CHILDREN'S MENTAL HEALTH RESEARCH

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Addressing parental substance misuse

Winter

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Children's Health Policy Centre

ABOUT THE CHILDREN'S HEALTH POLICY CENTRE

As an interdisciplinary research group in the Faculty of Health Sciences at Simon Fraser University, we aim to connect research and policy to improve children's mental health. To learn more about our work, please see childhealthpolicy.ca.

ABOUT THE *QUARTERLY*

In the *Quarterly*, we present summaries of the best available research evidence on children's mental health topics, using systematic review and synthesis methods adapted from the *Cochrane Collaboration* and *Evidence-Based Mental Health*. The BC Ministry of Children and Family Development funds the *Quarterly*.

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This Issue

NEXT ISSUE

Treating childhood obsessive-compulsive disorder

At any given time, an estimated 20,000 Canadian children struggle with obsessive-compulsive disorder. We review interventions to help these children.

How to Cite the *Quarterly*

We encourage you to share the *Quarterly* with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). Please cite this issue as follows:

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Alcohol and drugs don't mix with parenting

You feel like you're always put on the second shelf. You feel like you're not number one in your parents' life and that makes you feel horrible…

— Fifteen-year-old girl[1]

I wish someone would tell my mum the impact it's having on her family.

— Twelve-year-old girl[2]

Approximately one in 10 Canadian children under the age of 12 lives with a parent with a substance use disorder.

Most parents strive to nurture their children well. But for some parents, substance use interferes. In fact, approximately one in 10 Canadian children under the age of 12 lives with a parent with a substance use disorder.[3]

Sadly, for many of these children, parental substance misuse is not the only hardship they face.[4, 5] Researchers who have tracked outcomes for children with substance-misusing parents over the long term (10 years or more) have found significantly greater risks for a wide range of adversities. These include poverty, parent and sibling criminal activity, other parental mental health problems, child maltreatment, foster care placements and even death.[4, 5] Canadian public health surveillance data also indicate that alcohol and drug misuse is a common concern in cases of substantiated child maltreatment.[6]

It needs to be recognized that not all parents with substance misuse problems are abusive or neglectful. Rather, substance-misusing adults have been found to parent on a *continuum* — ranging from poor to satisfactory.[7] As well, some studies have found that socio-economic disadvantage is actually a better predictor of problematic parenting than substance misuse per se.[7]

Although much is known about risks, we also need to know what protects children when parents misuse substances. Three studies have attempted to provide this information by looking at families where alcohol was a problem. One found that a strong relationship with a non-substance-misusing mother protected young children from developing behavioural and emotional problems.[8] Another found that high levels of family closeness and adaptability protected school-age children from developing behavioural and emotional problems.[9] The final study revealed that high levels of open communication protected adolescent girls (but not boys) from depressive symptoms.[10]

High levels of family closeness and adaptability protected school-age children from developing behavioural and emotional problems.

What can society do?

The most effective approach for helping children is to prevent parents from engaging in problematic substance use. And as with all prevention efforts, it is most helpful to start early, before young people become parents. To this end, in previous issues of the *Quarterly* we have identified a number of effective substance use prevention and treatment programs for adolescents.

But if early prevention and treatment efforts are not offered or do not succeed, much can still be done to help families. For example, in a previous *Quarterly*, we identified programs that successfully reduce alcohol use in pregnancy. And in the upcoming Review article, we identify programs for parents with substance use disorders that can assist both parents and children.

Where to find local treatment resources

BC's Alcohol and Drug Information and Referral Service provides information about substance treatment programs across the province. This free, confidential service is available 24 hours a day. Call 604-660-9382 in the Lower Mainland or 1-800-663-1441 in the rest of BC. Their website provides additional information.

Keeping children safe is everyone's responsibility

Even when parents are committed to addressing their substance problems, and especially when they are not, children may be at risk for maltreatment. For this reason, any adult who suspects that a child is being abused or neglected because of caregiver substance misuse (or for any other cause) is legally and ethically obliged to report the concern to the local child protection agency.[11] This agency is then responsible for investigating and ensuring children's safety. In BC, child protection workers may be from either the Ministry of Children and Family Development (MCFD) or a Delegated Aboriginal Agency. (For more information on finding local child protection agencies, please visit the Canadian Child Welfare Research Portal or the MCFD website.)

Sometimes well-meaning individuals make other attempts to assist, such as referring children for individual counselling even though parents are still actively misusing substances. However, it is important to recognize that counselling will be of limited use when children continue to be in situations that are detrimental to their well-being.

Other helpful steps can also be taken to support children when parents are misusing substances, including addressing unmet needs. For example, many of these children lack even one adult who can provide them with consistent supports.[12] Yet there is strong evidence that emotional support from extended family members, teachers and other caring adults can greatly help disadvantaged children thrive as adults, despite great adversity.[13] Consequently, every adult — from coaches to daycare workers to next-door neighbours — can help by being that one adult who supports the child.

The most effective approach for helping children is to prevent parents from engaging in problematic substance use.

Supporting kids by supporting parents

When parents misuse substances, children often suffer harmful consequences. To help ensure that fewer children face this form of adversity, interventions for adults need to focus on helping children too. But is this happening and are these interventions effective? We set out to answer these questions by reviewing interventions aimed specifically at assisting children of parents with substance use disorders.

Much can be done to help families when parents have substance problems.

To identify relevant interventions, we conducted a systematic search using our usual methods. We accepted four randomized controlled trials (RCTs) evaluating three different programs: *Focus on Families* (which is completely unrelated to the Christian group Focus on the Family), *Parent Skills Training*, and *Relational Psychotherapy Mothers' Group* (which was evaluated in two separate RCTs).[14–26] We then identified and retrieved any additional relevant articles on these four accepted RCTs (e.g., articles published outside our search date range).

All four RCTs recruited parents from community-based substance treatment programs in the United States in the 1990s or 2000s.[20, 22, 25, 26] *Focus on Families* accepted mothers or fathers who had been in methadone treatment for heroin abuse for at least 90 days and who had a child between three and 14 years living with them.[20] To be eligible for *Parent Skills Training*, fathers had to be diagnosed with an alcohol use disorder and be living with a child who was between eight and 12 years, as well as living with a non-substance-misusing female partner.[22] In contrast, participation in *Relational Psychotherapy Mothers' Group* was restricted to heroin-abusing mothers experiencing challenges with parenting a child under 16.[24, 26]

Helping parents become more effective

All three programs provided parent education. In *Focus on Families*, social workers taught heroin-abusing parents and their partners about child development and communications, as well as specific parenting techniques (e.g., using rewards and consequences) during 32 group sessions.[17] Children participated in 12 of these sessions so parents could practise their new skills.[17] Notably, *Focus on Families* was the only program that directly included children.

Focus on Families *stood out — for achieving multiple enduring benefits.*

In *Parent Skills Training*, graduate-level therapists taught alcohol-misusing fathers and their female partners practices for improving children's behaviour over six sessions, provided separately to each couple.[22] Specific techniques taught included noticing and rewarding appropriate behaviours, ignoring inappropriate behaviours, and providing clear instructions to children.[27]

The *Relational Psychotherapy Mothers' Group* took a slightly different approach. Rather than being directive and teaching specific parenting techniques, the program encouraged mothers to explore the strengths and limitations of their own parenting strategies.[24] Still, some specific techniques were discussed, such as alternatives to physical punishment.[24] In the initial RCT, a psychologist and drug counsellor provided the 12 group sessions.[24] In the replication RCT, graduate-level therapists delivered the sessions.[26]

Two programs provided additional services to intervention parents. In *Focus on Families*, case managers helped mothers and fathers further apply their learning from the parenting sessions in weekly home visits, typically delivered over nine months.[14] During these visits, case managers also promoted children's participation in community activities and helped parents to re-engage in school or work and to secure other needed services.[17]

In *Relational Psychotherapy Mothers' Group*, women also participated in 12 supportive group therapy sessions. This intervention promoted women's coping and their acknowledging of past parenting challenges — to further improve current parenting.[24]

Keep them coming back

Recognizing the challenges of retaining participants in treatment, *Focus on Families* implemented specific strategies to encourage parent and child involvement. The program began by acknowledging the economic struggles facing most participating families: 59% of families were receiving government financial assistance, and 77% of children were receiving subsidized school lunches. So *Focus on Families* provided practical supports, including supplying transportation and child care for the group parent education sessions.[14]

The program also offered families incentives for their involvement, including tickets to zoos, aquariums and baseball games as well as small toys for children.[14] Beyond providing children with positive recreational opportunities that were likely otherwise unavailable, these incentives and supports encouraged participation in the parenting sessions. This study suggests that many families who are characterized as "hard to reach" *can* successfully engage when practitioners use practical strategies to support and encourage them.

Treating parents' underlying substance problems

All parents — in both intervention and comparison groups — received treatment for their substance problems. In *Focus on Families*, all heroin-abusing parents received methadone as well as individual and group counselling.[17] In *Parent Skills Training*, alcohol-misusing fathers in the intervention group received individual cognitive-behavioural therapy *and* behavioural couples therapy (which included communication and problem-solving skills training to reinforce sobriety), while comparison fathers received only one of these two treatments.[22]

In both trials of *Relational Psychotherapy Mothers' Group*, all participants received methadone, group counselling and case management.[24] However, in the

Parenting interventions are crucial for children when parents have substance problems.

replication trial, *comparison* mothers (but *not* intervention mothers) also received 24 weeks of group recovery training, which focused on identifying substance use triggers, avoiding dangerous situations and coping with cravings.[26] (Providing an intervention exclusively to the comparison group is highly unusual in RCTs as doing so may result in the comparison group outperforming the intervention group.) Table 1 provides a summary of these four programs and their participants.

Table 1: Program and Participant Characteristics

Program	Parenting Interventions	Substance Treatments	Participants
Focus on Families* [14,17]	• Parent education (32 group sessions) • Home-based case management (39 family sessions)	• Methadone • Individual psychotherapy • Group psychotherapy	Heroin-abusing men or women (n = 144) + their partners + children
Parent Skills Training* [22]	• Parent education (6 couple sessions)	• Individual psychotherapy • Couples psychotherapy	Alcohol-misusing men (n = 30) + their female partners
Relational Psychotherapy Mothers' Group I* [24]	• Parent education (12 group sessions) • Supportive psychotherapy (12 group sessions)	• Methadone • Group psychotherapy • Case management	Heroin-abusing women (n = 61)
***Relational Psychotherapy Mothers' Group II**† [26]	As above	As above plus • Group recovery training	Heroin-abusing women (n = 127)

* Intervention parents received parenting *and* substance treatments, while comparison parents received substance treatments only.
** Intervention fathers received parenting *and* both substance treatments, while comparison fathers received one of two substance treatments only.
† Intervention mothers received parenting *and* substance treatments (other than group recovery training), while comparison mothers received all substance treatments.

Focus on Families performed best

All three programs provided parent education and substance treatments. Yet child and parent outcomes differed markedly — both when the programs ended and at follow-ups ranging from six months (*Relational Psychotherapy Mothers' Group*) to one year (*Parent Skills Training*) to 15 years (*Focus on Families*). Of the three programs, *Focus on Families* stood out — for achieving multiple enduring benefits.

Focus on Families parents reduced their heroin use and improved their drug-refusal skills by the time the program ended and at one-year follow-up. Especially striking was the finding that intervention parents used heroin almost *two-thirds* less often than comparison parents at one-year follow-up.[17] However, by two-year follow-up, *Focus on Families* parents had maintained their superior drug-refusal skills but not their actual heroin use, compared with control parents.[18]

Focus on Families parents made other gains by one-year follow-up. Compared to intervention parents, they were significantly less involved in intimate-partner violence, as either victims or perpetrators.[17] This is striking because exposure to intimate-partner violence — which is a form of child maltreatment — can lead to significant emotional and behavioural problems for children.[28]

Focus on Families participants also changed their parenting in other important ways. These included setting more appropriate limits with children and learning to hold family meetings to plan for healthier, fun activities. Beyond this, as highlighted in Table 2, these parents also made personal gains — increasing their problem-solving skills and self-efficacy.[14, 17–19]

Table 2: Outcomes Favouring Intervention Participants (All Assessment Points)

Program	Post-test	6 Months	1 Year	2 Years	12–15 Years
Focus on Families[14, 17–21]	**Child** Not assessed	**Child** ↓ Stealing	**Child** None	**Child** None	**Child** ↓ Alcohol + marijuana use disorders (males only)
	Parent ↓ Heroin use ↑ Drug-refusal skills ↑ Parenting knowledge* ↑ Family meetings ↑ Problem-solving skills ↑ Self-efficacy	**Parent** None	**Parent** ↓ Heroin use ↑ Drug-refusal skills ↓ Intimate-partner violence ↑ Household rules**	**Parent** ↑ Drug-refusal skills ↑ Problem-solving skills	**Parent** Not assessed
Parent Skills Training[22, 23]	**Child** ↓ Anxiety + depression symptoms	**Child** ↓ Anxiety + depression symptoms	**Child** ↓ Anxiety + depression symptoms	Not assessed	Not assessed
	Parent None	**Parent** None	**Parent** None		
Relational Psychotherapy Mothers' Group I[24, 25]	**Child** None	**Child** None	Not assessed	Not assessed	Not assessed
	Parent ↓ Child maltreatment † ↑ Engagement with child ↑ Parenting satisfaction	**Parent** ↓ Heroin use ↓ Child maltreatment** ↑ Engagement with child			
Relational Psychotherapy Mothers' Group II[26]	**Child** ↑ Adjustment ‡ ↓ Depression symptoms	**Child** None	Not assessed	Not assessed	Not assessed
	Parent None	**Parent** None			

* Measured at 1 month post-test. ** Significant for parent but not child reports. † Significant for both parent and child reports. ‡ Significant for child but not parent reports.

Children participating in *Focus on Families* experienced other gains — in addition to their parents using less heroin, engaging in less intimate-partner violence and being more skillful at parenting. At six-month follow-up, they stole significantly less than comparison children.[17] Even more notable, by final follow-up — which occurred 12 to 15 *years* after program completion — intervention boys were significantly less likely to be diagnosed with alcohol or marijuana use disorders.[20] Unfortunately, *Focus on Families* did not produce the same protections against substance use disorders for girls.[20]

Other programs produced more modest gains

Parent Skills Training also led to parenting improvements. In particular, at all three assessment points (from post-test through one-year follow-up), children reported having significantly fewer anxiety and depressive symptoms.[22, 23] Surprisingly, children made these gains despite there being no significant differences between intervention and comparison parents regarding several crucial outcomes, such as child maltreatment (including intimate-partner violence exposure) and alcohol use.[22, 23]

In contrast, outcomes for *Relational Psychotherapy Mothers' Group* varied over time and between the two RCTs. In the initial RCT, the intervention led to significantly lower rates of child maltreatment and to significantly higher levels of mothers engaging with their children — immediately after the program and six months later.[24, 25] As well, intervention mothers in this RCT used significantly less heroin by six-month follow-up.

Perhaps surprisingly, despite intervention mothers having made these important gains, outcomes for children did not differ on the one assessed *child* outcome. Specifically, children's overall adjustment (defined as the absence of both emotional and behavioural concerns) was not significantly better in the intervention group at either post-test or follow-up.[24]

Then the replication trial for *Relational Psychotherapy Mothers' Group* produced only temporary gains. For example, while children of intervention mothers showed better initial adjustment, including fewer depressive symptoms, these benefits faded by six-month follow-up. As well, by six-month follow-up comparison families actually achieved more gains than intervention families. Specifically, comparison children showed significantly better adjustment and comparison mothers showed significantly better overall functioning.[26]

These findings suggest that the *Relational Psychotherapy Mothers' Group* was unsuccessful. But its poorer performance may be due, in part, to the unusual design of the replication trial, wherein comparison mothers (but not intervention mothers) received group recovery training. This added intervention may have given the comparison group an inadvertent advantage.

Setting our standards: The value in assessing long-term outcomes

The goal of the *Quarterly* is to provide summaries of high-quality research evidence on children's mental health topics. Our inclusion criteria typically vary depending on the quality and quantity of available research for any given topic. For assessing intervention effectiveness, in particular, we usually require randomized controlled trials (RCTs) with at least three-month follow-up. We do this because it is crucial to know whether any benefits for children persist after the intervention ends. For example, researchers determined that initial gains from the *Relational Psychotherapy Mothers' Group* replication RCT did not persist — only because they tracked outcomes for six months after the program ended.

As well, long-term outcome evaluations can reveal surprising findings. For example, some children were only three years old when *Focus on Families* began, which meant that child substance use could not be assessed until many years after the program ended. Because researchers invested the resources to pursue this critical long-term outcome, they learned that significantly fewer boys developed substance use disorders 12 to 15 years later — a very significant benefit. So the price of conducting long-term research is often offset by the important knowledge gained.

Implications for practitioners

Our findings suggest that much can be done to help families when parents have substance problems. And our findings strongly suggest that while substance treatment clearly benefits parents, this is not enough when children are involved. Parent education also needs to be provided.

In particular, the *Focus on Families* trial showed that intensive *parent education* and *home-based case management* led to lasting benefits for children — ranging from parents using substances less frequently and engaging in less intimate-partner violence to fewer boys developing substance use disorders more than a decade later.

The *Focus on Families* trial needs to be replicated, particularly with parents who misuse substances other than heroin, and in Canadian settings. For example, can the program successfully address alcohol problems, which are far more common than heroin problems? As well, for communities considering a program similar to *Focus on Families*, what are the essential elements that need to be delivered, keeping in mind that success most likely depends on delivering the program in full? Key elements of *Focus on Families* include:

1. Providing parents with *both* intensive parent education *and* substance treatment
2. Providing multi-faceted interventions (e.g., for *parenting,* both group skills training sessions and home-based case management, and for *substances,* medical, individual and group treatments)
3. Ensuring adequate intensity and duration (e.g., 30+ parenting sessions and 30+ home visits over nine months)
4. Offering added supports to help parents succeed (e.g., by returning to school or work)
5. Involving the children in a safe manner, so parents have opportunities to practise and receive feedback on the new skills they are developing

Our findings also have more general implications for policy and practice. Intensive interventions such as *Focus on Families* may be costly, particularly in the short term. But the benefits for parents and children are remarkable and may pay for themselves over the long term — through reduced parental substance misuse, better care for children, reduced child maltreatment, and fewer substance disorders in boys more than 10 years later.

Parenting interventions are crucial for children when parents have substance problems. And integrating these interventions into substance treatment programs could help and encourage parents. For example, providing parenting and substance treatments in the same clinic could reduce stigma and travel costs, making it easier for parents to participate and learn. However, children's needs are

All service providers need to collaborate closely to support these families — across disciplines, across sectors, and across typical clinical and funding boundaries.

always paramount. So it is crucial to ensure child-friendly and safe environments in any setting where programs take place.

Many parents who struggle with substances need much more than just parenting and substance treatment programs. As the *Focus on Families* findings suggested, providing these parents with pragmatic supports, such as helping them to resume school or return to work, can greatly encourage well-being by addressing the underlying socio-economic adversities.

All service providers need to collaborate closely to support these families — across disciplines, across sectors, and across typical clinical and funding boundaries. Just as most children's mental health practitioners do not have the expertise to treat substance-misusing adults, most adult practitioners lack expertise in children's mental health. So both groups must collaborate closely if parents and children are to have good outcomes.

Parental substance misuse has serious and lasting negative effects on children, persisting across all the essential domains of child development and often continuing into adulthood. The main reason to consider implementing more intensive and comprehensive programs, and to find the necessary resources to do so, is that children suffer immensely when we do not intervene early. We also pay a collective price when we allow this to happen. This is because we incur avoidable and costly problems such as child maltreatment and intergenerational difficulties with substances and parenting.

The bottom line is that every adult who has a substance use disorder and who is caring for children should receive intensive and comprehensive programs — addressing both parenting *and* substance misuse. These parents should also receive pragmatic supports to address underlying socio-economic adversities, so that every child in this situation is helped.

The bottom line is that every adult who has a substance use disorder and who is caring for children should receive intensive and comprehensive programs — addressing both parenting and *substance misuse.*

Psychiatric medications: Is there safety in numbers?

To the Editors:
There appears to be an increase in polypharmacy — with multiple psychiatric medications being used with children and adolescents for treating behavioural difficulties and depression. What's the evidence to support this practice?

Dawn Knapton
Langley, BC

The increases in "polypharmacy" appear to be real. The prevalence of multiple psychiatric prescriptions for young people has risen approximately two- to sevenfold over the past decade.[29] Yet despite this increase, there is still limited information about the safety and efficacy of polypharmacy, because medications are typically tested in isolation rather than in combination.[30] Even so, researchers have documented numerous concerns with prescribing multiple medications, including increased side effects, lack of efficacy data, negative drug interactions, increased medication non-compliance and substantially higher costs.[31] Consequently, many experts recommend avoiding polypharmacy or using it only as a last resort.[32, 33]

However, avoiding polypharmacy does not mean that medications should be avoided altogether. Rather, with judicious use, psychiatric medications can be an important component in many treatment plans for children. To this end, practitioners first need to determine whether medication is indeed the most appropriate treatment for the young person's presenting concerns. For example, many common mental disorders experienced by children and youth — including anxiety, conduct disorder, depression and substance misuse — respond very well to psychosocial treatments and often do not require medications. Then when medications *are* deemed necessary, practitioners should only prescribe those with proven efficacy in children and youth.

On balance, practitioners should avoid prescribing multiple psychiatric medications whenever possible, given the limited safety and efficacy data on this practice. Practitioners should also carefully monitor for both benefits and side effects whenever they prescribe any medication. To reiterate, it's always imperative to ensure that medications are not used in place of safe and effective psychosocial interventions for children's mental disorders. Please see our previous *Quarterly*, which outlines first-line psychotherapeutic and pharmacologic treatments for a variety of mental disorders in children and youth.

Many common mental disorders experienced by children and youth… respond very well to psychosocial treatments and often do not require medications.

Contact Us

We hope you enjoy this issue.
We welcome your letters and suggestions for future topics. Please email them to chpc_quarterly@sfu.ca
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To identify high-quality research evidence on the effectiveness of interventions aimed at helping children of parents with substance use disorders, we conducted a comprehensive search — using methods adapted from the *Cochrane Collaboration* and *Evidence-Based Mental Health* and applying the following search strategy:

Table 3: Search Strategy

Sources	• Campbell Collaboration Library, Cochrane, CINAHL, ERIC, Medline and PsycINFO
Search Terms	• Parental, maternal or paternal substance abuse, substance use disorder, alcohol, cannabis, cocaine, heroin, intravenous, marijuana, methamphetamine or addiction *and* prevention, intervention or treatment
Limits	• Peer-reviewed articles published in English between 2003 and 2013 • Child participants aged 18 years or younger • Systematic review or randomized controlled trial (RCT) methods used

Reference lists of relevant systematic reviews were then hand-searched to identify additional RCTs. Next we applied the following inclusion criteria — requiring original articles to meet *all* criteria to be included in our final review.

Table 4: Inclusion Criteria for RCTs

- Interventions aimed at children of parents with substance use disorders
- Clear descriptions of participant characteristics, settings and interventions
- Random assignment of participants to intervention and comparison groups at study outset
- Follow-up of three months or more (from the end of intervention)
- Attrition rates below 20% at post-test or use of intention-to-treat analysis
- Outcome measures assessed using two or more informant sources (children, parents, others)
- Reliability and validity of all primary outcome measures documented
- Levels of statistical significance reported for all primary outcome measures

Two independent assessors then reviewed all abstracts and retrieved and reviewed salient articles to ensure relevance and accuracy, reaching consensus regarding final inclusion in the review. Data were then extracted and summarized by the team.

For more information on our research methods, please contact

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BC government staff can access original articles from BC's Health and Human Services Library.

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