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Substance abuse treatment engagement among mothers: Perceptions of the parenting role and agency-related motivators and inhibitors

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Abstract

This qualitative study explored 1) the parenting role as a motivator and inhibitor to engaging in substance abuse treatment and 2) parenting-related, agency-imposed barriers and facilitators to substance abuse treatment engagement. Nine focus groups (n=45) were conducted with current and former male and female recipients of treatment services in one south eastern state. Using inductive thematic analysis, transcripts were analyzed to identify key themes related to parenting. Females were overrepresented in our groups and were more vocal than males regarding issues of parenting as these related to treatment. Among mothers, motivations for treatment related to parenting included involvement with child protective services and the desire to be a better parent. Inhibitors for treatment included anxiety over separation from child, debilitating guilt, and parenting demands. Facilitators for participation included mother-child residential programs, services for children, concrete support, and advocacy and emotional support. Barriers for participation included decreased access to the child and barriers specific to mother-child residential programs. To enhance treatment engagement among parents, providers can address agency-level barriers and draw upon the parenting role as intrinsic motivation for change. Policies and services are needed that promote flexibility, choice, and support parents to engage in treatment services.

Keywords

substance use disorder; alcohol and drug treatment; residential treatment; child well-being; child protective services; qualitative research

1. Introduction¹

Approximately 7.5 million children younger than 18—over 10% of all children in the United States—live with a parent who had an alcohol use disorder in the prior year (Center for Behavioral Health Statistics and Quality, 2012). These numbers may increase when one considers those children living with parents who either abuse alcohol or illegal drugs

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¹CPS: Child protective services

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). An enduring body of research has revealed associations between parental substance abuse and negative outcomes for families on dimensions including parenting practices (Conners-Burrow, McKelvey, Pemberton, Lagory, Mesman, & Whiteside-Mansell, 2013; Das Eiden, Peterson, & Coleman, 1999; Fals-Stewart, Kelley, Fincham, Golden, & Logsdon, 2004; Hien & Honeyman, 2000; Miller, Smyth, & Mudar, 1999; Stover & Kiselica, 2015), child developmental issues (Osborne & Berger, 2009; Risser, Messinger, Fry, Davidson, & Schewe, 2013; Seay & Kohl, 2013; Staton-Tindall, Sprang, Clark, Walker, & Craig, 2013), and child welfare involvement (Jaudes, Ekwo, & Van Voorhis, 1995; Smith, Johnson, Pears, Fisher, & DeGarmo, 2007; Williams, Tonmyr, Jack, Fallon, & MacMillan, 2011).

Parents' decisions to utilize and participate in substance abuse treatment can be impacted by their parental responsibilities as well as their experiences with the treatment agency (Neger & Prinz, 2015; Niccols, Milligan, Sword, Thabane, Henderson, & Smith, 2012; Tracy & Martin, 2007). Being a parent can also increase the complexity of obtaining treatment (McMahon, Winkel, Suchman, & Luthar, 2002). It is notable that much of the research on parenting and substance abuse treatment focuses on mothers, highlighting the role of childbearing and greater involvement with the family as challenges to recovery (Rodriguez, Chodhury, Mitrani, & Guerra, 2016; Teel, 2016). For instance, McMahon and colleagues (2002) found that the number of children, cohabitation with a sexual partner, and ethnic minority status were all associated with a fewer contacts for substance abuse treatment by mothers (McMahon, Winkel, Suchman, & Luthar, 2002). Comparing samples of pregnant women who accepted versus declined substance abuse treatment, Messer, Clark, and Martin (1996) found that women with higher numbers of children were more likely to decline treatment. Higher responsibilities for child care among these mothers may decrease their likelihood to engage in treatment. However, parents' experiences of the agency's services and flexibility to accommodate parents also impact their likelihood of remaining in treatment (Grella, Needell, Shi, & Hser, 2009). For example, the provision of child care is an important agency support for women with children that increases the likelihood they will participate in substance abuse treatment and the length of time they will remain in treatment (Brown, Vartivarian, & Alderks, 2011; Campbell, Alexander, & Lemak, 2009). When agency supports (e.g., child care) are not available for families, it becomes more difficult for parents to participate in treatment.

Some research supports the idea of parenting status as a primary motivator or reason to participate in substance abuse treatment. Hanson, Saul, Vanderploeg, Painter, and Adnopoz (2015) describe parenting as a "primary positive reinforcement" for substance abuse treatment as sobriety and stronger parenting reciprocally reinforce each other (p. 163). In a sample of criminally involved women dependent on cocaine, Saum, Hiller, Leigey, Inciardi, and Surratt (2007) found that a woman having custody of her children was a strong predictor for participation in substance abuse treatment program. Women have reported that maintaining or regaining custody of their child and the child's well-being are both strong motivators to engage in substance abuse treatment (Jessup, Humphreys, Brindis, & Lee, 2003; Scott-Lennox, Rose, Bohlig, & Lennox, 2000). This focus on the child and the family's overall well-being has been found to support parents' participation in treatment.

However, explanations for the conflicting understanding of parenting status as both a motivator and an inhibitor are limited, particularly in relationship to the influence of parental responsibilities and the role of agencies in addressing these barriers (McMahon et al., 2002). Prior research has also called for an examination of the influence of parenting status on substance abuse treatment receipt among parents in rural areas (Brown et al., 2011).

The current study addresses this gap in the literature regarding the theme of parenting-related motivators and inhibitors to engaging in substance abuse treatment; specifically, we utilize a series of focus groups at agencies in a south eastern state to assess parents' perceptions of factors that facilitated or impeded their engagement with services. Our research questions are explored via qualitative data collected in these focus groups and address the following issues: 1) how clients describe the parenting role as a motivator and inhibitor to engaging in substance abuse treatment and 2) client perspectives on parenting-related, agency-imposed barriers and facilitators to substance abuse treatment engagement.

2. Methods

2.1. Study procedures

The current study utilized emic qualitative data from a broader needs assessment and evaluation of substance use treatment and recovery services in a south eastern state. As part of the original assessment, we obtained client perspectives on services at eight agencies participating in a state wide funded initiative. These focus groups were conducted at baseline, prior to any modification of services, and included agencies located in both rural and urban locales representative of the state as a whole.

In order to obtain clients' perceptions of the services they received at the agencies, in-person client focus groups were conducted with current and former recipients of substance abuse treatment services at each of the eight substance abuse treatment agencies. A total of nine focus groups were conducted, with number of participants in each group ranging from 3–6 persons, for a total of 45 participants. Clients were recruited for the focus groups by substance abuse treatment agency contacts. Participants had to be at least 18 years of age and current or recent recipients of services from the substance abuse treatment agency. Human subject protocols and all study procedures were approved by a university Institutional Review Board. Informed consent was obtained from all focus group participants. Using a semi-structured focus group guide, participants were asked to discuss how they heard about the agency's programs, treatment motivations, their decisions to use the programs, their experiences in the programs, their futures, and suggestions for improving the programs. Focus groups were audio-recorded and transcribed verbatim.

2.2. Study participants

The majority of participants identified as female (82.2%) with a mean age of 34.02 years ($SD = 10.95$). Participants ranged in age from 19 to 63 years. Participants identified as white non-Hispanic (71.1%), black non-Hispanic (26.7%), or Hispanic (2.2%). They reported a wide range of educational attainment: some high school (24.4%), high school graduates or GED (15.6%), some college (44.4%), bachelor's degree (6.7%), graduate degree or

professional licensure (6.7%). One-third of the participants were engaged in full- or part-time employment (33.3%) and two-thirds were unemployed (62.2%). A small percentage of demographic data was missing: age (2.2%), gender (0%), race (0%), education (2.2%), employment (4.4%).

2.3. Data analysis

Focus group transcripts were analyzed using inductive thematic analysis (Krueger, 1997). First, team members used first-cycle basic coding and second-cycle axial coding to identify key themes in the transcripts as these related to the goals of the broader study. Specific to the current study, the first author, who specializes in research on parenting and substance abuse, then read each transcript to identify additional themes related to parenting and the impact of having children on involvement with the substance abuse agency. Accordingly, a preliminary codebook was developed for parenting-related themes. The data and preliminary codebooks were then reviewed and adapted based on feedback of the second author and the full study team in order to decrease bias. Transcripts were coded using MAXQDA version 11.1.1. A conceptual cluster matrix was utilized to determine the frequency of themes across the focus groups. Within this fully coded data set of client focus groups, parenting was the third most prevalent theme (136 quotes, or 18% of all quotes), following only ‘program strengths’ (28%) and ‘program weaknesses’ (21%); lesser mentioned themes (less than 10% of quotes) included those such as suggestions for improving services, motivations for using services, and family support for the client’s participation in services. It is notable that, while both men ($n = 8$) and women ($n = 37$) were present in our sample, only one of the 136 quotes on parenting came from a male (less than 1% of parenting quotes—relative to 4% from males for quotes on each program strengths and weaknesses). Accordingly, all quotes utilized here to illustrate themes came from female clients.

3. Results and Discussion

3.1. Parenting as motivation

In all nine focus groups, participants described parenting as a source of motivation to obtain substance abuse treatment. Within this broader theme, parents discussed two sub-themes: child protective services involvement and the desire to be a better parent.

3.1.1. Child protective services involvement—In all nine focus groups, one or more participants reported they were receiving substance abuse treatment due to involvement with child protective services (CPS). Participants described both external and internal motivation due to CPS referrals. External motivations described CPS as the sole explanation for the decision to enter treatment. One mother stated, “Me, I had my baby [Date]. They found cocaine in my system. So that’s how I got here.” Externally motivated statements were simple and indicated an “if-then” relationship: If you are referred by CPS, then you have to attend substance abuse treatment.

Internal motivations described CPS as a referral source but explained that children were the true motivation for engaging in substance abuse treatment. One mother described her involvement with CPS:

I'm in drug court for child neglect and possession of meth. That was my only option, besides jail. When I pled into drug court, I was already six months clean. I was already in the process of going through [CPS] to get my child back. So, I took it for the reason I was already clean and wanting to change my life to get my little girl back.

Another parent provided a similar explanation for deciding to stay in treatment after her CPS case ended:

[CPS] dismissed our case 'cause I gave my son to my mother for temporary custody. I don't even have to be here now, and I chose to stay ... I promised my son that I would stay, and that's what I intend to do.

Although originally referred due to involvement with CPS, these mothers described that their underlying motivation for staying in treatment was for their children, not their involvement with CPS. Regarding referrals to treatment by CPS, two focus group participants discussed this concept:

P1: *And we all had a choice, you know? Whether you're court ordered, probation ordered, [CPS] ordered, you have the choice to run with the children.*

P2: *There is a choice. And there's a lot of people that say, "Well, you're court ordered, so you had to go." Nobody has to. You could run. You could go to jail. You can opt other. It does come down to a choice.*

A similar dialogue also occurred in another focus group supporting the concept of CPS referrals leading to internal motivation. However, some statements indicating an internal motivation may be due to a social desirability bias. The presence of an interviewer asking about motivation may encourage some participants to present their motivation differently than their true feelings.

In the treatment literature, there have been discussions about the implications of mandating services for clients (Rittner & Dozier, 2000; Rockhill, Green, & Newton-Curtis, 2008). Research indicates that this mandate creates an obligation that increases treatment seeking (Hser, Maglione, Polinsky, & Anglin, 1998; Rockhill et al., 2008; Wild, Roberts, & Cooper, 2002). Participant statements in this data support the concept of internally progressing from force-motivated treatment to empowerment. Several participants' statements indicate that they have reclaimed their right to choose to participate in services regardless of their referral source. Compliance with a referral to mandated treatment is an important indicator of successful outcomes (Rittner & Dozier, 2000). However, these statements reflect not just compliance, but commitment to the process. Although treatment outcomes were not examined, participants' statements indicate a need to further consider client interpretation of whether or not they feel mandated to services, not simply the referral source, when examining the concept of mandated participation among CPS clients.

3.1.2. To be a better parent—In seven of nine focus groups, participants described their motivation to seek treatment by describing a desire to create a better life for their children than they had experienced in the past. One parent described her motivation to stay in treatment and its direct connection to improving the life of her children:

Because you're getting treatment, you're doing what it takes to make your life better and your children, your relationship with your children better. You're doing what it takes to be able to keep your children, I mean ... You becoming drug free. A better life.

Several mothers described their motivation to engage in treatment as simply "to be a better mom." Some parents described how sobriety really helps parents get to know their children better. For example, a parent said:

You finally just start noticing like little details. Like even if it's he moves his hand a certain way or he, you know, you start to really learn their personalities when you're sober. And you really get to see it for the first time.

This mother's statement indicates that sobriety results in a new awareness of parenting and, perhaps, the opportunity to take active steps to enhance this relationship. Findings from these focus groups support the concept of offering parenting programs to individuals receiving substance abuse. In order to help parents strengthen their new relationships with their children, access to evidence-based parenting programs during substance abuse treatment is recommended.

3.2. Child as inhibitor

Six of the nine focus groups included statements about how having a child inhibited a participant's desire or ability to initiate or continue in treatment for substance use. These statements fell into three categories: being away from the child, debilitating guilt, and demands of parenting.

3.2.1. Being away from child—In three focus groups, participants discussed concerns about how treatment takes time away from their children. Concerns about being away from children for both shorter and longer periods of time were discussed by participants. Assisted with childcare arrangements, one mother with a newborn discussed how being away from her child for sessions was affecting her treatment. She stated:

Twenty or thirty minutes. That's fine. But when you wanna try to have me sit there for an hour and a half, I'm like constantly thinking I need to get back to my kid and take care of my kid. Because somebody else is taking care of him all day while I'm gone, and I feel like it just kinda takes away from my family time.

Participants discussed concerns about leaving children during inpatient treatment. One focus group discussed the decision to leave their children for a 90-day inpatient program:

P: *In 90 days, it's like 80-something percent make it.*

P: *But ninety days being away from your kids?*

P: *Hanging around a bunch of females.*

P: *Yeah.*

P: *That's the scary thing.*

For over 20 years, concerns about separation from children have been commonly cited as a barrier to treatment among mothers (Beckman, 1994; Copeland, 1997; Rockhill et al., 2008). This strongly anticipated finding was not present in all groups. This may be due to the availability of mother-child residential programs in selected regions of [state withheld for blind review] designed to address this barrier for mothers.

3.2.2. Debilitating guilt—In two different focus groups, parents described overwhelming guilt related to their children that makes them want to give up and leave treatment. One parent stated, “I can’t help my baby, so boom. Forget y’all. I’m gonna go over here and use this substance.” For this parent, relapse was directly associated with guilt over her child. A mother whose children were in foster care stated, “I mean there’s been nights I literally felt worthless and my children are suffering because of me.” In response to this statement, several other focus group members discussed how holding herself accountable for what happened to her children is a sign of recovery.

Although the concept of parent-related guilt as a barrier to treatment is not frequently mentioned in the literature, guilt and shame are common emotions to emerge during substance abuse treatment (McGaffin, Lyons, & Deane, 2013). For some parents, the focus of this guilt and shame may be on regrets or concerns for their children. As described by the focus group members, recovery often involves addressing these feelings, forgiveness, and acceptance of one’s prior decisions (McGaffin et al., 2013). When working with parents in treatment for substance use disorders, practitioners should provide parents with sufficient time to process these guilty feelings. Motivational interviewing can help parents see recovery as a step towards stronger parent-child relationships.

3.2.3. Demands of parenting—Among parents, the everyday task of childcare and meeting children’s needs can prevent parents from initiating or continuing with treatment. One mother stated:

Like the day, you know it’s rainy. You don’t have to go to work. You just want to stay in bed and sleep. It kinda gets hard especially when you, you know, you have to be a mommy, go to work, and get [treatment] on top of that.

In addition to the fatigue that some parents experience, other parents discussed complicated time management strategies that have to be undertaken to get to treatment. In discussing why she was late to the focus group itself, one mother gave an example of the everyday experiences that get in the way of continuing with treatment. She stated, “I had to go to my son’s school to take, you know, another pair of shorts because he had fell in the mud. Then run and drop my daughter off then come here. So that’s why I was late.” Her statements support the concept that parents are busy and have multiple logistical challenges in a given day.

Parenting young children results in a decreased amount of free time. When compared to adults without children, each parent in a dual-earner, two-parent household, has an average of 1.6 hours of free time less per day for each child under age four and 0.8 hours of free time less per day for each child age 4–14. (Ekert-Jaffe & Grossbard, 2015). Single parents likely have even less free time. Parents in this sample expressed difficulties in time constraints

based on limited time and a multitude of obligations. Given that parents actually do have less time to spend on new tasks than individuals seeking treatment who do not have children, creative treatment strategies might be employed to provide flexibility for parents who are seeking treatment. One such strategy involves in-home treatment for parents, which prevents the need for the client to travel or find childcare (Oliveros & Kaufman, 2011).

3.3. Parent-specific service facilitators

In eight of nine focus groups, participants discussed ways that substance abuse treatment agencies and their agency policies facilitate or encourage the participation of parents in substance abuse treatment. Four parent-specific themes emerged within service facilitators: mother-child residential programs, services for children, concrete support, and advocacy and emotional support.

3.3.1. Mother-child residential programs—The opportunity to participate in a program in which mothers and children reside together during treatment was a strong facilitator for many participants to enter substance abuse treatment. For women in mother-child residential programs, the ability to bring their children with them was a large facilitating factor for treatment. Several women made statements that they selected their treatment agency provider based on this key factor. For women who were in other types of programs, the concept of mother-child residential programs was exciting:

That's a woman's number one strength is her children and that ... a lot of some of the reason that I've never went into inpatient because my children. I'd be away from them for so long, you know? So, I mean this would be a great group.

Many recipients of the mother-child residential programs discussed positive experiences with these programs. A participant who had almost completed treatment at a mother-child residential program stated, "It's a wonderful program, I mean the [mother-child residential program] helped me with my daughter. I've been able to stay with my daughter in a secure environment." Other mothers described additional strengths of the mother-child residential programs including comfortable facilities to house families and services for children on-site. A mother who participated in a mother-child residential program described all the services the agency provided. Then she stated, "I could not ever imagine until I actually got there. Then I was like, 'wow!' It was inspiring."

Some evidence indicates that residential mother-child substance abuse treatment programs are effective at improving maternal substance abuse and parenting-related factors including decreasing drug use (Metsch et al., 2001), addiction severity (Killeen & Brady, 2000), and parental stress (Killeen & Brady, 2000), and improving treatment retention (Hughes et al., 1995). Preliminary research also supports that child behavior problems are decreased through mother-child residential treatment (Killeen & Brady, 2000).

3.3.2. Services for children—Focus group participants reported that they really appreciated receiving services for their children from substance abuse treatment agencies. Specific child-focused services reported by participants included child and family therapy, child activities, and childcare. Parents were interested in and appreciated the inclusion of

individual and family counseling with their children and teenagers. A woman in residential mother-child treatment discussed the high level of services provided to children in the treatment center she is in:

I think the parent child bonding aspect of it is a huge thing because a lot of us ... we have kind of pushed the child aside or have trouble bonding due to the drug use. And it's especially now, in the past couple of years, it's become more family bonding focused. The moms have treatment plans. The babies, the toddlers, and the preschoolers have treatment plans. We're all assessed. We all have goals to reach. And the strengths, we could write a book on it.

Participants discussed numerous activities provided for children including outings to the circus and museums for families receiving residential mother-child treatment, family weekends for parents receiving inpatient treatment, and holiday events. These events were a highlight of treatment for families. Access to childcare during treatment sessions was reported as an important service for children. A mother discussed how her child receives childcare while she receives treatment by stating, "I still come here five days a week knowing my baby is watched after. They have great staff at [treatment center]."

3.3.3. Concrete support—In three of the nine focus groups, concrete supports provided by the agency were discussed. Specific items mentioned included diapers, birth control, temporary housing payment assistance, and transportation to prenatal care or pediatric appointments. One mother discussed how she lost her housing after her children were removed from her care. She stated:

I got evicted from my home so that I wasn't able to move anything. So, I had to just walk out the door. Leave the door open. Go down to the storage, take the lock off, and just raise it and say there. ... So, the [agency program] here is gonna help me to get out and get a place, you know, started. Then help me with furniture and things. And I think that's wonderful you know.

This mother's loss of her children and home all occurred right before she went into treatment. She appreciates the concrete supports that will help her transition back to the community. This finding is consistent with prior studies that have supported the provision of concrete services for individuals in treatment (Neger & Prinz, 2015).

3.3.4. Advocacy and emotional support—The advocacy and support provided by treatment staff were a strength of treatment that encouraged parents' participation in treatment. One participant stated, "They're like our advocate to [CPS] and our attorneys." Another participant from the same focus group stated, "They're our voice." In a separate focus group, a participant further explained the type of support provided to her:

They also help like if you need letters or if you need somebody to talk to [CPS] or talk to court, go to court with you. You know, they're there. Most time, you know, if you go to court you're there by yourself. It's nice when you go to court or go before a board, or whatever, that you've got somebody there that you know.

One mother described the support she received in treatment:

And another awesome, awesome strength about it was when I walked in, and I was told that I was not a bad mother, that I was a sick mother and I was gonna get better. And that was huge. And that I was told that they would trust me until, they would trust me unless I gave them a reason not to. And I didn't have anybody else in my life that was gonna do that right then.

Although not widely discussed, some participants did report characteristics they thought were important to providing support. For example, one mother felt that it was important that the female facilitator also have children in order to be supportive. Other participants described group characteristics that were important for treatment: female-only groups and parent-only groups.

Social and emotional support are important to women in recovery for substance abuse (Tracy, Munson, Peterson, & Floersch, 2010). Although participants briefly discussed group member characteristics that motivated treatment, they primarily focused on the emotional support obtained from group leaders. Parents appreciated when that support focused on their role as parents.

3.4. Parent-specific service barriers

Eight of the nine focus groups discussed the ways substance abuse treatment agencies and their agency policies create barriers to participation in substance abuse treatment for parents. These barriers fell into two specific categories: access to children and barriers specific to mother-child residential programs.

3.4.1. Access to children—Participants discussed concerns that policies in substance abuse treatment agencies limit parents' access to their children. Parents discussed a desire to have their children with them in treatment. Aware that mother-child residential programs were being offered elsewhere, some parents described their desire to participate in that type of program. One parent stated, "If I could have my kids with me through recovery, I would have less chance of relapse or suicide or drinking alcohol." Participants discussed the emotional toll that separation during treatment and limited visitation posed to their children. One participant stated, "She cried 'cause she couldn't come visit me." The structure and rules on visitation and contact with children were the largest parent-specific barrier imposed by agency policies.

3.4.2. Barriers specific to residential mother-child programs—Focus group participants at mother-child residential programs reported a few agency policy limitations specific to these types of residential programs. The first limitation was that mothers found being surrounded by other families in close quarters to be tough. One mother stated, "There were fears and challenges living among sixteen women and up to 32 children. Yeah, you have to learn patience and tolerance." Mothers discussed wanting family time with just their children. They also wanted their children to have more time away from the treatment center:

Even the children, you know the children are all cooped up in here, too ya know?
It'd be nice to take ... Even go on events with the kids. Take the kids to the park.

‘Cause you know, you’re a child, you know? No child should be cooped up in a rehab.

Mothers also expressed concerns about the shared childcare duties of the mothers in the residential mother-child programs. Participants described how they would take turns providing childcare for the children in the center. Some participants made statements that they did not enjoy watching other people’s children. With an awareness that this is a tiring job assignment in the treatment center, the mother responsible for assigning other mothers to childcare duty stated:

Basically, I try to be fair. We have to do break and relief. Like when we go out for our cigarette breaks, we have to have two people watching the kids ‘cause we’re leaving the floor. So, I try to be fair as possible cause we only got eight girls.

More often, mothers did not want another individual in recovery watching their own children. Although corporal punishment was not utilized, a mother reported her concern about other mothers in the center getting on to her children or being “disappointed in your children.” One mother stated:

I don’t want nobody to take this the wrong way, but I’m a drug addict myself. I am coming off drugs and I know how it is. I wouldn’t want somebody else that’s comin’ off drugs to be near my kids.

Many of the barriers to mother-child residential programs could be addressed through policy changes. However, the flexibility to choose the type of program that will meet one’s needs was important to the participant. In this line of thinking, there were several statements indicating that mother-child residential treatment is a strong choice for some but not what every parent would select. These differing perspectives were exemplified by one mother’s statement, “Yeah, we have different views. I don’t think that I should bring my sons somewhere like that, you know? I don’t think it’s a good place for children. I think you need to focus on yourself and get clean.”

3.5. Limitations

There are study constraints that limit the generalizability and scope of the findings. As the initial purpose of this data was not to examine parenting, parenting status was not collected as a demographic. However, many participants self-identified in their focus group responses as parents, and parenting emerged as an important theme in the data. Parenting-related statements were present in every focus group. Only statements that identified the speaker as a parent through parenting-specific references are included in this analysis. Nevertheless, collection of data on parenting status and number of children would improve future research on this topic.

A second limitation is that our groups contained few males, and males were less vocal on the topic of parenting. Research indicates that a substantial number of males—as well as females—seeking treatment are parents and that a majority of these parents are highly involved with their children (Collins & Grella, 2003; McMahon, Winkel, Luthar, & Rounsaville, 2005). Given that fathers’ substance use and recovery may play an important role in child well-being (Andreas & O’Farrell, 2008; Kelley & Fals-Stewart, 2004; Stover &

Kiselica, 2015), an important direction for future research is examination of the role that fathering plays in parents' access to substance abuse treatment.

A third limitation is that we sampled only those persons already in contact with a system of care, and thus impact of parenting for those who did not access (or maintain) treatment is unknown. Finally, we allowed agencies to recruit focus group participants from their client base; the selection of participants by treatment agency contacts may bias the sample towards individuals who are compliant with treatment, more articulate, or those who have positive things to say about the substance abuse treatment agency.

3.6 Summary

In sum, our participants often cited parenting as a motivator for treatment engagement, noting child-protective service mandates, custody issues, and improved relationships with their children as factors. Children were perceived as inhibitors to treatment engagement in relation to parents being separated from their children during treatment, logistics of arranging for childcare, and parenting demands with associated parenting guilt. Agency-related factors that might address these barriers include flexible options such as integrated mother-child treatment programs (Niccols et al., 2012), in-home treatment for parents (Oliveros & Kaufman, 2001), tangible services such as assistance with housing and transportation (Neger & Prinz, 2015), and provision of emotional support and advocacy so essential to recovery (Tracy et al., 2010).

4. Conclusions

Within these focus groups, having children was perceived by some participants to be a motivation and, by other participants, to be an inhibitor in their substance abuse treatment. Prominent themes in our study included child protective service involvement as an initial trigger to seeking treatment, as well as the mothers' own concerns for their children. Mothers were concerned about time away from their children while in treatment, and the time-intensive demands of parenting sometimes created challenges in accessing treatment. Flexible treatment options, mother-child treatment programs, and services specific to children were mentioned as factors that may facilitate access to treatment. Agencies and state/local policymakers might also consider reviewing policies to assure that treatment access includes family-friendly options that allow parents quality time focused solely on their own children.

Although being a parent imposes logistical barriers to treatment engagement, the emotional connection with the child can provide a strong source of motivation to obtain treatment. However, for some parents, a strong parent-child bond may actually inhibit the initiation of treatment due to the conflicting goals of self-care versus caring for one's child. To enhance treatment engagement among parents, agencies must examine the manner in which their services and providers create barriers and facilitators to participate in services. Motivational interviewing can also be provided to parents to shift the perception of children from inhibitor to motivation. Future research should continue exploring the complexity of how gendered and non-gendered parental responsibilities of males and females intersect with agency factors to promote or inhibit parental engagement in treatment. Policies are needed that

promote flexibility, choice, and support for parents from a variety of traditional and non-traditional family structures to engage in treatment services.

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