

Identifying parental substance use and misuse in clinical practice

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While it is difficult to ascertain how extensive the problem of parental substance misuse is in Australia today, international estimates from the USA indicate that approximately 9% of children live in families with parental alcohol abuse or dependence and substance dependence (Office of Applied Studies, 2003). UK estimates of illicit drug use (excluding alcohol) suggest that 2–3% of children in England, and 4–6% of children in Scotland, have parents with drug problems (Advisory Council on the Misuse of Drugs [ACMD], 2003). It seems likely that at least 10% of Australian children also live in families with parental substance misuse (Dawe et al., 2007). However, parental substance misuse rarely occurs in isolation. Parents are often experiencing a range of other problems that affect children's outcomes, including a range of psychological problems that affect mood. Spousal relationships are often strained and, in many families, accompanied by domestic violence. Children of these relationships develop a range of behavioural problems from early childhood and these, in turn, often result in difficulties in settling into the school system. By middle childhood, if little is done, children may be failing to meet minimum literacy and numeracy standards, and engaging in behaviour and conduct problems that make classroom management difficult (see Dawe et al., 2007, for an extensive review of this literature).

Given the elevated risk of poor outcomes for children, it is imperative to develop a range of strategies, both at a policy level and in clinical practice, that will reduce the risk of such outcomes. The issue is a complex one and will require a range of treatment responses offered across health, child protection and drug and alcohol services. This brief article will address the issue of identification of substance misuse. How does a clinician determine if a parent is a problematic substance user within the context of routine clinical practice? For those in drug and alcohol treatment agencies, this is a relatively straightforward matter, as such information is clearly core business. But what of those in agencies who come into contact with multi-problem families but are not directly presented with a substance use issue (e.g., general practice or child health services)? Alternatively, how does a practitioner who learns of parental substance use gauge whether this use may be adversely affecting children?

Screening for substance misuse

It is possible to ascertain if there is problematic use of substances by a family member quite simply in the context of an interview by asking a series of basic questions. This could include asking about the three most recent times a "substance" was used and, in the case of alcohol at least, the quantity consumed. Box 1 provides an example of the kind of question and response that would allow for reasonable screening for an alcohol problem. Clearly, Scenario 1 would suggest that the person was a regular heavy drinker, and very probably exceeding recommended guidelines for low risk drinking (National Health and Medical Research Council [NHMRC], 2001). However, Scenario 2 would suggest that further questions about alcohol consumption are not needed. This approach can be used with all substances and provides a good starting point for determining if a parent has a substance use problem.¹

When does substance use impair the capacity to provide adequate parenting?

This is a very complex question and can only really be answered in the context of a full interview that obtains information on both the extent of the use of substances and other factors that may influence parenting. However, there are several key issues that are specific to substance use that are always worth considering. These relate to the psychoactive effects of the substance used, that is, the effects of substance intoxication and the severity of the individual's dependence on the substance.

In relation to intoxication, it is important to remember that different drug classes have different effects on behaviour and mood. Substances are often broadly classified into sedatives (e.g., alcohol, benzodiazepines) and psychomotor stimulants (e.g., amphetamines, cocaine, ecstasy). See Box 2 for a list of effects for those substances that are most widely used: alcohol, cannabis and amphetamines.

¹ Implicit in this line of interviewing is the assumption that the interviewer will be familiar with both the NHMRC guidelines and the calculation of standard drinks. Further information on both of these issues can be obtained from www.nhmrc.gov.au/consult/_files/draft_australian_alcohol_guidelines.pdf

Box 1

Scenario 1: Interview Monday morning

Q. *When did you last drink alcohol?*

A. Last night (Sunday).

Q. *How much did you drink?*

A. Three glasses of wine.#

Q. *When was the time before that?*

A. Saturday.

Q. *How much did you drink?*

A. A lot—felt pretty crook the next day.

Q. *When was the time before that?*

A. Friday night—that was a big night as well ... went out with friends from work and we drank till about 2 am.

After some discussion on quantity of alcohol drunk, you determine that this was about five or six standard drinks.

Scenario 2: Interview Monday morning

Q. *When did you last drink alcohol?*

A. Umm—Saturday night.

Q. *How much did you drink?*

A. Three glasses of wine.#

Q. *When was the time before that?*

A. The previous weekend.

Q. *How much did you drink?*

A. A couple of glasses of wine at a BBQ.

Q. *When was the time before that?*

A. Can't really remember—I'm not much of a drinker.

After some discussion on quantity of alcohol drunk, you determine that this was about two standard drinks.

Intoxication with any substance impairs the capacity to provide sensitive and responsive parenting. A question often asked is if there are some substances that are worse than others. Again, this is a difficult question to answer in isolation, but it is worth highlighting that those substances that result in drowsiness and impair concentration and attention can reduce levels of parental supervision. Children are at risk of neglect of their immediate physical and emotional needs, such as meals and regular bedtime routines. They may also be at risk of accident, harm by others or injury due to a lack of parental monitoring. Thus, a parent who is intoxicated with alcohol may fall asleep and leave children unattended for extended periods of time.

Substances that produce a state of agitation, restlessness and impaired judgement, such as amphetamines, bring a different set of problems. These may include a failure to appropriately regulate responses to children, such that child behaviour may be misconstrued and reacted to inappropriately. At the most extreme, for example, are parents whose use of amphetamines has led to heightened levels of suspiciousness and hostility, perhaps accompanied by subclinical features of psychosis that include delusional beliefs of persecution (see Dawe & McKettin, 2005, for further details).

The problems associated with dependent use of substances

Dependence on a substance is associated with daily use of the substance and, in the absence of use, the occurrence of withdrawal symptoms. Irrespective of the class of substance, dependent use will almost always affect parental capacity. In addition to issues relating to intoxication and withdrawal are those related to the procurement of the substance. In the case of alcohol, this is usually bought legally, thus the issues surrounding procurement relate to the impact this has on family finances. However, in the case of illicit substances, procurement is often more time-consuming and requires involvement in criminal activity. Children are often placed at considerable risk, as they may be left unsupervised for periods of time while the parent is trying to buy substances; children may be exposed to drug dealing in the home environment, violence associated with drug dealing, drug using, and drug manufacturing paraphernalia.

What to do when there are reasonable grounds for believing that substance use is impacting on parental capacity

It is important for those working in agencies that do not have the assessment and treatment of substance abuse problems as their core business to first **identify** that there may be a potential problem. This information clearly needs to be placed in a context in which information on the family circumstances are also taken into consideration. For example, daily prescribed use of methadone should not, in itself, raise any concerns about parental capacity. Heavy, frequent binge drinking may, however, be a significant risk factor if children are also left alone, or are exposed to intoxicated adults. Having some idea of the **extent** to which a parent is using substances, bearing in mind that the use of illicit drugs is associated with criminal activities related to procurement, is the next issue to be determined. Finally, **referral or liaison** with appropriate drug and alcohol treatment services should be undertaken. However, this should be done in the context of supporting the family and working collaboratively with the parent(s) to achieve the best outcome for the children. Often the most difficult decision is gauging when referral to a substance abuse

Box 2

Key features of intoxication of each substance included in this article—adapted from the DSM IV

Alcohol

Maladaptive behavioural or psychological changes, such as sexual or aggressive behaviour, labile mood and impaired judgement, that occurs after drinking alcohol.

Other signs may include: slurred speech, lack of coordination, unsteady gait, and impairment of memory and attention.

Cannabis

Maladaptive behavioural or psychological changes, such as impaired motor coordination, euphoria, anxiety, sensation of slowed time and social withdrawal, that occurs after use of cannabis.

Other signs may include: increased appetite, dry mouth, tachycardia.

Amphetamines

Maladaptive behavioural or psychological changes, such as euphoria or affective blunting, changes in sociability, hyper-vigilance, interpersonal sensitivity, tension or anger, that occur after use of amphetamines (and related substances).

Other signs may include: tachycardia or bradycardia, pupillary dilation, elevated or lowered blood pressure, perspiration or chills, agitation.

treatment service will result in a family withdrawing from a service. Sometimes it is better to ensure that a parent with a substance misuse problem feels supported by the agency and that part of the work of the agency is to motivate the parent to seek help for a substance use problem. As always, the welfare of the children is paramount and clinical sensitivity and common sense are essential.

Useful resources on screening and assessment instruments

Dawe, S., Loxton, N., Hides, L., Kavanagh, D., & Mattick, R. P. (2002). *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders* (2nd ed., Monograph Series No. 48). Canberra: National Drug Strategy, Department of Human Services and Health. Retrieved 30 January 2008, from [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publhlth-publicat-document-mono48-cnt.htm/\\$FILE/mono48.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publhlth-publicat-document-mono48-cnt.htm/$FILE/mono48.pdf)

Parental drug use and families website. Australian Drug Info Clearinghouse. Retrieved 30 January 2008, from http://druginfo.adf.org.au/newsletter.asp?ContainerID=parental_drug_use___families1

Please also refer to the literature highlights in this edition, which include information on recent publications related to parental substance use.

References

- Advisory Council on the Misuse of Drugs. (2003). *Hidden harm: Responding to the needs of children of problem drug users*. London: Home Office.
- Dawe, S., Frye, S., Best, D., Moss, D., Atkinson, J., Evans, C. et al. (2007). *Drug use in the family: Impacts and implications for children* (ANCD Research Paper No. 13). Canberra: Australian National Council on Drugs. Retrieved 30 January 2008, from http://www.ncd.org.au/publications/pdf/rp13_drug_use_in_family.pdf
- Dawe, S., & McKetin, R. (2004). The psychiatric comorbidity of psychostimulant use. In A. Baker, N. K. Lee, & L. Jenner (Eds.), *Models of intervention and care for psychostimulant users* (2nd ed., pp. 154–168, Monograph Series No. 51). Canberra: National Drug Strategy, Department of Health and Aged Care. Retrieved 30 January 2008, from [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publhlth-publicat-document-mono51-cnt.htm/\\$FILE/mono51.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publhlth-publicat-document-mono51-cnt.htm/$FILE/mono51.pdf)
- National Health and Medical Research Council. (2001). *Australian alcohol guidelines: Health risks and benefits*. Canberra: Author.
- Office of Applied Studies. (2003). *Children living with substance-abusing or substance-dependent parents* (The NHSDA Report). Washington: Author. Retrieved 30 March 2005, from <http://www.oas.samhsa.gov/2k3/children/children.htm>

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