues into adolescence as young people take on greater responsibility for looking after the home and assuming the care of a parent and younger siblings. Nonetheless, the majority of adolescent children whose parents are problem drug users attend school regularly. When parents are unable to look after adolescent children adequately, the normal pace of emotional maturity can be accelerated and for some the relationship between parent and child is reversed. Problem drug use can result in parents continuing to put their own needs above those of their adolescent children, leading to feelings of worthlessness and anger. To deal with these emotions young people may resort to self harm, illicit drug use, spending long periods outside the home, or leaving home altogether.

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198 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development*. 2<sup>nd</sup> Edition. London: The Stationery Office.

199 Barnard, M. (2007) *Drug Addiction and Families*. London: Jessica Kingsley Publishers.

200 Covell, K. and Howe, R.B. (2009) *Children, families and violence: Challenges for children's rights*. London: Jessica Kingsley Publishers.

9.46 Parental problem drug use is a feature in the backgrounds of many young homeless people. Loneliness and isolation are not the experience of all adolescents whose parents misuse drugs. Friendships are valued highly and many teenagers of parents with drug problems gain solace and support from friends, regardless of whether they are able to discuss family problems. Sadly for some, unplanned moves, often as a result of drug related issues, mean adolescents experience school changes, lose ties with their community and perhaps most mourned, lose the support and love of close friends. The key factors that support young people living with parental problem drug use include practical and domestic help, a trusted mentor with whom the adolescent can discuss sensitive issues, a mutual friend, and the ability to separate safely, either psychologically or physically, from stressful situations.

### **Parental problem alcohol use**

9.47 The Government's strategy on alcohol reduction defines harmful drinking as: *'Drinking at levels that lead to significant harm to physical and mental health and at levels that may be causing substantial harm to others... Women who regularly drink over 6 units a day (or over 35 units a week) and men who regularly drink over 8 units a day (or 50 units a week) are at highest risk of such alcohol-related harm'*<sup>201</sup>.

9.48 Findings from the *General Lifestyle Survey 2008* suggest that 7% of men and 4% of women regularly drink at higher-risk levels: rates which have fallen slightly over the past few years. In addition to regular higher-risk drinking, problems can also result from binge drinking or, for example, drinking before driving. Nearly a fifth of men and 14% of women are drinking more than twice the lower-risk limit at least one day per week, a figure that is used as a proxy for 'binge drinking' at a population level<sup>202</sup>. It is estimated that up to 1.3 million children are affected by parental alcohol problems in England (Strategy Unit 2004). An analysis of calls received by ChildLine<sup>203</sup> shows that the majority (57%) of callers identified their father or father figure as the problem drinker, a third their mother or mother figure and 7% indicated both parents had a drink problem.

9.49 The impact of excessive alcohol consumption on parents' capacity to look after their children will depend on their current mental state and personality, their experience and tolerance of alcohol and the amount of alcohol consumed. For example, parenting may be affected because excessive drinking can affect concentration, induce sleep or coma, or reduce psychomotor co-ordination. In addition inhibitions may be lost, which can result in diminished self control and violence.

9.50 Parental problem drinking can be associated with violence within the family and the physical abuse of children, but who has the alcohol problem is relevant. Alcohol misuse by a father or father figure can be related to violence and the physical abuse of children, while mothers with an alcohol problem are more likely to neglect their children<sup>204</sup>. Children are most at risk of suffering significant harm when alcohol misuse is associated with violence. If parents with a chronic drink problem stop drinking, the physical reactions they experience may also affect their capacity to meet the children's needs.

As noted in relation to chronic drug misuse, severe and chronic alcohol problems are likely to continue over time and, although treatment may result in abstinence, relapse is possible. The adverse effects of parental alcohol misuse on children are less likely when

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201 Department of Health, Home Office, Department for Education and Skills and Department for Culture, Media and Sport (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*. London: Department of Health and Home Office. Page 3.

202 General Lifestyle Survey 2008, *Smoking and Drinking among adults 2008*. ONS: 2010.

203 ChildLine (1997) *Beyond the limit: children who live with parental alcohol misuse*. London: ChildLine

204 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

not associated with violence, family discord, or the disorganisation of the family's day to day living. Particularly important is the presence of a parent or family member who does not have an alcohol problem and is able to respond to the child's developmental needs.

9.51 Many of the problems associated with problem alcohol use during pregnancy could be ameliorated to some extent by good ante-natal care. However, pregnant women with alcohol problems may not attend ante-natal care until late in pregnancy because they fear professionals will judge them. The effect of drinking on the developing foetus is related to the amount and pattern of alcohol consumed by the mother, and the stage of gestation. The foetus is most vulnerable to damage during the first three months but is at risk throughout pregnancy. Drinking during pregnancy, particularly in the first three months, is associated with an increased rate of miscarriage. Heavy drinking can cause Fetal Alcohol Syndrome (FAS), whose features include growth deficiency for height and weight, a distinct pattern of facial features and physical characteristics and central nervous system dysfunction. A syndrome that does not show the full characteristic features of FAS, Fetal Alcohol Spectrum Disorder, has been reported, and may develop at lower levels of drinking than is reported for FAS. The Chief Medical Officer and NICE both advise pregnant women or women trying to conceive to avoid drinking alcohol. If they choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk. The NICE guidelines emphasise the importance of avoiding alcohol especially during the first three months of pregnancy as this is the key time for organ and nervous system development<sup>205</sup>. It is generally accepted that heavy alcohol consumption during pregnancy increases the risk of damage to the foetus. Most mothers with alcohol problems, however do give birth to healthy babies. Only approximately 4% of pregnant women who drink heavily give birth to a baby with Fetal Alcohol Spectrum Disorder<sup>206</sup>.

9.52 Once born, babies may be likely to suffer significant harm. When alcohol problems result in parents being pre-occupied with their own feelings and emotions they may fail to notice or respond appropriately to their baby. Chronic alcohol problems may limit the mother's capacity to engage with and stimulate her baby. A consistent lack of warmth can result in the infant becoming insecurely attached. Supervision is essential to keep the more mobile infant safe from harm, but harmful drinking can affect parents' concentration and lead to a lack of oversight. Chronic drinking may also mean parents fail to recognise when their baby or infant is unwell, or delay seeking medical help for minor injuries if these have resulted from a lack of supervision. The infant's health may also be affected because high levels of alcohol consumption can depress appetite, and parents may fail to respond to their child's need for food. Research suggests parental problem drinking may also impact on the young child's cognitive development. Babies and infants are more likely to be protected from significant harm when one parent does not have an alcohol problem and is able to respond to the emotional and cognitive needs of the child, there is sufficient income and good physical standards in the home and the parent who is drinking at harmful levels acknowledges their problem and receives treatment<sup>207</sup>.

9.53 Parental alcohol problems continue to affect the health and development of children during middle childhood. For example, children's health may be endangered because, although alcohol consumption is not common during this period of childhood, maternal

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205 National Institute for Health and Clinical Excellence (2008) *Updated NICE guideline published on care and support that women should receive during pregnancy*.  
[www.nice.org.uk/media/E5D/8B/20080222AntenatalCare.pdf](http://www.nice.org.uk/media/E5D/8B/20080222AntenatalCare.pdf)

206 Abel, E.L. (1998) 'Fetal Alcohol Syndrome: The American Paradox.' *Alcohol and Alcoholism* 33, 3, 195-201.

207 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

drinking increases the likelihood that children aged 10 years will start drinking<sup>208</sup>. Learning may also be affected. Children of parents with chronic alcohol problems are more likely to experience reading problems, poor concentration and low academic performance<sup>209</sup>. When parents are intoxicated they may not be capable of encouraging the child to learn, or of providing sufficient support with schooling. Alcohol can make parents behave in inconsistent and unexpected ways, loving and caring at one moment and rejecting and cold at another. This can leave children feeling betrayed, let down, angry, and uncertain that they are loved. Middle year children tend to feel guilty and blame themselves for their parents' drinking; emotions which are compounded when parents deny the problem. A further possible consequence of parental problem drinking is that children may grow up too quickly, having to look after themselves, younger siblings and their alcoholic parent. It should not be assumed that all children in middle childhood who live with a parent with alcohol problems experience emotional and behavioural difficulties. Older siblings and close relatives can provide children with much needed emotional and practical support. Unfortunately, wider family and friends are often unaware of the family difficulties as a fear of stigma and ridicule may keep all family members silent. There is considerable evidence to suggest that the combination of parental chronic drinking with domestic violence causes a more detrimental impact on children than parental alcohol misuse in isolation<sup>210</sup>.

9.54 To ensure children understand the physical changes that result from puberty and how to cope safely with new relationships, they need the support of their parents or carers. When alcohol problems dominate parents' lives children may be left to deal with these issues alone. Chronic alcohol problems may also result in parents failing to provide adolescents with adequate supervision. Research suggests youngsters aged 11-12 years are more likely to use alcohol, cannabis and tobacco if their parents have an alcohol problem<sup>211</sup>. Young people who start drinking at an early age are at greater risk of poor health and being involved in accidents and accidental injury. The relationship between parental problem drinking and young people's drinking patterns is complex, because observing the devastating effect alcohol has on their parents' lives may act as a strong deterrent<sup>212</sup>. Young people's education may continue to be affected by their parents' alcohol problems and they may find themselves facing the stress of examinations with little or no support. Education may also be interrupted because teenagers feel compelled to stay at home to look after their parent or younger siblings. A lack of educational attainment has long term effects on young people's life chances. However, generalisations should not be made. For some young people school offers an escape from the problems at home and an opportunity to build a different life from that of their parents. Relationships between teenagers and their parents can also be affected. Chronic alcohol problems may result in parents putting their own needs above those of their children, leaving teenagers feeling let down, angry and worthless.

Teenagers may experience physical neglect when drinking takes precedence and there is not sufficient money for household essentials and clothes. Such neglect may jeopardise friendships or lead to bullying. To keep up appearances some young people may resort to stealing or other illegitimate ways of obtaining money to keep up appearances.

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208 Macleod, J., Hickman, M., Bowen, E., Alati, R., Tilling, K. and Davey Smith, G. (2008) 'Parental drug use, early adversities, later childhood problems and children's use of tobacco and alcohol at age 10: birth cohort study.' *Addiction* 103, 1731-43.

209 Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

210 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

211 Li, C., Pentz, A. and Chou, C-P. (2002) 'Parental substance use as a modifier of adolescent substance use risk.' *Addiction* 97, 1537-50.

212 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

Others may seek to escape the difficulties within the home by withdrawing into themselves, using alcohol or drugs, or leaving home altogether<sup>213</sup>.

Many young people who leave home will experience homelessness which is associated with poorer mental and physical health and an increased likelihood of substance misuse<sup>214</sup>.

9.55 It is important not to assume that all young people will have problems just because they grow up living with a parent who has alcohol problems. The majority outgrow their childhood problems<sup>215</sup>. Research suggests that the following factors can support young people: sufficient income and good physical standard in the home, regular medical and dental checks, a trusted adult, a mutual friend, supportive and harmonious family environment, and regular attendance at school, work-based training or a job<sup>216</sup>.

### Parents with a learning disability

9.56 The cause of learning disabilities can have its roots in genetic factors, infection before birth, brain injury at birth, brain infections or brain damage after birth.

A learning disability may be mild, moderate, severe or profound, but it is a life-long condition. Traditionally, scores on standardised intelligence tests have been used to define learning disability. However, difficulties arise over how to classify those with borderline IQs (70 to 85), and individuals who exhibit different ability levels across the components of IQ tests. The Department of Health's definition of learning disability encompasses people with a broad range of disabilities.

*'Learning disability includes the presence of:*

- *a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with*
- *a reduced ability to cope independently (impaired social functioning);*
- *which started before adulthood, with a lasting effect on development'*<sup>217</sup>.

9.57 The most recent research estimates that there are 985,000 people in England with a learning disability, equivalent to an overall prevalence rate of 2% of the adult population<sup>218</sup>. Estimates of the number of adults with learning disabilities who are parents vary widely from 23,000 to 250,000<sup>219</sup>.

9.58 It is important not to generalise or make assumptions about the parenting capacity of parents with learning disabilities. Parental learning disability is not correlated with child abuse or wilful neglect, although there is evidence that children may suffer neglect from omission where parents are not adequately supported or where there was no early intervention. In most cases where physical or sexual abuse occurs it is the mother's male partner who is responsible<sup>220</sup>.

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213 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

214 Quilgars, D., Johnsen, S. and Pleace, N. (2008) *Youth homelessness in the UK. A decade of progress?* York: Joseph Rowntree Foundation.

215 Velleman, R. and Orford, J. (2001) *Risk and Resilience: Adults who were the children of problem drinkers*. Amsterdam: Harwood Academic Publishers.

216 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

217 Cm 5086 (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: The Stationery Office. Cm 5086 2001, p.14, paragraph 1.5.

218 Emerson E. and Hatton, C. (2008) *People with Learning Disabilities in England*. Lancaster: Centre for Disability Research.

219 Department of Health and Department for Education and Skills (2007) *Good practice guidance on working with parents with a learning disability*. London: Department of Health.

220 Booth, T. and Booth, W. (2002) 'Men in the Lives of Mothers with Intellectual Disabilities'. *Journal of Applied Research in Intellectual Disabilities* 15, 187-199.

A study of Serious Case Reviews found that in 15% of cases parents had a learning disability<sup>221</sup>.

9.59 Parents with learning disabilities will need support to develop the understanding, resources, skills and experience to meet the needs of their children. Such support is particularly important when parents experience additional stressors such as having a disabled child, domestic violence, poor physical and mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. It is these additional stressors when combined with a learning disability that are most likely to lead to concerns about the care and safety of a child. A study of children living with learning disabled parents who had been referred to local authority child's social care services highlighted the need for collaborative working between children's and adults' services and support for the family that lasts until the children reach adulthood<sup>222</sup>. There are many examples of positive practice in supporting parents with learning disabilities<sup>223</sup>.

9.60 Parental learning disability may impact on the unborn child because it affects parents in their decision-making and preparation for the birth. Many women with learning disabilities are poorly informed about contraception and the significance of changes in their menstrual pattern and, as a result, may fail initially to recognize their pregnancy. The quality of the woman's ante-natal care is often jeopardized by late presentation and poor attendance. When women with learning disabilities do attend antenatal care they may experience difficulty in understanding and putting into practice the information and advice they receive.

9.61 For new born babies to thrive they need love, adequate nutrition, sleep, warmth, and to be kept clean. Mothers with learning disabilities may not know what is appropriate food for the baby and developing infant and experience difficulty in establishing a beneficial routine. Health checks may be missed and when the baby is unwell a mother with learning disabilities may not recognise the seriousness of the illness. As the infant develops and becomes more mobile, parents with learning disabilities may not realise the importance of supervising bath times and ensuring the infant is protected from potential dangers within the home. The ongoing support and advice from their wider family and health workers will be essential to ensure parents adapt to their babies changing needs. The infant's cognitive development may be delayed due to an inherited learning disability. However, the environment can still make a difference; children brought up in a warm and stimulating environment will have better outcomes than those with inherited learning disabilities that are not<sup>224</sup>. Mothers with learning disabilities may experience difficulty in engaging with and providing sufficient stimulation for the infant's development and learning. For example, a learning disability may curtail parents' ability to read simple stories to their children and result in a restricted repertoire of nursery rhymes and other songs. Finally, babies and infants may be left with unsafe adults because parents fail to recognise the threat they pose, or lack the self confidence to prevent them having access to the child.

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221 Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebottom, P., Dodsworth, J., Warren, C. and Black, J. (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-7*. London: Department for Children Schools and Families.

222 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

223 Working Together with Parents Network (2009), *Supporting parents with learning disabilities and difficulties: stories of positive practice* Norah Fry Research Centre.; DH/DCSF *Joint Good Practice Guidance on Supporting Parents with a Learning Disability*.

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_075119](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075119); SCIE *Knowledge Review on disabled parents and parents with additional support needs*.

[www.scie.org.uk/publications/knowledgereviews/kr11.pdf](http://www.scie.org.uk/publications/knowledgereviews/kr11.pdf).

224 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

Babies and young children can be supported by the presence of a non-abusive, caring adult, other responsible adults such as grandparents involved in the care of the child, ongoing support for the parent, stable home, adequate finances, and harmonious family relationships<sup>225</sup>.

9.62 The impact of parental learning disability on children becomes more evident during middle childhood<sup>226</sup>. Children's health may suffer because of a lack of hygiene and a poor diet. Health problems may not be recognised or adequately dealt with, for example dental and doctor's appointments may be missed. Learning may also be affected. Parents with literacy and numeracy problems will have difficulty in helping with school work and encouraging learning. Children's school attendance may be erratic or frequently late. Parents' own poor school experiences may mean they are reluctant to attend school events, and they may experience difficulty in understanding and putting into practice the advice teachers give them. A learning disability may affect parents' capacity to set boundaries and exert authority as their children reach middle childhood; a situation that can be exacerbated if the child is more able than their parent. Children's self image and self esteem may be affected if parents do not understand the importance of recognising the individuality of their children. Parental learning disabilities may also affect children's relationships within the family and with their peers. Inconsistent parenting can cause children to become anxious and uncertain of their parents' affection; emotions which will be exacerbated if parents fail to protect their children from childhood abuse. The consequences of abuse and neglect, particularly in relation to hygiene, low self esteem, and poor control over emotions and behaviour, may result in children being rejected and bullied by their peers. Finally, growing up with parents with learning disability may mean that an able child assumes a major caring role within the family, and as a consequence loses out on his or her own childhood. Positive outcomes for middle year children are associated with the provision of emotional and practical support by relatives, particularly grandparents, regular attendance at school, empathic and vigilant teachers, sufficient income, good physical standards in the home, and belonging to organised out of school activities<sup>227</sup>.

9.63 Teenagers of parents with learning disabilities may be left to cope alone with the physical and emotional changes that result from puberty. Parents themselves do not fully understand the significance of puberty and they may fail to educate, support or protect their children. The problems are compounded when parents need to care for an adolescent child with profound learning and physical disabilities. Physical and emotional neglect, low self esteem and inadequate supervision increases the likelihood that young people will engage in risky behaviour, such as drinking and drug taking, self harming, and early sexual relationships. When children are more intellectually able than their parents, acting effectively and setting boundaries as they reach adolescence becomes more difficult<sup>228</sup>. The likelihood that education will suffer continues into adolescence. Learning disabilities can result in parents not attending meetings and other school events and not having the capacity to support teenagers through the stress of examinations. Research suggests that many children of parents with learning disabilities experience school related problems such as being suspended for aggressive behaviour, truancy, frequent punishment, being bullied and having few friends<sup>229</sup>.

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225 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

226 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

227 Cleaver, H. and Nicholson, D. (2007) *Parental Learning Disability and Children's Needs: Family Experiences and Effective Practice*. London: Jessica Kingsley Publishers.

228 James, H. (2004) 'Promoting Effective Working with Parents with Learning Disabilities.' *Child Abuse Review* 13, 1, 31-41.

229 Cleaver, H., Unell, I. and Aldgate, A. (2010) *Children's Needs – Parenting Capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use, and domestic violence on children's safety and development. 2nd Edition*. London: The Stationery Office.

Teenagers who are more able than their parents are increasingly likely to take on the parenting role, becoming responsible for housework, cooking, correspondence, dealing with authority figures, and the general care of their parents and younger siblings. When parents become increasingly dependent on their teenage children it may lead both parties to feel resentful and angry. For many teenagers peer friendships are a source of great support, but low self esteem and behavioural and emotional problems can make it more difficult for teenagers to make friends. Young people whose parents have a learning disability will benefit from factual information about sex and contraception, a trusted adult or peer with whom they can discuss sensitive issues, a good friend, regular attendance at school, training or work, practical help in the home, and access to a young carers projects.

9.64 To support families where a parent has a learning disability a specialist assessment will often be needed and is recommended<sup>230</sup>. Where specialist assessments have not been carried out and/or learning disability support services have not been involved, evidence from inspections has shown that crucial decisions could be made on inadequate information<sup>231</sup>.

9.65 Adult learning disability services, and community nurses, can provide valuable input to core assessments and there are also validated assessment tools available<sup>232</sup>. However, most parents with learning disabilities do not meet eligibility criteria for adult services and a lack of cooperation between children's and adults' services can create great difficulties.

9.66 A comparative study of methods of supporting parents with learning disabilities found that group education combined with home based support, increases parenting capacity<sup>233</sup>. In some areas, services provide accessible information, advocacy, peer support, multi-agency and multi-disciplinary assessments and on-going home based and other support. This 'parenting with support' appears to yield good results for both parents and children<sup>234</sup>.

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