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Integration of Parenting Skills Education and Interventions in Addiction Treatment

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Abstract

Objectives—Children of parents with substance use disorders are at risk for a variety of adverse outcomes, and maladaptive parenting behaviors appear to be an important mediator of this risk. Although numerous research studies have highlighted the promise of parenting interventions in modifying parenting behavior, very little is known about the integration of parenting skills education and interventions into addiction treatment programs.

Methods—In this study, a convenience sample of 125 addiction treatment programs in the U.S. was drawn. A key staff member was interviewed to gather basic information about the extent and nature of parenting skills education interventions offered at their program. In addition, respondents were asked to rate the importance of parenting skills relative to other addiction treatment priorities.

Results—Descriptive analyses revealed 43% reported some form of parenting classes, but few used a structured curriculum.

Conclusions—Given the known beneficial influence of effective parenting practices on reducing adverse childhood outcomes, it is surprising that relatively few substance abuse treatment programs have adopted structured parenting skills interventions as part of their standard service offerings. More research is warranted on the extent to which parenting skills interventions are integrated into the continuum of services available to parents with a substance use disorder.

Keywords

Drug treatment; parenting; parenting interventions; parenting skills education; services; substance use disorders

In 2009, approximately four million adults ages 18 and older received addiction treatment in the US (Substance Abuse and Mental Health Services Administration, 2010a). Although we

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Conflicts of Interest
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do not know how many of these adults are parents or are raising children, based on general population data, we know that approximately 38% of males and 45% of females live with a child under the age of 18 (Halle, 2002), and likely many more might be responsible for at least one child that does not live with them in the same household. Studies of adults in substance abuse treatment that have queried parenting status generally find that anywhere from 19% to 53% live with children under 18 prior to entering treatment. These estimates vary greatly by gender and type of treatment entered (Gerstein et al., 1994; Grella et al., 2003; McMahon et al., 2005; Wechsberg et al., 1998).

Children of parents with substance use disorders (SUD) have increased risk for a variety of adverse consequences including early conduct problems (Kuperman and Schlosser, 1999), lower academic achievement, and adolescent and young adult drug involvement (Walden et al., 2007; Clark and Winters, 2002). Maladaptive parenting behaviors appear to be an important mediator of the intergenerational transmission of SUD risk and other psychiatric symptoms (Johnson et al., 2001) and parental SUD may play a critical role in this. For example, research has demonstrated that parental SUD is associated with impaired parent-infant interactions (Burns et al., 1997; Eiden, 2001; Eiden & Leonard, 2000; Mayes et al., 1997; Tronick et al., 2005) harsh parenting and child abuse potential (Hien et al., 2010; Kim et al., 2010), child neglect (Dunn et al., 2002; Chaffin et al., 1996), decreased levels of monitoring and supervision (Chassin et al., 1993), parent-child conflict (El-Sheikh and Flanagan, 2001), perception of less parental warmth (Barnow et al., 2002), inconsistent discipline (Dishion et al., 1999), as well as destructive marital conflict (Keller et al., 2008). Moreover, external factors such as financial stressors due to unemployment might also influence the quality of parenting, and be exacerbated in a family where one or both parents has an SUD.

In contrast, several aspects of parenting behavior have been shown to reduce or mitigate the risk for adolescent substance involvement, including adequate levels of parental monitoring and supervision, parent disapproval of underage drinking, high quality parent-child interactions, low family conflict, and general communication. These parental influences have been studied in relation to adolescent substance use involvement using both general population samples (Brook et al., 2009; Cohen et al., 1994; Latendresse et al., 2008; Tobler and Komro, 2010) and as described above, in families affected by parental SUD.

Research studies have demonstrated that parenting skills among substance-abusing parents can be improved by using standardized methods. For example, in their study of 170 women in residential addiction treatment who were participating in the Nurturing Program for Parents of Children From Birth to Five Years Old, Camp and Finkelstein (1997) found that women who received a specialized parenting component during treatment made improvements in self-esteem and showed significant increases in parenting knowledge and attitudes. Similarly positive results have been demonstrated among mothers in substance abuse treatment participating in the Mothers and Toddlers Program (MTP; Suchman et al., 2010) as well as the Relational Psychotherapy Mothers' Group (RPMG; Luthar and Suchman, 2000), a developmentally informed, supportive psychotherapy group designed for mothers with heroin addiction who have children up to 16 years of age. Further, preliminary results examining the effectiveness of the Partners in Parenting (PIP; Bartholomew et al., 2000) curriculum indicate that substance-abusing mothers who participated in PIP described better attitudes toward parenting strategies as well as reduced family conflict (Knight et al., 2007). Moreover, it turns out that clients in addiction treatment are interested in receiving such services when they are offered. McMahon et al. (2007) found that 84% of fathers in a drug treatment sample stated that they would be interested in counseling to help them become more effective parents.

In addition to these interventions developed specifically for substance-abusing parents, a variety of other evidence-based parent training curricula are currently available to reduce children's aggression and behavior problems and increase social competence (e.g., the Incredible Years, see Webster-Stratton et al., 2010 for description) as well as to reduce risks and enhance protection against early substance use initiation in children and early adolescents (e.g., Preparing for the Drug Free Years, see Haggerty et al., 1999). These sorts of interventions may also be useful for increasing parental competence and decreasing the risk for problems among offspring of substance abusing parents, although much more research is needed to examine how these interventions may need to be modified for parents with an SUD (Bromberg et al., 2010; Suchman et al., 2004).

Unfortunately, however, we know very little about the extent to which parenting skills are addressed during the course of addiction treatment for adults who are caregivers of children, and if so, what kinds of curricula are offered. Most of our knowledge about services provided in addiction treatment facilities comes from the National Survey of Substance Abuse Treatment Services (N-SSATS), which annually collects information from all facilities in the US; both public and private that provide addiction treatment. The survey includes questions on whether facilities offer childcare or residential beds for clients' children, whether or not family counseling is offered, and whether services are provided to pregnant or post-partum women. However, it does not specifically query whether parent training or parenting skills services are offered, nor does it ask respondents to estimate the number of clients served by their facility that are parents or actively raising children.

To begin to address gaps in our knowledge regarding whether parenting skills education or interventions are integrated into adult addiction treatment programs, we surveyed a convenience sample of addiction treatment facilities in the US. Specifically, we wanted to learn more about the types of parenting skills development services offered at each facility, to assess the relative priority treatment programs place on parenting skills, and to explore program characteristics associated with the delivery of specialized parenting services.

Methods

Sampling and Recruitment

The Substance Abuse and Mental Health Services Administration's Substance Abuse Treatment Facility Locator, a product of the N-SSATS survey, served as the initial sampling frame for this project. It provides a listing of all private and public facilities that are licensed, certified, or otherwise approved for inclusion by their State addiction treatment authority as well as by treatment facilities administered by other federal agencies. Four addiction treatment programs from each of the 50 states in the US were randomly selected by choosing four random numbers (n, x, y, and z) for each state from 1 to 50 and choosing the n^{th}, x^{th}, y^{th}, and z^{th} program according to those numbers. The 200 selected programs were mailed a letter that described the purpose of the study and informed them that they would receive a telephone call regarding potential participation. Approximately two weeks later, a research assistant called the facility and requested to speak to someone who could answer questions about the program and the services provided. We were unable to achieve contact with 8 sites (5 were closed; 1 telephone number was no longer in service, and 2 telephone numbers failed to reach anyone, even after 10 telephone attempts).

Of the 192 programs that were successfully contacted, 11 were deemed ineligible to participate because they did not provide any addiction treatment (n=3), provided only detoxification or peer-led services (n=3), provided services to adolescents only (n=3), had no one available who would be qualified to complete the survey (n=1), or were part of a larger program that was already participating in the survey (n=1). A total of 38 programs

that were contacted refused to participate in the survey. No reason for refusal was given in 30 cases, however, 5 indicated that they were not interested, and 3 reported that they were too busy or did not have the time to participate. Consent to participate by an appropriate person could not be obtained for another 18 programs, despite attempting at least 10 telephone calls. In total, 125 programs participated in the survey, representing 62.5% of the programs sampled. Consent was obtained verbally because the interview was completed on the telephone and the protocol was approved by the Treatment Research Institute Institutional Review Board.

Data Collection Procedures

Telephone interviews were conducted and lasted between ten and twenty minutes. Responses were recorded on a paper survey without any identifying information and entered into a computer spreadsheet for analysis.

Measures

Facility characteristics—Each respondent was asked to provide some basic information about his or her program, such as for profit/not for profit status, modality (inpatient/residential, outpatient), and whether the program treated women, men, or both sexes. Respondents were also asked to estimate the percentage of clients served at their facility who have children under the age of 18.

Parenting skills services—Respondents were asked about how parenting issues were addressed during individual sessions with counselors in an open-ended fashion as well as how often parenting issues were addressed in group sessions or group therapy (available response options were “regular basis”, “informal basis”, or “hardly at all”).

The survey items regarding the provision of education and services provided to clients who are parents were developed for this study *de novo* because of the lack of inclusion of such items in larger national surveys. The first three authors reviewed the open-ended responses and created nine codes to categorize how parenting issues were addressed during individual sessions. Although it is *possible* that parenting issues could be addressed in a variety of different ways within a single program, all responses could be classified with a single code (as such response frequencies total 100%). Questions were asked regarding whether the program offered formal classes on parenting skills, and if so, the educational degree of the person who led these classes. In an open-ended way, respondents were asked to describe the issues that were covered in classes and the types of materials that were given to parents with children, if any. Based on review of responses provided, six codes were created to classify the issues covered in classes. Again, although it is *possible* that multiple issues could be covered in classes, all responses could be classified with a single code. Nine codes were created to classify open-ended responses to the types of materials given to parents and children, including a code to indicate whether a combination of different types of materials were given. Programs were coded as providing specialized parenting services if parenting issues were addressed regularly in group sessions or formal classes; this variable was then used as a dependent variable in the analyses.

Program emphasis—One aim of the research was to better understand the relative importance of various parenting and relationship skills compared to other treatment priorities. Therefore, respondents were asked “Can you tell me to what extent your program puts an emphasis on the following issues?”, then given a list of items. Parenting skills and teaching patient’s children about the meaning of addiction and its effects on the family were included in the list. The other issues on the list were abstinence, staying drug-free, and

finding employment after treatment. The degree of emphasis of each item was measured on a 4-point Likert scale (“very great”, “great”, “somewhat”, “not at all”).

Data Analysis

Descriptive statistics were used to generate frequency distributions of these and other categorical items. To gauge the relative priority of parenting topics compared to other addiction treatment issues, items assessing the importance of various issues were sorted by their mean level of importance. Additionally, non-parametric, Wilcoxon signed-rank tests were conducted to assess the equality of the distribution of responses to the Abstinence/ Staying Drug-Free item to the distribution of responses to items pertaining to parenting. In addition to examining how many programs offered different types of parenting services, we also conducted logistic regression analyses in order to determine whether various program characteristics (e.g., for profit status, the provision of both inpatient and outpatient services, serving female clients only, and having 50% or more of their clients as parents) influenced the likelihood of delivering specialized parenting services. Characteristics that were associated with providing parenting services at the bivariate level were included in a multivariate model to assess the strength of the association after holding constant all other characteristics. All analyses were conducted in Stata (StataCorp, 2007).

Results

Respondent and Facility Characteristics

Most respondents had been employed at their program for two years or more, with 45% having been employed for six or more years (Table 1). Approximately three-quarters (78%) of the programs were not for profit. With respect to treatment modalities offered, 29% provided inpatient or residential services, while 28% provided outpatient services, and 43% provided both. Most programs (82%) provided services to both men and women, however 15% reported providing services to women only and 2% reported providing services to men only. Estimates of the proportion of clients serviced who had children under the age of 18 ranged greatly (from 10% to 100%), however 50% reported that at least half of their clients had children under the age of 18.

Parenting Skills Education and Interventions

Table 2 lists the frequency of responses to questions related to various parenting education and interventions. Many programs indicated that parenting was not addressed (11%), was addressed on an “as needed” basis (28%), or when it was an explicit part of the treatment plan (6%). Some programs (13%) addressed parenting through providing referrals to other providers in their program or outside agencies or addressed basic or general skills (9%). Few programs (6%) addressed specific skills in individual sessions, and even fewer (3%) used a specific curriculum. With respect to how often parenting issues were addressed in group, the majority of respondents (60%) indicated that these issues were addressed on an informal basis or hardly at all. Similarly, less than half of the respondents (43%) indicated that formal classes on parenting were available in their program. In the programs that provided formal classes, most (65%) were led by Master’s level staff. However, only 19% of the programs that provided formal classes reported using a specific curriculum. The majority of programs provided some sort of print or online materials related to parenting to their clients; however, 22% of programs did not provide any materials. In summary, analyses revealed that 52.8% of programs offered at least some form of specified parenting skills education or intervention (summing codes for “as-needed”, as part of the treatment plan, basic/general skills addressed, specific skills addressed, or a specified curriculum used).

Relative Priority of Parenting Issues

Table 3 shows how respondents rated parenting issues compared to other addiction treatment issues. Clearly, abstinence and staying drug-free ranked as the highest priority with almost all (94%) of respondents indicating a “very great” or “great” level of importance. In contrast, parenting skills and teaching children about addiction ranked significantly lower than abstinence and staying drug free. Over half (59%) of the respondents indicated that a “very great” or “great” level of importance was placed on the issue of parenting skills, and only 26% reported that they placed a “very great” or “great” level of importance on the issue of teaching children about addiction and its effects.

Correlates of Providing Parenting Education or Interventions

As mentioned earlier, programs were coded for the presence/absence of providing parenting education. As Table 4 shows, certain program characteristics were associated with an increased likelihood of providing such specialized services, including programs serving only female clients (AOR=5.78, p=.028), and programs where greater than 50% of their patients had children under the age of 18 (AOR=2.46, p=.035).

Discussion

This study, which surveyed a convenience sample of addiction treatment programs, found that 59% placed either a “very great” or “great” emphasis on developing parenting skills of their clients, 43% offered some type of parenting classes, but few incorporated a standardized curriculum. Moreover, parenting skills was not ranked as a high priority component relative to other clinical goals and issues addressed in addiction treatment. To our knowledge, ours is one of the first studies to systematically document the extent to which parenting skills education or interventions is an integral part of services provided by addiction treatment programs.

Recent data gathered as part of the National Household Survey on Drug Use and Health (NSDUH) between 2002 and 2007 show that over 8.3 million children under 18 years of age (11.9%) lived with at least one parent who met dependence or abuse criteria for an alcohol or drug use disorder during the past year (Substance Abuse and Mental Health Services Administration, 2009). In addition to its worrisome prevalence, parental SUD also confers enormous risk to children living in these families. Given the known beneficial influence of effective parenting practices on reducing adolescent drug use risk, it is surprising how few treatment programs have adopted parenting skills interventions as part of their standard service offerings. It is possible that some programs might address parenting in the context of addressing more general family management issues. There might be opportunities to discuss parenting skills when discussing how to rebuild relationships between patients and their children and significant others.

There is growing interest in extending addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (Kelly and White, 2011; Arria and McLellan, 2012) and nesting such sustained support services within Recovery-Oriented Systems of Care (ROSC; White, 2009). These approaches, which place great emphasis on enhancing the health and functioning of substance-affected families and breaking the intergenerational transmission of SUD, will increase the calls for greater parenting support services as an integral element of addiction treatment and peer-based recovery support services.

Some limitations should be noted. First, the sample was not a representative sample of addiction treatment programs in the US and therefore estimates from this study need to be replicated by other studies using a more systematic sampling strategy. For example, because

of time limitations, we did not collect extensive data on the size of the treatment program, urbanicity of the clientele, or other detailed facility characteristics. However, findings from the 2010 N-SSATS survey indicate that approximately 70% of facilities that provide substance abuse services in the US operate as not for profit or government (federal/state/local/tribal) entities and that 80% provide outpatient services, suggesting that our sample is roughly comparable on these dimensions (Substance Abuse and Mental Health Services Administration, 2010c). Perhaps one implication of the findings should be an increased level of attention to this issue in ongoing surveys that assess characteristics of the addiction treatment system in the US. Finally, no attempt was made to confirm the reports of the respondent; namely, no administrative data was gathered to assess the veracity of the responses regarding the proportion of clients with children under 18 and the presence or absence of parenting skills education or interventions as part of services offered by the treatment program. Because there is a greater chance of over- rather than under-estimating the extent of parent-focused services that are available to patients, it is probably safe to say that the proportion of treatment programs who reported providing at least some services directed at parents might be inflated.

Because of these limitations, the study findings should be viewed as preliminary and are in need of confirmation by other studies that use more systematic sampling methods and more comprehensive assessments, but provide a first step in acquiring new information about this critical topic. Future research should utilize larger samples and investigate the types of parenting skills education or interventions available within treatment programs in more detail. Moreover, more work should be conducted to evaluate the long-term outcomes of providing such services within the context of addiction treatment. Although most recent findings from the NSDUH still indicate that far fewer individuals who could benefit from treatment actually receive it [approximately 20.9 million persons in the U.S. met DSM-IV diagnostic criteria for an illicit drug or alcohol use problem but did not receive treatment at an addiction facility in the past year; (Substance Abuse and Mental Health Services Administration, 2010b)], addiction treatment represents a promising opportunity to intervene with substance–affected parents around parenting issues.

It is also true that many individuals with substance-related problems might seek care outside of specialty care services or attend self-help groups only. This fact, coupled with recent financial challenges confronting addiction treatment programs to do more with less resources, (which might include a reluctance to address family issues comprehensively) suggests the need to identify possible alternatives to providing parenting interventions as part of formal addiction treatment. For example, it might be beneficial for addiction treatment programs to form relationships with community-based parenting support groups as well as new recovery community support institutions (e.g., grassroots recovery community organizations, recovery community centers). To answer questions about feasibility, implementation, and effectiveness, a new line of research should be formed around the integration of parenting interventions into the continuum of services and resources available to parents with active substance use problems and those in recovery. Until then, based on the available evidence showing the importance of parenting on adolescent behavior, improving parenting skills of clients with children living at home should be at least considered as an essential component of standard addiction treatment programs and perhaps in the future be implemented as an integral and routine element of comprehensive planning for recovery oriented systems of care.

Conclusions

Children of parents with substance use disorders are at risk for a variety of adverse outcomes, and maladaptive parenting behaviors appear to be an important mediator of this

risk. Although numerous research studies have highlighted the promise of parenting interventions in modifying parenting behavior, very little is known about the integration of parenting skills interventions into addiction treatment programs. To our knowledge, ours is one of the first studies to systematically document the extent to which parenting skills education or interventions are offered as part of services provided by addiction treatment programs, and we found that less than half offered some type of parenting classes and few incorporated a standardized curriculum. Although an important first step, additional research is needed to better understand the relative emphasis on improving parenting skills and the extent to which parenting education or interventions are integrated into the continuum of services for SUD clients with children.

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Table 1

Respondent and Treatment Program Characteristics (*N*=125)

Variables	*n*	%
Respondent Tenure at the Program		
1 Year or Less	11	8.8
2–5 Years	58	46.4
6 or More Years	56	44.8
Organizational Status		
For Profit	26	20.8
Not For Profit	98	78.4
Both	1	0.8
Program Type		
Inpatient/Residential	36	28.8
Outpatient	35	28.0
Both	54	43.2
Clientele		
Women Only	19	15.3
Men Only	3	2.4
Both	102	82.3
Estimated Percent of Clients with Children <18		
0–24	6	4.8
25–49	39	31.2
50–74	40	32.0
75 or more	23	18.4
Don’t Know	17	13.6

Table 2

Specialized Programming on Parenting Skills Education in Treatment (*N*=125)

Variables	*n*	%
Parenting Addressed in Individual Sessions		
Not Addressed in Individual Sessions/Only Addressed on Other Components of Treatment	14	11.2
Addressed on an “As Needed” Basis or “Individualized” to Client’s Needs	35	28.0
Addressed as Part of the Treatment Plan	8	6.4
Addressed through Referrals (to Outside Agencies or to Programs within the Agency)	16	12.8
Basic/General Skills Addressed	11	8.8
Specific Skills Addressed	8	6.4
Specified Curriculum Used	4	3.2
Other	8	6.4
Not Specified/Don’t Know/Missing	21	16.8
Frequency Parenting Issues are Addressed in Group (*N*=122)		
On a Regular Basis	49	40.2
On an Informal Basis	48	39.3
Hardly at All	25	20.5
Formal Classes on Parenting		
Currently Available (*N*=121)	52	43.0
Educator Skill Level (*N*=52)*		
PhD	1	1.9
Masters	34	65.4
Bachelors	10	19.2
Associates or Technical	4	7.7
Don’t Know	3	5.8
Issues Addressed (*N*=52)*		
Specific Curriculum Used	10	19.2
Specific Skills Addressed	22	42.3
Basic Parenting Skills	14	26.9
Other	1	1.9
Not Specified/Don’t Know/Missing	5	9.6
Materials Offered to Parents (*N*=116)		
None	26	22.4
Print Materials (Specified)	12	10.3
Print Materials (Unspecified)	46	39.7
Online Materials	6	5.2
Combinations of Different Types of Materials	10	8.6
Other	4	3.5
Not Specified/Don’t Know/Missing	12	10.3

*Asked only of facilities that offer formal classes on parenting.

Table 3

Extent of Program Emphasis Various Addiction Issues (N=125)

Variables	Very Great		Great		Somewhat		Not at all		Summary Statistics	
	n	%	*n*	%	*n*	%	*n*	%	*M*	*SD*
Abstinence/Staying Drug-Free	97	77.6	21	16.8	7	5.6	0	0.0	3.7	0.6
Understanding/Working the 12–Steps	80	64.0	28	22.4	16	12.8	1	0.8	3.5	0.7
Re-building Relationships with Children	66	52.8	43	34.4	16	12.8	0	0.0	3.4	0.7
Re-building Relationships with Spouses	50	40.0	53	42.4	19	15.2	3	2.4	3.2	0.8
Finding Employment After Treatment	37	29.6	53	42.4	29	23.2	6	4.8	3.0	0.9
Parenting Skills ***	36	28.8	38	30.4	44	35.2	7	5.6	2.8	0.9
Teaching Children about Addiction and its Effects ***	15	12.0	18	14.4	44	35.2	48	38.4	2.0	1.0

NOTE: Topics are sorted by average level of emphasis.

Non-parametric, Wilcoxon signed-rank tests were conducted to assess the equality of the distribution of responses to the Parenting Skills item and to the distribution of responses to the Abstinence/Staying Drug-Free item as well as to assess the equality of the distribution of responses to the Teaching Children about Addiction and its Effects item and to the distribution of responses to the Abstinence/Staying Drug-Free item.

*** p<0.001

Table 4

Predictors of Specialized Parenting Programming (*N*=122)[a]

Program Characteristics	Bivariate Predictors[b]			Multivariate Predictors		
	OR	CI	*p*	AOR	CI	*p*
For Profit Status	0.62	[0.26–1.50]	0.290			
Provision of Outpatient and InpatientServices	1.68	[0.80–3.53]	0.167			
Female Clients Only	8.17	[1.79–37.21]	0.007	5.78	[1.21–27.54]	0.028
50% or More Clients With Children	3.19	[1.42–7.17]	0.005	2.46	[1.06–5.71]	0.035

[a]Programs were coded as providing specialized parenting services if parenting issues are addressed in regularly in group sessions or formal classes (3 respondents failed to provide information on how often parenting issues were addressed in group).

[b]Bivariate analyses were conducted to assess the strength of each predictor individually; those significant at $p<0.10$ were entered into a simultaneous multiple logistic regression analysis to assess their relative strength.

AOR=Adjusted Odds Ratio