# Parents with Co-Occurring Mental Health and Substance Abuse Conditions Involved in Child Protection Services: Clinical Profile and Treatment Needs

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ABSTRACT

This article reports findings of an exploratory study of 71 parents with substance abuse conditions involved in a child dependency court. Over half (59%) of the parents had a cooccurring mental health condition. Parents with co-occurring conditions (PWCC) differed in several important ways from those with only substance abuse conditions. PWCC were also more likely than their case managers to report a need for mental health treatment. Implications for child welfare practice and research are offered.

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Parental substance abuse has clearly been identified as a major contributing factor in cases of child abuse and neglect since the mid-1980s. Current estimates from national studies suggest that 50% to 80% of all confirmed neglect or maltreatment cases involve substance abuse (NCASAC, 1999.) Addiction treatment is now standard protocol for parents to maintain or regain custody of their children and avoid termination of parental rights (Karoll & Poertner, 2002; Smith, 2003). However, less attention has been given to the high prevalence of mental health conditions that have been found to co-occur with the abuse of alcohol and other drugs in both population studies (Kessler et al., 1997) and clinical settings (e.g., Stromwall & Larson, 2004; Mowbray, Ribisl, Solomon, Luke, & Kewson, 1997). The co-occurrence of mental health conditions may be an important factor in understanding parents with substance abuse.

This exploratory study examined the prevalence of co-occurring mental health conditions among parents with dependency cases involving substance abuse in one zip code in a Southwestern state during 2001-2002. We compared key variables for parents with co-occurring substance abuse and mental health conditions (PWCC) and those who had a substance abuse diagnosis alone. We then compared parents' self-reports of mental health severity and treatment needs with their case managers' perceptions of treatment need. With this information, training needs of case managers and appropriate services for PWCC can be identified.

## Literature Review

### *Child Welfare and Parental Substance Abuse*

Substance abuse among parents involved in dependency cases is now well-documented (Semidei, Radel, & Nolan, 2001). Recent estimates suggest that up to 80% of all dependency cases have parental substance abuse as a contributing factor (NCASAC 1999; Karoll & Poertner, 2003). Children from

substance abusing families are more likely to be placed in out-of-home care and remain there longer than children from non-substance abusing families (NCASAC, 1999). Family drug courts with case managers trained in substance abuse are a recent intervention strategy being used in several states to help meet the needs of these families while adhering to the timelines of the Adoption and Safe Families Act (NCASAC, 1999).

*Child Welfare and Parental Mental Illness*

A parent's mental health condition is considered a risk factor for child abuse and neglect. This problem, though increasingly recognized, has received little attention. In an analysis of national child welfare data, the Administration for Children and Families (ACF) (2004) determined that 22 % of the parents in dependency cases had a mental health problem. Between 1985 and 1995, the out-of-home-placements of children with a parent with a mental illness doubled (Woodhouse, 2002) and these parents were at greater risk of losing custody than parents without a mental health condition (Green, 2002). Child welfare practitioners are not adequately trained to assess mental health conditions (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004). One result of this lack of training is that parents are not referred to services that might help them manage symptoms and regain custody. The ACF (2004) estimated that 26% of parents with mental health problems in dependency cases were not referred to mental health treatment.

*Child Welfare and Parental Co-Occurring Conditions*

Up to 10 million U. S. individuals demonstrate symptoms characteristic of co-occurring conditions (Sack, 2004), with numerous negative consequences that can affect parenting ability. These include social isolation, unemployment, homelessness, violence, noncompliance with medications, increased family and legal troubles, and hospitalization (Carey, Roberts, Kivlahan, Carey, & Neal, 2004; Laudet, Magura, Knight, & Vogel, 2002; Messina, Burdon, Hagopian, & Prendergast, 2004). Despite increasing recognition of co-occurrence (Minkoff, 2001), researchers have not examined PWCC involved in dependency cases. The previously mentioned ACF (2004) study analyzed substance abuse and mental health conditions separately, as did Jellinek et al. (1992) in a study of parents in the Boston Juvenile Court. This study found that a parental psychiatric diagnosis was documented in 31% of the cases and substance abuse was either documented or alleged in over half the cases. However, the researchers did not specify how many parents experienced both conditions.

Wattenberg, Kelley, & Kim (2001) reviewed the records of 97 Minnesota children whose parental rights were terminated and found that the 57.7 % of the mothers had a history of multiple problems, including substance abuse and 47.5% had "serious and persistent mental illness (i.e., depression, bipolar disorder, schizophrenia, or personality disorders)" (p. 413). It is not possible to determine how many of these women experienced both conditions, although when developmental or other disabilities were included, 80% of the cases had dual or multiple conditions. Further, although the authors report that the 56 fathers in this sample also had multiple problems, no information regarding their mental health status is given. Only one-third of the parents received either a mental health or chemical dependency assessment prior to termination of parental rights, although half received some type of substance abuse treatment.

*Expectations for Parents Involved in the Child Welfare System*

Parents with substance abuse conditions in dependency court often encounter a standard set of conditions for maintaining or regaining custody even though best practices suggest an individualized plan be developed to fit each unique family situation (Pecora, Whittaker, Maluccio & Barth, 2000). Case plans typically require that parents complete substance abuse treatment, attend parenting classes, consistently attend visitations, meet with caseworkers, complete job training if needed, and have safe and stable housing. Research has found little clear evidence about the necessary components for reunification, although judges and caseworkers report a continuum of factors used to make that determination (Karoll & Poertner, 2002).

The perception of parent compliance with court-ordered assessment and treatment for substance abuse is a key factor in decisions regarding termination of parental rights (Atkinson & Butler, 1996; Jellinek et al., 1992; Karoll & Poertner, 2002), even beyond the effect of behavior change itself (Smith, 2003). The ability to follow through with court-ordered treatment may be severely impacted by mental health symptoms. Parents with undiagnosed or untreated cooccurring mental health conditions, therefore, may be less able to comply.

*Environmental Context of Parents with Co-Occurring Conditions*

Finally, PWCC and the child welfare system itself are situated within a societal context that commonly holds negative attitudes toward and discriminates against people with mental health conditions (Cooper, Corrigan, & Watson, 2003; Corrigan et al., 2000; Martin, Pescosolido, & Tuch, 2000; Murray & Steffen, 1999; Wahl, 1997) and substance use conditions (Bell, Dru, Fischer, Levit, & Sarfraz, 2002; Corrigan et al., 2000; Martin, Pescosolido, & Tuch, 2000; Murphy-Berman, Sullivan, & Berman, 1993). Those who have co-occurring conditions are subject to both of these forms of discrimination (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997), experiencing what has been called "double jeopardy" (Brown & Saura, 1996; Champlain & Herr, 1995). Further, parents who have been charged with children maltreatment, whether or not this allegation is related to mental health or substance use issues, may experience stigma (see Weiner, Perry, & Magnusson, 1988). Thus, PWCC involved with child protective services may experience multiple forms of oppression. If case managers hold attitudes similar to those found in these studies, then it is possible that they would devalue parents' perspectives.

In this exploratory study of parents who are involved in dependency court due to substance abuse, we look at (1) the prevalence of and characteristics associated with cooccurring conditions, (2) whether PWCC report they need treatment for mental health conditions, and (3) whether case managers' assessments of parents' need for mental health treatment matches those of the parents.

## Method

*Sample*

This study is a secondary analysis of data from a study evaluating the effectiveness of a Family Drug Court intervention (Author, 2004). For this analysis, we studied all parents (N = 75) who had one or more children removed from their custody by Child Protective Services (CPS) because of parental substance abuse within one year and who resided in a single zip code area in a U.S. Southwestern city. Of these, four had missing information on substance abuse and were excluded from analyses. Therefore, the sample for the present study consists of 71 parents.

*Data Sources and Instruments*

Data for the current analyses were gathered from three sources. First, CPS workers provided demographic information and prior family court history as part of their intake process. Second, a research team member who was a licensed clinical social worker gathered existing documentation about mental health conditions through a file review. We then constructed a variable to denote whether or not the parent had a mental health condition. Parents had a mental health condition if at least one of the following criteria was found in the file: a psychiatric diagnosis, psychotropic medication prescription, or case manager's notation of history. Third, case managers administered the Addiction Severity Index (ASI), Fifth Edition (McLellan, Luborsky, O'Brien, & Woody, 1980; McLellan, Kushner, Metzger, Peters, et al., 1992) to parents after the initial CPS intake. The ASI is a one hour semi-structured interview designed to identify seven potential problem areas in people with substance abuse conditions: medical, employment and support, alcohol and other drug use, legal, family/social, and psychiatric. It gathers information on recent (last 30 days) and lifetime problems. The ASI also contains items completed by the case manager. The legal status subsection was not administered to this sample.

*Data Analysis*

SPSS Version 12.0 for Windows was used for all analyses. After calculating descriptive statistics for the entire sample, descriptives were calculated for parents with only substance abuse conditions and for PWCC. To compare these two groups of parents, chi-square tests of independence were used to compare responses on key variables. To examine PWCC ($N$ = 42) more closely, we selected them from the sample for further analyses. Cross-tabulations were run of parents' assessment of the severity of their mental health conditions and of their need for treatment for mental health conditions; Pearson's $r$ was used to determine whether these two variables were correlated. Finally, a cross-tabulation was run to determine whether parents' assessments of their need for mental health treatment matched that of their case managers, and Pearson's $r$ was used to determine whether these two variables were correlated. Where cell sizes dropped below 5 in 2x2 tables, Fisher's exact test was used in place of the chi square. The small sample limited the likelihood of statistical significance and necessitated the inclusion of a liberal $p$ value of .10 for significance. This $p$ value, however, is sometimes considered acceptable for small samples (Rubin & Babbie, 2001).

## Findings

### *Sample Demographics*

As seen in Table 1, two-thirds of the 71 parents were women. A majority (60%) were non-Latina/o White. One-third (32%) of parents were Latina/o, the majority of whom were of Mexican descent. The remaining parents were either non-Latina/o Black (6%) or American Indian (2%). Parents ranged in age from 19 to 48, with a mean age of 29 years; they had an average of two children. Forty-two (59%) of the 71 parents were classified as parents with cooccurring conditions (PWCC).

Table 1
*Sample Demographics*

| | Parents with Co-occurring Conditions *n* = 42 | Parents with Substance Abuse Condition Only *n* = 29 | All Parents *n* = 71 |
|---|---|---|---|
| Female (%) | 76% | 52% | 66% |
| Average Age, Range | 29, 19-45 | 29, 20-48 | 29, 19-48 |
| Ethnicity | | | |
| Non-Latina/o White (%) | 56% | 66% | 60% |
| Latina/o (%) | 36% | 27% | 32% |
| Non-Latina/o Black (%) | 5% | 7% | 6% |
| American Indian (% | 3% | 0% | 2% |
| Average Number of Children, Rang | 2.2, 1-5 | 1.9, 1-5 | 2.1, 1-5 |

### *Comparing Parents with and without Co-Occurring Conditions*

A significantly higher proportion of PWCC were female than in the sample as a whole ($\chi 2 = 4.59$, $df = 1$, $p < .05$) (see Table 2). PWCC differed significantly on four additional variables from parents with only substance abuse conditions. PWCC were significantly more likely to have a previous family court history ($\chi 2 = 6.74$, $df = 1$, $p < .01$), and to report a lifetime history of substance abuse treatment ($\chi 2 = 13.1$, $df = 1$, $p = .000$), a lifetime experience of serious anxiety or tension ($\chi 2 = 3.18$, $df = 1$, $p < .10$), and a lifetime history of sexual abuse ($\chi 2 = 2.88$, $df = 1$, $p < .10$). The two groups did not differ in lifetime history of treatment for mental health conditions ($\chi 2 = .225$, $df = 1$, $p > .05$).

Table 2
*Chi Square Comparisons of Parents with Substance Abuse Only vs. Those with Co-occurring Conditions on Key Variables (N = 71)*

| | Parents with Co-occurring Conditions *n* = 42 | Parents with Substance Abuse Condition Only *n* = 29 |
|---|---|---|
| Had previous family court history | 38*** | 10 |
| Had been in controlled environment for psychiatric or substance abuse treatment past 30 days | 7 | 0 |
| Lifetime history of substance abuse treatment | 64*** | 21 |
| Suicidal thoughts or attempts in the past 30 days | 14 | 7 |
| Lifetime experience of suicidal thoughts or attempts | 8 | 28 |
| Lifetime experience of serious depression | 83 | 72 |
| Lifetime experience of serious anxiety or tension | 84* | 64 |
| Lifetime history of sexual abuse | 48* | 28 |
| Family member with substance abuse history | 71 | 72 |
| Family member with psychiatric history | 47 | 38 |
| Lived alone or with children only in past 3 years | 14 | 10 |
| Had serious relationship problem in past 30 days | 48 | 59 |
| Current chronic medical problems | 30 | 20 |

*p<.10, **p<.05, ***p<.01, ****p<.001

Table 3
*Parents' and Case Managers' Assessments of Mental Health Condition Severity and Treatment Need*

| | Condition Severity as Assessed by Parent $n$ = 34 | Treatment Need as Assessed by Parent $n$ = 34 | Treatment Need as Assessed by Case Manager $n$ = *22* |
|---|---|---|---|
| Extreme | 21% | 35% | 9% |
| Considerable | 41% | 29% | 14% |
| Moderate | 9% | 6% | 14% |
| Slight | 12% | 9% | 41% |
| None | 18% | 21% | 23% |

*Note*. Totals may be greater than 100 due to rounding.

*Examination of Parents with Co-Occurring Conditions*

*Mental health condition severity and need for treatment.* Sixty-two percent of PWCC reported that they were considerably or extremely troubled or bothered by their psychological or emotional problems in the last thirty days (see Table 3, Column 1). Sixty-four percent of these parents rated treatment for their mental health condition as considerably or extremely important (see Table 3, Column 2). Parents' assessments of problem severity and treatment need were highly correlated ($r$ = 0.83, $p$ = 0.000).

*Comparing parents' and case managers' assessments.* As seen in the third column of Table 3, case managers' assessments of parents' mental health treatment needs did not match parents' own assessments. Case managers assessed parents' needs as considerably or extremely important for only 23%. They rated treatment as only slightly or moderately important for 55% and not at all important for 23%. Although parents and case managers' assessments of treatment need were positively correlated ($r$ = 0.56, $p$ = .01), they matched for only 43% of the parents. In 83% of the cases in which the assessments did not match, parents rated treatment as more important than did their case managers. A crosstabulation (not shown) revealed a pattern suggesting that mismatches may be more likely when parents report higher treatment need. When parents reported low or no treatment need, case managers' assessments matched in 100% of the cases. However, when parents reported a high treatment need, case managers' assessments matched in only 36% of the cases, a significant difference (Fisher's exact test, $p$ = .10).

One explanation for mismatched parent and case manager assessments could be that case managers deem the parents' own assessments to be clinically questionable. We explored this possibility by examining two items of the ASI that ask about case managers' confidence in the parents' self-report. When asked whether the information was significantly distorted by the parent's misrepresentation, case managers said, "Yes" in only one of the 21 cases that included responses to all of these variables. When asked whether the information was significantly distorted by the parent's inability to understand, in all cases case managers said, "No." Thus, case managers' reported levels of confidence do not explain these findings.

## Discussion

Consistent with population and clinical studies (Kessler et al., 1997; Mowbray, Ribisl, Solomon, Luke, & Kewson, 1997; Stromwall & Larson, 2003), this exploratory study of parents in the child welfare system found a high rate (59%) of co-occurring conditions. The high rate of co-occurring conditions is a critical finding. Co-occurring mental health and substance abuse conditions appear to be the norm rather than the exception among parents in the child welfare system. Although this sample was small, it was inclusive of all cases referred to child protective services from that geographic location within a set time frame. Knowing the rate of such conditions suggests the importance of developing screening mechanisms to be used with all parents at intake in order to determine appropriate and individualized intervention strategies.

Previous studies have found that the case manager and judges' perceptions regarding parents' compliance with treatment is primary in determining child placement outcomes (Atkinson & Butler, 1996; Jellinek et al., 1992; Karoll & Poertner, 2002; Smith, 2003). Parents with an unrecognized mental health condition are likely to have more difficulty in seeking out and completing substance abuse treatment. Given the evidence that women with co-occurring conditions drop out of substance abuse treatment (leave against medical advice) at a higher rate than

women with substance abuse alone (Watkins, Shaner, & Sullivan, 1999), mothers with cooccurring conditions may be at risk for poorer dependency outcomes because they are less able to comply with the court's requirement. Indeed, Newmann & Sallmann (2004) have found that a higher percentage of mothers with co-occurring conditions than those experiencing substance abuse alone report being separated from a child against their will.

In this study, more women than men had co-occurring conditions. Given the gender bias that exists within child welfare and the larger society (Risley-Curtiss & Heffernan, 2003) and the higher proportion of single mothers vs. single fathers, women are the identified perpetrator in most cases of child neglect due to parental substance abuse. Understanding women's experience of co-occurring conditions, therefore, is even more important for practice in child welfare. PWCC were significantly more likely to have a history of sexual abuse and report a lifetime history of severe anxiety. This finding coincides with other studies of individuals with co-occurring conditions, particularly among women (Newmann & Sallmann, 2004). Posttraumatic stress disorder, in particular, has been found to be much more common among women with co-occurring conditions than men (Stromwall & Larson, 2004). Treatment of trauma is an important component of treatment of co-occurring substance abuse and mental health conditions in community samples (Finkelstein et al., 2004).

Perhaps one of the most striking findings is that in many ways, PWCC were not significantly different than parents who only had substance abuse conditions. They were similar in age, number of children, typical living arrangements and chronic medical conditions. They had similar family histories and reported similar levels of disruption in primary relationships. They did not vary with regard to lifetime history of serious depression or suicidal thoughts. Even so, their co-occurring condition was associated with a history of unsuccessful substance abuse treatment and previous involvement in dependency court suggesting that for this select group of parents, traditional case management strategies have been ineffective. PWCC were no more likely than the substance abuse alone group to have received previous treatment for their mental health condition. Identifying and treating the co-occurring conditions, therefore, may be imperative for them to fulfill their parenting role safely and effectively.

Indeed, the majority of PWCC said they were considerably or extremely troubled by their mental health conditions and that they had a considerable or extreme need for mental health treatment. Our finding that case managers did not validate these needs is particularly disturbing. Despite case managers' assertions that they had confidence in parents' statements, they actually discounted parents' perspectives. There are at least two possible explanations for this finding. First, case managers may have internalized society's negative views of parents who abuse substances. If so, then they may not value parents' opinions despite their statements that they do so. Second, training for case managers in this study may have focused solely on substance abuse treatment, leading them to look only for problems and treatment options associated with substance use: as the saying goes, "If one's only tool is a hammer, then everything is a nail."

*Limitations*

Before discussing implications of this exploratory study, several limitations are important to consider. This was not a random sample of families within child welfare, thus generalization beyond this group is limited. The small initial sample size and missing data on some variables led to very small *n*s for some analyses; these factors combined to shrink the number of cases to 21 for the analyses of matches between case managers' and parents' assessments. The statistical power of the significance tests thus was undermined. In addition, there were multiple comparisons for the relatively small sample which may result in an increase in Type I error.

The method of determining which parents had a mental health condition also limits the findings. While we feel the constructed variable is a conservative measure because it did not rely on judgments about the parent's behavior or observed symptoms, future research should be confirmed by a standardized measure like the Diagnostic Interview Schedule (Robins, Helzer, Croughan & Ratcliff, 1981) which yields a psychiatric diagnosis for interview subjects. However, this method was not available in this secondary analysis. Therefore, the results should be considered exploratory.

*Implications for Working with Parents in Child Welfare Settings*

Despite these limitations, the findings hold practice implications. First, case managers need to be trained to recognize co-occurring conditions. If their failure to acknowledge parents' needs is due to their holding oppressive attitudes, then anti-oppression training is called for. If this failure is due to a lack of

understanding of mental health conditions and treatment, then training regarding appropriate treatment modalities is needed.

Integrated treatment has been demonstrated to be effective for individuals with cooccurring conditions (Finkelstein, et al., 2004; Minkoff, 2001; Najavits, 2001); it needs to be further specialized by gender and psychiatric condition (Stromwall & Larson, 2003). Since most parents involved with child protection are women, caseworkers' understanding of the complicated relationship among a trauma history, resulting mental health conditions and subsequent substance abuse is critical (Najavits, 2001). Many behavioral health practitioners were trained to separate substance abuse and mental health problems, believing that complete abstinence was necessary before accurate mental health diagnoses could be made. An integrated treatment model allows practitioners to address both conditions simultaneously. Innovative practice models also incorporate parenting practices into treatment (SAMSHA, 2004). The availability of integrated treatment should be a concern for practitioners. While many localities are moving toward integrated treatment, its accessibility varies due to funding and eligibility. When accessibility of treatment is limited, the timelines delineated in the AFSA pose formidable barriers for PWCC (Risley-Curtiss, Stromwall, Hunt & Teska, 2004; Glennow, 2003).

*Implications for Research*

Advances have been made in recent years in collecting valid and reliable data on families in the child welfare system. In particular, more systematic information has been collected regarding child characteristics related to outcomes. Yet there is still a significant lack of consistent information about parents and their experience in the child welfare system. Future research should address this knowledge gap to improve family outcomes. As one part of this effort, important constructs such as "compliance with court orders," "treatment," "case management" and "reunification" need to be clearly and consistently operationalized.

Given the findings of this study, further research is needed to better understand the specific mental health conditions experienced by parents who are engaged in the child welfare system. More research is also needed regarding both the availability of integrated treatment and its impact on parenting.

Child welfare services come from a strong tradition of concern for the well-being of children potentially at risk of abuse or neglect, emphasizing parent change. Over the past two decades, the role of parental substance has become the focus of intervention efforts. Given these findings, it is now imperative to assess the mental health conditions of parents in addition to their use of substances in order to develop appropriate and effective intervention strategies. By doing so, we will better meet the needs of abused and neglected children and their families.

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