ASSESSING SUBSTANCE ABUSE QUESTIONS IN CHILD CUSTODY EVALUATIONS

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Substance use is rampant in contemporary society, but little attention has been paid to it in the context of child custody evaluations (CCEs). This article provides concrete suggestions for integrating issues about substance abuse into a more overarching CCE and discusses specific assessment strategies.

Keywords: *child custody; substance abuse; parenting; evaluation; drugs; alcohol; toxicology*

It is an all too well-established fact that substance abuse (drugs and alcohol) is a chronic and pervasive problem today. More than 7 million people older than age 26 have used illicit substances in the past month, and more than 50 million have used alcohol (Substance Abuse and Mental Health Services Administration [SAMHSA], 2002). Parenting obviously can be seriously impaired when a parent abuses substances (Horvath, Logan, & Walker, 2002). Additionally, when a parent is undergoing the stresses of a child custody evaluation, pressures and tensions invariably increase, thereby adding to the impulse to seek relief in drugs and/or alcohol. For all three reasons—pervasiveness of the problem, potential for impaired parenting, and increased likelihood of excessive use when in a custody battle—evaluators are well advised to routinely assess for substance abuse problems when conducting a child custody evaluation (CCE), even when the issue has not been raised by either parent.

The impact of drug and alcohol use has been researched in many contexts. Workplace issues (Lennox, Steele, Zarkin, & Bray, 1998; Vasse, Nijhuis, & Kok, 1998), educational issues (Bauman & Phongsavan, 1999; Zoccolillo, Vitaro, & Tremblay, 1999), professional impairment (Brooke, 1997; Good, Thoreson, & Shaughnessy, 1995), suicidality (Dube et al., 2001; Pages, Russo, Roy-Byrne, Ries, & Cowley, 1997), psychiatric comorbidity (Brady & Sonne, 1995; Harrison & Chick, 1994), and physical comorbidity (O'Connor & Schottenfeld, 1998) have all been examined. Assessment issues in special circumstances such as medical patients (O'Connor & Schottenfeld, 1998), people seeking psychotherapy (Carey & Teitelbaum, 1996), domestic violence (Brookoff, O'Brien, Cook, Thompson, & Williams, 1997; Dalton, 2001; Irons & Schneider, 1997; Smith, 2000), and child abuse (Kelleher, Chaffin, Hollenberg, & Fischer, 1994) have also been examined. There has also been some work done in the areas of family functioning and parenting (Brooks, Gaines, Mueller, & Jenkins, 1998; Haugland & Havik, 1998; Shuntich, Loh, & Katz, 1998; Stoltenberg, Mudd, Blow, & Hill, 1998) and the impact of parental substance use on the mental health of children of divorce (McMahon & Gianninni, 2003; Short, 1998). Although there has been attention to the issue of assessing drug and alcohol issues as a part of clinical practice (Carey & Teitelbaum, 1996), the entire question of substance abuse issues in CCEs has never been appropriately explored.

Authors' Note: *This article is based in part on a presentation by the senior author at the AFCC's Fifth International Symposium on Child Custody Evaluations, AZ, November 8, 2002.*

FAMILY COURT REVIEW, Vol. 42 No. 2, April 2004 375-383

INFORMED CONSENT: A DIFFERENT BREED

There are two types of consent when there are concerns about possible substance abuse. First, there is the familiar informed consent that is routinely used: It is concerned with process (i.e., issues in testing, urine toxicology, collaterals, etc.). However, an additional informed consent is at least potentially necessary when investigating substance abuse allegations. This is because of federal regulations and rules that preempt any state statute, specifically Title 42 of the Code of Federal Regulation (CFR) Part 2 (Statutory Authority for Confidentiality of Drug Abuse Patient Records, 2004). This regulation requires explication of different standards for informed consent. The intent of this law is to provide a high level of confidentiality for clients who seek drug and alcohol treatment so that their disclosures in treatment cannot harm them. This law was written to protect any substance abuser who wanted treatment but might refrain from seeking that help for fear of retaliation. Basically, 42 CFR Part 2 provides an additional layer of confidentiality on any information obtained in treating substance abuse.

However, it is unclear if this extends to information collected as part of a CCE, especially if the evaluator works in an agency that receives federal funds or if the evaluator receives public funding even in other parts of his or her practice. Consequently, to provide maximum protection for client and evaluator both, the evaluator should be careful to follow federal guidelines when obtaining the subject's informed consent for any evaluation that may contain a substance abuse component.

The way the senior author deals with this conundrum is by having two documents signed. One document used is an informed consent for the entire CCE process, which includes the drug and alcohol issues as part of the broader informed consent. The second is specific to the requirement of 42 CFR Part 2.

A release for substance abuse evaluations that meets these federal guidelines must have components that are similar to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations, namely,

- to whom the information will be released,
- a description of the type of information to be released,
- a statement that the consent may be rescinded at any time, and
- a time limit for the use of the information obtained. (HIPPA, 1996).

Federal guidelines also require that the report have a statement barring re-release of the information. Such a statement would be:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficiently for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. (Prohibition on Redisclosure, 2004)

The resulting procedure meets the federal requirements but does not meet the informed consent requirements that are shared by the mental health professions who do CCEs. Consequently, to meet the professional requirements, evaluators should incorporate into their sepa-

rate informed consent documents as many specifics about the process of the evaluation as are foreseeable including what type of physical testing (if any) will be used.

INVESTIGATION STRATEGY

It goes without saying that any substance abuse investigation must be conducted with both parents to preserve the evaluator's neutrality. In addition to the client interview, other sources of collateral information may prove useful to validate the information provided by the client or offer an objective data source when a client's candor is in question.

These potential sources include the following:

Department of Motor Vehicle records. In addition to looking for accidents and citations or convictions for driving while intoxicated, the evaluator should examine the subject's driving record for speeding, reckless driving, and even convictions that do not seem to have a direct relationship to substances, such as bald tires. Keep in mind that plea agreements where a defendant pleads down to a lesser charge are frequent in traffic courts, especially when a litigant is represented by counsel.

Pharmacy abstracts. Pharmacies maintain a list of all prescriptions their clients have had filled. Interestingly enough, although those addicted to prescription medications will often visit numerous physicians in their quest for new prescriptions, they are less likely to visit more than one pharmacy to have the prescription filled. The evaluator should, during a different part of the evaluation, perhaps even prior to the initiation of the evaluation when litigants are filling out forms, request the name of the pharmacy that the evaluee uses and later require the evaluee to provide a pharmacy abstract. These are routinely provided by pharmacies to their customers for insurance or tax purposes.

Collateral contacts. Most evaluators make it a point to include several collaterals in every evaluation. Including elements of the substance abuse evaluation is a natural extension of this process. It requires that the evaluator obtain collateral information from people with whom the client works and whom the client sees socially. Work collaterals can offer information about work attendance, reliability, and punctuality, all issues that may correlate to substance use. Social collaterals can address the social milieu that surrounds a client and the type of social situations in which the client engages.

Avoid multiple evaluations. One of the reasons the authors suggest that the substance abuse evaluation be performed by the CCE instead of being contracted out to another professional is that so many of the procedures routine to child custody evaluations also can provide useful data for the substance abuse evaluation. Relationship history, employment history, and the parent's recollection about the child developmental history are all rich sources of material about potential parental substance use.

CLIENT INTERVIEWS

It is a maxim in the field that substance abuse is a disease of denial. However, that denial rarely takes the shape of denying substance use altogether but rather minimizing the extent of

this use and/or believing that this pattern of use is the norm. Interview strategies need to take those mechanisms into account. The interviewers must manage their reactions to whatever they are told to make sure that they do not react as though what the client is telling them is out of the ordinary. Questions should be asked as though substance use experiences are fairly common (e.g., "Who has told you that you drink too much?" not "Has anyone ever told you that you drink too much?"). Additionally, evaluators must continue asking questions until they get a good sense for the actual quantity and frequency that substances of abuse are used.

A structured interview approach is recommended to be sure that all potential domains of interest are addressed systematically and, of course, that the same questions are asked of all parties. Each substance should be inquired about individually. Such an interview should include the following components:

ALCOHOL

1. When and what was your last drink?
2. How old were you when you had your first drink?
3. When was the first and when was the last time you were drunk? (It is this writer's experience, which is supported by research [Rogers et al., 2000] that those who insist they have never at least tried alcohol may have hidden social problems, as such experiences are typical. Although there certainly may be excellent reasons for an evaluee never to have used alcohol, reasons for the failure to indulge in such a standard rite of passage should be explored.)
4. What is your favorite brand of alcohol? (Watch for an extensive, highly detailed description of any particular brand that goes beyond what is generated in the ubiquitous alcohol advertising as such behavior suggests an unusual level of knowledge that can only be gained from extensive experience.)
5. How much alcohol does it take to begin to feel its effects and to get drunk? (Over time of alcohol use, tolerance increases: It takes more alcohol to achieve the same result. So it is important to get a sense for how tolerance has changed in the client. Reverse tolerance is the point in addiction at which it takes less of the substance to achieve the same effect of intoxication. Reverse tolerance does not occur until after years of use.)
6. When was the last time you had more than four drinks (or for women, three drinks) in one evening? (It has been my experience that most people who can answer this question easily in the context of a CCE evaluation are problem drinkers.)
7. Have there been any periods when you have avoided using alcohol? When, why, for how long, and why did you start again?
8. Have there been times when you have been drinking and later people said you did things you did not remember? (This is a blackout and indicative of considerable alcohol use over a long period of time.) Have you done things that were uncharacteristic or you later regretted?

MARIJUANA

It is suggested that the interviews regarding illicit drugs begin with marijuana as it is the most socially acceptable and widely used illegal drug. Start by asking about drug use in general and, if the client denies any such use, ask in an incredulous tone, "Not even marijuana?" Again, if the client denies ever having tried any alcohol or drugs, a closer inspection into the client's social skills may be warranted.

1. What was your age when you first used and the circumstances of your first use?
2. When was your last use and reasons for last use?
3. What is the length of time between uses?
4. What is the greatest quantity you possessed at any one time?

5. Have you ever bought more than you needed to sell to pay for your use?
6. Do you use it alone, with friends, or both?
7. Where do you obtain it? How much do you pay and how much do you buy at once? (The evaluator should first determine from an unbiased source what the current price of marijuana is in the area. The cost per ounce decreases as a greater amount is purchased. If the client quotes an amount far below the current street price, suspicions are raised as to how much is being purchased at once. Obviously, larger purchases may signify greater use.)

Identical questions should be asked regarding other illegal drugs. Additional pertinent facts concerning individual drugs include the following:

Cocaine. Inquire as to the method of administration. This will indicate how long the individual has been using the substance: Most users begin with snorting the drug, then, when their nose becomes too irritated, switch to injections or freebasing. Freebasing requires a high skill level and suggests prolonged usage. It is also potentially quite dangerous and can lead to fires. Inquire as to how the user has been coming down from the cocaine "high" as oftentimes users will turn to another drug (sometimes heroin or another barbiturate) or alcohol to ease the crash. Knowing how to do this suggests significant familiarity with the drug.

Crack. A cocaine derivative but even cheaper. It is more popular in certain parts of the country than others and is often associated with violent acting out.

Heroin and barbiturates. Pay particular attention to the price and quantity purchased. Lower paid price suggests well-rehearsed method of acquisition, and purchasing higher quantities is more unusual than with marijuana and cocaine.

Amphetamines. Inquire into the use of Ritalin, Adderall, and other medications used to treat Attention Deficit Hyperactivity Disorder (ADHD) as these are rising in popularity as substances of abuse; also ask about diet pills. All of these are classified as amphetamines.

Methamphetamines. These drugs have the same chemical makeup and will show up on any toxicology screen as amphetamines. However, the use of methamphetamine tends to lead to aggressive and sometimes violent behavior, whereas plain amphetamines will simply cause insomnia, irritability, and loss of appetite. Note that methamphetamine is known by various names, including Ice, Crystalm, and Crystal Meth.

Hallucinogens. Rarer, these include LSD, PCP, and psychedelic mushrooms. LSD has made a comeback in recent years among adolescents, and psychedelic mushrooms are generally found connected to the food industry.

Ecstasy (MDMA). Typically a drug used at raves and parties by adolescents and college-aged young adults.

Homeopathic and over-the-counter remedies. Some homeopathic remedies contain significant amounts of alcohol, as do some cold medicines.

Inhalants. These are most popular with adolescents but should be asked about anyway to ensure thoroughness.

TESTS FOR SUBSTANCE ABUSE

PSYCHOLOGICAL TESTS

There is no psychological test that can reliably screen for substance abuse. The MAC-R Index on the Minnesota Multiphasic Personality Inventory 2 (MMPI-2) detects only addiction potential, not current use. If someone has been addicted in the past but is currently living a sober lifestyle, that person is still likely to test positive for addiction potential as this is more a personality style instead of a measure of current status (Friedman, Lewak, Nichols, & Webb, 2001). The idea behind the Substance Abuse Subtle Screening Inventory (SASSI) (Miller, 1994) is a good one. Essentially, it is an attempt to identify substance abuse through a self-report of symptoms that are associated with substance abuse without directly asking the central question. The Michigan Alcohol Screening Test (MAST) (Selzer, 1971) is considerably less subtle, asking questions more directly. NCS also has an Alcohol Use Inventory (Horn, Wanberg, & Foster, 1987) that it markets. However, it is the senior author's opinion that these instruments add very little to a good interview.

PHYSICAL TESTS

All physical tests attempt to infer the presence or absence of substances of abuse in the subject's blood. However, the ability to make that inference is limited by a variety of factors. The first, as described in Table 1, is that substances of abuse are excreted at rates that vary depending on the specifics of the substance, the quantity ingested, the health status of the subject, and the variability in human physiology. Second, no lab test can rule out use; it can only rule out presence of the substance at the detection levels of the test. This is particularly problematic in urine and saliva testing. The third is that such testing cannot distinguish between recreational and abusive substance use.

Blood test. Expensive and highly intrusive and therefore is rarely, if ever, used in the context of a CCE.

Breath testing. Can only test for alcohol and can only find evidence of alcohol within a few hours of use.

Urine toxicology testing. Can be administered and analyzed by a lab, but less reliable screenings such as those available from companies such as AlcoPro (www.alcopro.com) are inexpensive and easily administered by the clinician or laboratory. Urine testing has the advantage of being able to be easily repeated with the same client over time but also has the disadvantage of being fairly easy to adulterate either before or after the sample is acquired. This is because the testing is not about whether a particular substance is present in the sample, but whether the concentration falls above detection limits. Consequently, if a subject increases the volume of urine, either by increasing the intake of fluids or by using a diuretic (e.g., tea), this may reduce the concentration below detection levels.

Saliva testing. Essentially involves some of the same biological mechanisms as urine and is more easily done in an evaluator's office. It lends itself to repetitive testing over time but is not immune from preacquisition adulteration.

Table 1
Excretion Rate

Alcohol	One drink per hour
One dose amphetamines	1 day
More doses amphetamines	More days
Most barbiturates	48 hours
Long-acting barbiturates (e.g., Phenobarbital)	2 to 3 weeks
Most benzodiazepines	2 to 5 days
Chronic use benzodiazepines	4 to 6 weeks
Cocaine (Benzoylecgonine metabolite)	2 to 5 days
Methadone	2 days
Opiates	1 to 3 days
Quinine (opiate used to cut substance)	5 days
Agonist (opiate)	2 to 3 days
THC (e.g., marijuana) occasional user	3 to 10 days
THC (e.g., marijuana) chronic user	30 days
PCP	2 days
Quaaludes	Less than 1 day

Hair tests. Have become more available recently. They have the potential for determining drug use over the past 3 to 6 months, but there is no way of knowing how much of the substance was used or how often. Thus, an occasional user will have the same test results as one who uses regularly. It is also not possible for a hair test to determine when the last use was or prove the absence of use. People with differing genetic heritage have differing sensitivity to having substances of abuse end up in hair follicles. Persons with dark skin and dark hair are disproportionately sensitive to positive reactions, whereas lighter skinned, fair-haired people are much more insensitive. Therefore, the results of a hair sample are far from always being reliable.

The patch. A relatively new way to test for substance use. Rather than testing for past use, it essentially tests for use as it is being worn. It is similar to a Band-Aid that collects sweat as the person is wearing it. It can be worn for a week and cannot be removed by the wearer without voiding it. The absorbent pad can then be tested and will indicate if the wearer has used substances of abuse while wearing it.

Positive results in urine and saliva screenings should then be confirmed with gas chromatography, especially in forensic rather than clinical applications, because screening procedures have a high false positive rate and the second-level procedures reduce any doubt. A positive hair sample or patch result is usually put through this procedure as a matter of course.

It should also be noted that the effects of substance abuse take place very quickly after use of the substance. Therefore, an occasional user who uses when caring for children may present a far more worrisome picture than the heavy, regular user who is able to abstain when children are present. Additionally, the evaluator needs to keep in mind that parents who abuse substances tend to have children who abuse substances. Therefore, in such systems the evaluator should also determine the level of use or future risk of the children involved in the litigation, as well as address substance abuse–specific treatment recommendations for the children.

PARENTING PLANS FOR SUBSTANCE-ABUSING PARENTS

The specifics of the particular child in question also need to be taken into consideration. Issues such as a child's age, resiliency, and previous relationship with the substance-abusing parent must also be considered in a risk-benefit paradigm. When making recommendations, the evaluator must take all these contingencies into account. Supervised or therapeutic visitation is a good possible interim step. Other measures designed to maintain parental contact, while protecting the child against any potential negative effects of the substance abuse, may include new technologies such as home telephonic breath analysis or video monitoring. It is likely that more technological advances will become available in the near term.

Parenting plans need to be individually tailored to the problems created by the specific pattern of abuse. In parents with a history of substance abuse, the length of time needed to assume a reliable recovery is dependent on many factors, including the type of addiction(s) and the length of the addiction. The evaluator also needs to consider other stressors on the individual that may trigger a relapse.

Probably the most important thing that an evaluator needs to keep in mind is, as Vinson (1997) pointed out, that substance abuse is not a dichotomous variable, and this is even more true in the context of a CCE. The regnant question is not so much if a parent has a substance abuse problem per se, but rather the extent (if any) of the substance use on their parenting of the particular child(ren).

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