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# Substance-abusing Mothers and Fathers' Willingness to Allow their Children to Receive Mental Health Treatment

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## Abstract

The purpose of this study was to examine attitudes of substance-abusing mothers and fathers entering outpatient treatment toward allowing their children to participate in individual- or family-based interventions. Data were collected from a brief anonymous survey completed by adults at intake into a large substance abuse treatment program in western New York. Only one-third of parents reported they would be willing to allow their children to participate in any form of mental health treatment. Results of chi-square analyses revealed that a significantly greater proportion of mothers reported they would allow their children to participate in mental health treatment (41%) compared to fathers (28%). Results of logistic regression analyses revealed even after controlling for child age, mothers were more likely than fathers indicate their willingness to allow their children to receive mental health treatment; however, type of substance abuse (alcohol versus drug abuse) was not associated with parents' willingness to allow their children to receive treatment. Parental reluctance to allow their children to receive individual or family-based treatment is a significant barrier in efforts to intervene with these at-risk children.

### Keywords

alcohol; drug use; children of alcoholics; children of substance abusers; mental health treatment

Despite increased prevention efforts, parental substance abuse is an unremitting problem. In the United States 8.3 million children, approximately 1 in 10, are estimated to live with a parent who met criteria for substance abuse or dependence (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Although many children who reside in these homes many not require mental health services, a number of programs have been developed for children in need (see Johnson, Gryczynski, & Moe, 2011 for a review, see also National Center on Addiction and Substance Abuse at Columbia University, 2005). Children's involvement, however, rests on the willingness of parents to allow their children to take part in these programs.



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As compared to their peers, children of substance abusers (COSAs) are at greater risk for a variety of problems, including internalizing symptoms such as depression and anxiety (Billick, Gotzis, & Burgert, 1999; Hussong et al., 2008) and behavioral problems (Hussong et al., 2007, 2010, Stanger, Dumenci, Kamon, & Burstein, 2004). Compared to families in which neither parent were dependent on alcohol or illicit drugs, the offspring of parents with alcohol or other illicit drug dependence were at least three times more likely to experience externalizing disorders (i.e., ODD, ADHD, CD, and adult antisocial behavior; Marmorstein, Iacono, & McGue, 2009). Furthermore, parental substance abuse is associated with offspring propensity for SUD (Braitman et al., 2009; Chalder, Elgar, & Bennet, 2006; Grella, Lovinger, & Warda, 2013; Hussong, Huang, Serrano, Curran, & Chassin, 2012; Pearson, D'Lima, & Kelley, 2012; Peleg-Oren & Taichman, 2006; Trim, Schuckit, & Smith, 2010; Vermeulen-Smith et al., 2012). For instance, using data from the National Epidemiological Survey on Alcohol and Related Conditions, compared to offspring of non-AUD parents, children with one AUD parent had 2.5-fold increase for AUD (Yoon, Westermeyer, Kuskowski, & Nesheim, 2013).

Although genetic predisposition to substance use is a risk factor for many children (e.g., Kendler et al., 2012), alcohol or drug use divert the parent's energy and resources away from their children's needs and often expose children to parental mental illness, unemployment, high stress and so forth (see Grant et al., 2011). During periods of intense use, the substance-abusing parent may overlook the mental health needs of their children and the non-substance abusing parent may be preoccupied by their partner's addiction (Smyth, Mudar, & Miller, 1999). Related to this point, there are times when living with a substance-abusing parent may be frightening or disappointing and when children in these homes engage in inappropriate emotional and practical caregiving to parents (Arria, Mericle, Meyers, & Winters, 2012; Johnson etal ., 2011; Kelley et al., 2007).

Although female substance users are more likely to have children in their homes (Covington & Bloom, 2006), importantly, Stover, McMahon, and Eason (2011) found 30% of biological fathers entering treatment at a community substance abuse treatment facility had custody of a child under the age of 18. Similarly, Stover, Hall, McMahon, and Easton (2012) found 34% of men referred for a substance abuse assessment because of court involvement were living with at least one of their children. Stover and colleagues, however, did not examine the degree to which parents were involved in the minor care of their children. In an earlier study, Collins et al. asked 331 parents entering treatment at one of 19 substance abuse treatment agencies to indicate the frequency with which they engaged in the following activities with their children: (1) leisure activities away from home, (2) at home working on a project or playing together, (3) helping with reading or homework, and (4) eating meals together. Based on a median split for the sum of the item scores, they found 56.5% of mother and 51.5% of fathers had 'high involvement' with their minor children (Collins, Grella, & Hser, 2003). Although results of the Collins et al. study indicate that mothers and fathers entering treatment for substance abuse had nearly equal levels of high involvement, high involvement was associated with as lower addiction severity, less psychological distress, and better perception of parenting skills.

When parents enter treatment for substance abuse, their children often qualify for services that stem from recognition that their parent is in need of substance abuse treatment and/or other services. Therefore, it is critical to identify factors that may be associated with parents' willingness to allow their children to obtain mental health services. In the present study, we focus on two factors that may be associated with parents' decisions to allow their children to receive services: parent gender and the type of substance abuse.

Although Collins et al. (2003) found similar levels of high involvement among mothers and fathers entering treatment for substance use disorder, Stewart et al. demonstrated that even in homes with another adult present, substance-abusing mothers were more likely to be their children's primary caregiver (Stewart, Gossop, & Trakada, 2007). Furthermore, women generally have more positive attitudes toward seeking mental health treatment than men (e.g., Mackenzie, Scott, Mather, & Sareen, 2008). For these reasons, mothers may be more aware of and more likely to make decisions for their children's mental health care.

In addition to the above factors, parents' willingness to allow their children to receive mental health services may also be related to the specific type of substance abused. Secrecy and stigma pervade the use of illegal drugs (Hogan, 1988) and most drugs (e.g., opiates, cocaine, methamphetamines, and pain medication such as Oxycodone) are obtained illegally. In the case of drug use and or a combination of drug and alcohol use disorders, parents may be concerned that children will report criminal activities to an outsider/person of authority that draw attention of child welfare and in some cases may place the parent at risk for arrests. Illegal drug use is also associated with life stress and neighborhood characteristics, both of which are associated with parental monitoring and less adequate parenting practices (e.g., Pinderhughes & Hurly, 2008; Stewart et al., 2007). Thus, it is possible that parents who enter treatment for drug use (or a combination of alcohol and illegal drug use) may be less likely to allow their children to receive treatment than those who enter treatment for alcohol use.

A common access point to COSAs is when a parent enters substance abuse treatment. These children may benefit from age-appropriate mental health care that helps the child understand and cope with parental substance use and may prevent the onset of life-course persistent problems (see Moffitt, 1993). In the case of children, however, without parental permission they are not able to participate in mental health treatment. Obtaining mental health treatment is not just a concern for these children. Using data from the National Comorbidity Survey-Adolescent Supplement (NCS-A), Merikangas et al. (2011) found that 36.2% of adolescents with any mental disorder received any treatment. Factors associated with parental SUD may result in greater difficulty obtaining mental health care for children. For instance, fear of CPS involvement (Lester, Andreozzi, & Appiah, 2004), family discord/parent crises (Smith, Linnemeyer, Scalise, & Hamilton, 2013), and financial and other practical barriers (Serec, Švab, Kolšek, Švab, Moesgen, & Klein, 2012) may disproportionately affect the ability of these parents to obtain mental health care for their children.

Thus, the purpose of this brief report was to examine whether 1) mothers compared to fathers were more likely to allow their children to receive mental health treatment, and 2) whether type of parental substance use (alcohol versus drug/drug and alcohol abuse) was

associated with parents' willingness to allow their children to receive treatment. We hypothesized that 1) mothers would be more willing than fathers, and 2) alcohol use only would be more willing than those entering treatment for a drug or a combination of drug and alcohol use. Because child age may be associated with a parent's willingness to allow mental health treatment for their children (i.e., Covington, 2008), child age was included as a covariate in the models.

## Method

### Participants and Procedure

Data were examined from a total of 1113 respondents (682 fathers, 431 mothers) who indicated that they were parents and completed a brief survey at intake across a 24-month period (from July, 2010, to June, 2012), at one of three clinics that comprise a large agency located in western New York. Although the agency treats clients for addictions other than substance abuse, the agency advertises and is well known as a substance abuse treatment agency. Of the 1113 intake forms examined in the present study, over 97% of potential clients reported substance abuse as the reason for seeking treatment at the agency. In any given month, slightly more than one-half of clients (52%) are referred from drug courts, nearly one-third are self-referrals (32%), and approximately 16% are referred from Child Protective Services (CPS). Although clients are referred from drug courts and CPS, clients are not mandated to treatment.

To gain a better understanding of whether mothers and fathers who complete substance abuse intake differ (e.g., percent of mothers/fathers residing with their children, percent who reside with a partner), data from all parents entering treatment were examined.

To examine the primary research questions, a subset of all patients entering treatment (n = 992; 612 fathers, 380 mothers), who indicated that their youngest child was 25 years of age or younger (Mean = 8.54 years, SD = 6.87; Median = 7) were asked to complete a brief anonymous form about their willingness to allow their children participate in four mental health treatment options. Of those surveyed, 72.9% of parents (n = 723) had children under 18 only, 14.5% of parents (n = 144) had children between the ages of 18 and 25 only, and 12.6% of parents (n = 125) had both children under 18 and children between 18 and 25 years of age. Parents of 18 to 25 year olds only were included because 34% (n = 88) of these parents resided with their children, the family of origin remains the primary source of attachment for many emerging adults (Arnett, 2000), and the period before children leave home may represent a critical period for family therapy.

### Measures

Respondents completed demographic questions that assessed gender, whether they had children, number of children, children's ages, whether their children resided with them, and whether the parent resided with a significant other. We also asked participants their drug of choice. Because we were interested in whether respondents who were entering substance abuse treatment for alcohol misuse were more likely than those entering treatment for illegal drug use (e.g., crack/cocaine, heroin, opiates, prescription drugs) or illegal drug use and

alcohol use to allow their children to receive mental health treatment, we recoded drug of choice as alcohol only (coded as 0) or drug or drug and alcohol misuse (coded as 1).

**Questions assessing whether parent would allow the child to receive mental health treatment—**A subset of all participants were administrated a 4-item self-report measure that asked whether they would be willing to allow their children to participate in any of four mental health treatment options. Specifically, we asked respondents whether they would be willing to allow their children to participate in (1) *family-based treatment involving the children and the parents provided in the substance abuse treatment program by a family therapist* (Research Question 1); (2) *individual-based treatment for the children conducted in the substance abuse treatment program and provided by a family therapist* (Research Question 2); (3) *family-based treatment involving the children and the parents provided in a setting other than substance abuse treatment program (e.g., community mental health program, community family treatment program) by a family therapist* (Research Question 3); or (4) *individual-based treatment for the children conducted ina setting other than the substance abuse treatment program and provided by a family therapist* (Research Question 4). Responses to the four questions regarding their willingness to allow treatment were highly correlated (intercorrelations between the four questions ranged from .77 and . 87), thus, we recoded the parents' responses to the four questions into a single item such that that "1" indicated at least one treatment would be allowed and "0" indicated none of the four treatments would be allowed.

### Statistical Analyses

All statistical analyses were conducted within the Statistical Package for the Social Sciences program (SPSS Version 21; IBM Corporation, 2012). Tests of differences (*t*-tests) and association ($\chi^2$) were conducted to determine whether relationships existed between parent gender and demographic variables. Further, logistic regression analyses were conducted with either parent gender or alcohol versus combination drug and alcohol use as factors predicting parents' willingness to allow children to participate in treatment with youngest child's age included as a covariate to control for its influence. Predictors were coded as parent gender (mothers = "1", fathers = "0"), and type of substance use (drug or drug and alcohol use = "1", alcohol only = "0"). In examining willingness of the parent to allow children to participate in treatment, the four types of treatments were collapsed into a single dependent variable indicating whether the parent would allow at least one of the four treatments (coded as "1") or none of the treatments (coded as "0"). All analyses were conducted in

## Results

### Differences between Mothers and Fathers Entering Substance Abuse Treatment

Prior to hypothesis testing, we examined all parents (N = 1113; 682 fathers, 431 mothers) who completed the brief survey at intake into the substance abuse treatment program across the 24-month period. See Table 1 for complete descriptive statistics for the all-parents. Specifically, we wanted to examine whether mothers and fathers entering treatment for substance abuse differed in various demographic characteristics such as number of children,

based on a large sample of parents with intentions to enter substance abuse treatment. To examine these variables with respect to differences in mothers and fathers, an independent samples *t*-test and several chi-square analyses were conducted. Of those respondents who were entering treatment for substance abuse and one or more children in the eligible range ($n$ = 1075), mothers had more children on average than fathers, $t(1073) = -3.749$, $p < .001$. Gender was significantly associated with living with at least one child, $\chi^2$ (1) = 21.06, $p < .001$, $\Phi = .140$, such that a higher proportion of mothers reported living with their children compared to fathers. Gender was associated with having a significant other, $\chi^2$ (1) = 5.135, $p = .023$, $\Phi = .090$, that is, a smaller proportion of mothers compared to fathers reported having a significant other. Similarly, parent gender was significantly associated with living with one's significant other, $\chi^2$ (1) = 9.745, $p = .002$, $\Phi = .094$, such that a higher proportion of fathers reported living with their significant others compared to mothers. Gender was significantly associated with type of substance use, $\chi^2$ (1) = 38.44, $p < .001$, $\Phi = .238$. A higher proportion of mothers reported using illegal drugs or the combination of drugs and alcohol compared to fathers, who were more likely to indicate alcohol only.

### Comparison to all parents

Restricting the subsample to parents of children, 25 years of age or younger, reduced the sample to 992 parents (612 fathers and 380 mothers). To examine whether the subgroup of parents with children 25 years of age or younger was similar to the larger group of parents with children of all ages, parent gender differences were examined across the demographic variables. Mothers with children 25 years of age or younger still reported having more children on average than fathers, $t(989) = -3.78$, $p < .001$. Gender remained significantly associated with living with at least one child, $\chi^2$ (1) = 23.61, $p < .001$, $\Phi = .156$, such that a higher proportion of mothers reported living with their children compared to fathers. Although, gender was not significantly associated with having a significant other, $\chi^2$ (1) = 3.61, $p = .057$, $\Phi = .090$, the same trend, in which a smaller proportion of mothers compared to fathers reported having a significant other, was found. Similarly, gender was still significantly associated with living with one's significant other, $\chi^2$ (1) = 8.37, $p = .004$, $\Phi = .092$, such that a higher proportion of fathers reported living with their significant other compared to mothers. Gender remained significantly associated with type of substance use, $\chi^2$ (1) = 28.78, $p < .001$, $\Phi = .219$. A higher proportion of mothers reported using drugs or the combination of drugs and alcohol compared to fathers, who were more likely to indicate seeking treatment for alcohol only.

## Willingness of Parents to Allow their Children to Receive Mental Health Treatment

**Parent Gender—**Analysis of data across respondents who had at least one child of the age 25 or under and who completed the four research questions (n = 273) revealed parent gender was a significant predictor of willingness to allow children to receive mental health treatment. The odds that mothers will allow their child to receive treatment were 2.89 times the odds for fathers to do the same, *B(SE)* = 1.063(.368), *Wald's test* = 8.349, *OR* = 2.894, *95% CI* [1.407, 5.949]. Child's age was a non-significant predictor, *B(SE)* = .003(.002), *Wald's test* = 1.967, *OR*= 1.003, $p = .161$.

**Effect of type of substance abuse type—**In contrast to what was predicted, that parents with alcohol use problems would be more likely to allow child treatment, type of substance use (i.e., alcohol only versus drug/drug and alcohol combination) did not significantly predict parents' willingness to allow their children to receive mental health treatment, *B(SE)*= −.506(.512), *Wald's test* = .976, *OR* = .603, *95% CI* [.221, 1.644].

## Discussion

When a parent enters substance abuse treatment, this may provide a gateway for other family members to enter treatment. Although this circumstance may provide a critical opportunity, without the parents' permission, their children may not receive mental health services. The purpose of the present study was to examine whether parent gender and type of substance use for which the parent was entering treatment would be related to parents' willingness to allow their children to receive different forms of mental health treatment.

Mothers entering substance abuse treatment were more likely than fathers entering treatment to report that they would allow their children to participate in mental health treatment options (i.e., family-based treatment or individual treatment provided by a family therapist at the outpatient substance abuse treatment program or in another setting). These findings may reflect that parents often have gendered roles in their children's lives with mothers being more involved and responsible for childcare (e.g., Biehle & Mickelson, 2012; Collins et al., 2008). In fact, substance-abusing mothers are often their children's primary caregivers (Stewart et al., 2007). For this reason, mothers may have greater awareness of children's mental health needs. In addition, women generally have more positive attitudes toward seeking mental health treatment than men (e.g., Mackenzie et al., 2008) and may serve as a contact for their children's mental health needs. At the same time, the finding that mothers were more willing to allow their children into treatment is a paradox as mothers are more likely to believe that their participation in substance abuse treatment may affect their custody (Collins et al., 2009).

We also hypothesized that parents entering treatment for alcohol abuse would be more likely to allow their children to receive treatment than parents' entering treatment for drug abuse. Hogan (1988) argued that compared to alcohol misuse, the lifestyle associated with 'hard drug use' (e.g., primarily heroin, methadone, and cocaine) is associated with greater stigma, secrecy, and illegal activities. For these reasons we hypothesized that parents who misused drugs would be less willing. In contrast, alcohol is legal, and the most commonly misused substance. It is important to recognize that parents in the drug use group used any number of substances (e.g., heroin, cocaine, oxycontin, marijuana) alone or in combination with or without alcohol. It is possible that some types of drugs were associated with fewer stigmas than are typically associated with hard drugs which may have led to the lack of support for this hypothesis.

Although these results suggest that substance-abusing fathers may be more reluctant than substance-abusing mothers to agree to their children receiving mental health treatment, it is important to recognize that the majority of mothers and fathers were unwilling to allow their children to receive any form of mental health treatment. Approximately 59% of mothers

who were entering an outpatient substance abuse treatment for substance abuse were unwilling to allow their children to receive any of the four forms of mental health treatment. The percentage of fathers who were unwilling to allow their children to receive treatment was 72%. These results suggest that the majority of mothers and fathers entering treatment for substance abuse are not willing to allow their children to receive mental health treatment. These findings are similar to those of Redelinghuys and Dar (2008) who found that 41% of parents in inpatient treatment for substance abuse had current concerns about their children developing a substance abuse problem or were concerned that their children would develop a substance abuse problem in the future. Despite these concerns, nearly half of parents surveyed by Redelinghuys and Dar (2008) said they would not contact help for their children. They contend that substance-abusing parents may be reluctant to obtain support for their children due to fear of social services involvement, stigma or the lack of awareness of the range of help available.

In addition, in our experience, some parents are reluctant to admit that their children are aware of their own or their partners' alcohol or drug abuse despite, in some cases, family problems due to substance abuse. By refusing to allow their children to participate in mental health treatment, many parents may attempt to protect their children from becoming aware of the parent's addiction. Another reason why the majority of parents reported that they were not willing to allow their children to receive treatment, may be that substance abuse is often comorbid with other psychiatry disorders and social problems (Collins et al., 2003; Covington & Bloom, 2006; Hasin & Kilcoyne, 2012). Thus, problems other than substance abuse may impact parents' decisions to enter treatment. In fact, Nair et al. (1997) found multiple demographic and psychosocial risks predicted whether children with substance-abusing mothers had disrupted maternal care.

The present study has several notable limitations. We elected to survey respondents about their willingness to allow their children to take part in treatment during intake to a large outpatient substance abuse treatment program because we wanted the broadest sample possible. Although waiting until respondents engage in treatment might increase parent willingness their children to receive mental health services, the vast majority of substance abusers who need treatment do not receive it. Among those who engage in substance abuse services, the largest group engages in self-help group such as AA or NA (SAMSHA, 2011). Although surveying parents who take part in less formal treatment options is ideal, AA and NA programs are often reluctant to allow access to their members.

Furthermore, we asked parents whether they would allow their children to take part in various types of mental receive services; however, we did assess parents' perception of their children's mental health need. Related to this issue, previous research that has shown that parents often do not follow through with developmental testing for their children suspected of having developmental delays (King et al., 2010) and many parents do not follow through with children's mental health referrals due to personal crises and family discord (Smith et al., 2013). Thus, it is likely that some parents who indicate they would allow their children to receive mental health services would not actually follow through with treatment. In addition, many parents with SUD, especially those with severe addiction, may have barriers to obtaining care for their children such as transportation and insurance. Related to these

barriers, SUD is often associated with a host of psychiatric disorders (e.g., depression, anxiety, antisocial behavior, posttraumatic stress disorder), all of which may complicate the parent's ability to obtain treatment for themselves and their children. Unfortunately, we did not ask for information on psychiatric disorders or whether parents were their children's primary caregiver. Another limitation of the present survey is that we were unable to query parents regarding specific reasons for their responses. At present there are few methods of meeting the mental health needs of children whose parents are not identified by the criminal justice or child protective systems. Clearly, creative ways of meeting the needs of these children is imperative.

In conclusion, mothers entering substance abuse treatment were more likely than fathers entering substance abuse treatment to indicate that they would allow their children to receive mental health services; however, the majority of mothers and fathers entering outpatient treatment for substance abuse were reluctant to allow their children to receive individual or family mental health treatment either at the substance abuse agency or another mental health setting. Type of substance use (i.e., alcohol versus drug use) was not associated with parents' willingness to allow their children to receive treatment. Our results suggest that as compared to fathers, mothers entering substance abuse treatment may be more aware of their children's mental health needs and more willing to allow their children to receive services. We also found numerous differences between mothers and fathers suggesting the importance of treatment programs that are tailored to gender (e.g., see Covington, 2008 for a review). Our results also indicate that ways of helping meet the mental health needs of these children while preserving the family structure and encouraging parent treatment are of critical importance.

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**Table 1**

Descriptive Statistics of All Parents' Demographics

| | | Larger Study Sample | | | |
|---|---|---|---|---|---|
| | | Mothers | | Fathers | |
| | | *n* | *M(SD) or Proportion* | *n* | *M(SD) or Proportion* |
| **Number of children** | | 415 | 2.31 (1.19) | 660 | 2.03 (1.22) |
| **Living with at least one child** | | 218 | 0.52 | 252 | 0.38 |
| **Having a significant other** | | 188 | 0.78 | 336 | 0.85 |
| **Living with a significant other** | | 150 | 0.35 | 298 | 0.45 |
| **Substance Use**[1] | | 150 | 0.55 | 126 | 0.31 |
| **Total** | 1113 | 431 | 0.39 | 682 | 0.61 |

M=Mean; SD=Standard Deviation

[1]Substance Use=Drug or drug and alcohol use

**Table 2**

Descriptive Statistics of Subsample's Demographics

| | | Parents with Children 25 and Younger | | | |
|---|---|---|---|---|---|
| | | Mothers | | Fathers | |
| | | ***n*** | ***M(SD) or Proportion*** | ***n*** | ***M(SD) or Proportion*** |
| **Number of children** | | 380 | 2.34 (1.21) | 611 | 2.04 (1.24) |
| **Living with at least one child** | | 211 | 0.57 | 243 | 0.41 |
| **Having a significant other** | | 169 | 0.79 | 301 | 0.86 |
| **Living with a significant other** | | 132 | 0.35 | 267 | 0.44 |
| **Substance Use**[1] | | 135 | 0.56 | 120 | 0.34 |
| **Total** | 992 | 380 | 0.38 | 612 | 0.62 |

M=Mean; SD=Standard Deviation

[1]Substance Use=Drug or drug and alcohol use