Children and Youth Services Review 47 (2014) 10–17

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Infant risk and safety in the context of maternal substance use

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ARTICLE INFO

Article history:
Received 6 April 2013
Received in revised form 23 September 2013
Accepted 21 October 2013
Available online 29 October 2013

Keywords:
Infants
Substance-dependence
Domestic violence
Child protection

ABSTRACT

Substance-exposed infants are extremely vulnerable due to biological, environmental and systemic risk factors that commence in pregnancy and are compounded by the postnatal caregiving environment. Substance-dependent mothers face unique challenges in caring for an infant while managing drug use or pharmacotherapy. The vulnerability of infancy therefore requires thorough assessment of risk and a prompt response from service providers. Drawing upon a prospective case-study of twenty women accessing a specialist alcohol and other drug obstetric service, this article explores the factors which contributed to infant risk or safety from the perinatal period to the end of the infant's first year. Data sources included structured interviews with counsellors and child protection workers and semi-structured interviews with mothers. The findings demonstrate continuing exposure to risk identified in pregnancy, including substance use and domestic violence, and inadequate follow-up of infants after discharge from hospital. The ability of an obstetric provider to conduct accurate risk assessment was evident. In addition, a sub-group of infants at higher risk of removal from maternal care was identified. The argument is made for a differential response by the service system to ensure women in greatest need are provided with extensive support when infants are most vulnerable and mothers most open to help.

1. Introduction

All infants, due to total dependence on a caregiver to meet their needs, are vulnerable. Substance-dependent infants are extremely vulnerable due to biological, environmental, economic and systemic risk factors often beginning in pregnancy and compounded by the postnatal care-giving environment (VCDRC, 2000). Substance-dependent mothers face unique challenges in caring for infants while managing drug use or pharmacotherapy. This complexity in the mother/infant dyad requires thorough assessment of risk and a prompt response from service providers. Consequently, many substance-exposed infants are brought to the attention of child protection services in the perinatal period, particularly prior to discharge from hospital when vulnerability is heightened. Once they enter the child protection system, infant cases are more likely to be substantiated and to result in placement in out-of-home care where they tend to remain longer than other children (Zhou & Chilvers, 2010).

While perception of risk is ubiquitous in child protection practice, few studies report how risk is experienced and enacted (Stanford, 2010 p. 1067–1068). Equally, limited attention has been given to the subjective experience of substance-dependent women involved with child protection services (Davies & Krane, 2006). This article draws upon a prospective case-study of twenty women accessing a specialist alcohol and other drug (AOD) obstetric service. Two perspectives are presented: those of service providers and mothers to demonstrate the need for a differential response to risk when problematic parental substance use has been identified in the perinatal period.

2. Literature review

Data from the U.S. (Havens, Simmons, Shannon, & Hansen, 2009), the U.K. (Crome & Kumar, 2007) and Australia (Bartu, Sharp, Ludlow, & Doherty, 2006) indicate that approximately 5% of women use substances during pregnancy; although underreporting by women, and limited screening by hospitals, suggests these estimates are likely to be lower than actual rates (Anthony, Austin, & Cormier, 2010). Substance-use frequently continues in the postnatal period, and together with mental health problems and domestic violence, is present in the majority of notifications to child protection services in Australia (Council of Australian Governments, 2009), the U.K. (Forrester & Harwin, 2008) and the U.S. (Blythe, Heffernan, & Walters, 2010). Annual reviews of the deaths of children known to Child Protection conducted in the state of Victoria, Australia, repeatedly demonstrate that infants under twelve months of age are most likely to come to harm (VCDRC, 2000, 2012). While they vary in scope and approach, particularly in relation to mandatory reporting of unborn infants, where differences are found across and between countries, child protection systems generally seek to intervene early when in-utero substance use has been identified; the response, however, can vary greatly. For example, U.S. federal law mandates notification of infants exposed to in-utero substance use. Although the intent is to support pregnant women, there is potential in some states for prosecution on the grounds of child abuse (Drescher Burke, 2007). Child

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http://dx.doi.org/10.1016/j.childyouth.2013.10.021

protection systems in Australia are also operated by individual states and territories, with differences in mandatory reporting requirements; child protection policy nevertheless reflects an underpinning philosophy of harm reduction. The aim is to improve pregnancy outcomes, prevent or ameliorate the severity of parenting difficulties, assist mothers in recovery and reduce the need for involvement with statutory child protection services (Anthony et al., 2010). This approach is also evident in the U.K. where the policy response is to promote access to alcohol and other drug treatment, mental health services and parenting education for mothers (Gilchrist & Taylor, 2009). Obstetric services therefore play a critical role in the identification of at-risk infants and in initial decision-making to activate the formal service system, either through notification to statutory child protection, or through referral to child and family welfare services (Campbell, Jackson, Cameron, Smith, & Goodman, 2000). However, questions have been raised regarding the requisite skill and knowledge of professionals other than child protection workers in conducting risk assessment (VCDRC, 2000).

Concern with the reliability of risk-assessment has resulted in widespread use of risk assessment instruments to guide decision-making. Yet, even with the use of standardised instruments which have become central to child protection practice (Gillingham, 2006), variability in the appraisal of risk and confidence in performing assessments have been noted amongst child protection workers. Regehr, Bogo, Shlonsky, and LeBlanc's (2010) study of 96 Canadian child protection workers found that worker variables including age, level of stress and ability to engage family members correlated with confidence in performing assessments rather than the level of risk assessed. This finding has significant implications for infant practice in the context of maternal substance use. Concern for vulnerable infants is likely to increase worker anxiety and drive risk-averse practice, particularly after high profile media events of serious harm to infants or children (Connolly & Smith, 2010). Substance-dependent parents in the U.K. have been noted to resent child protection intervention if they perceive it to be based on judgement rather than evidence about parenting practices and to be more likely to respond with antagonism (Buchanan & Corby, 2005). Faced with confrontational behaviour, workers are more likely to assess child risk as higher, as noted amongst participants in LeBlanc, Regehr, Shlonsky, and Bogo's (2012) Canadian study. The association between substance use and violence noted in U.K. child protection samples (Stanley, Miller, & Richardson Foster, 2012) is likely to further contribute to a 'culture of fear' pervading practice (Davies & Krane, 2006) leading to a spiral of mutual mistrust between parents and workers that may paradoxically leave the most vulnerable infants and children most exposed to risk. Studies conducted in the U.K. indicate that when domestic violence combines with the secrecy, resistance, denial and hostility that often characterises interactions between substance-dependent parents and service providers, workers may be more inclined to avoid contact with families (Forrester & Harwin, 2008) or to direct attention to mothers rather than the perpetrator of violence (Stanley, Miller, Richardson Foster, & Thomson, 2011). For their part, mothers experiencing domestic violence may be reluctant to ask for help for fear of being directed to separate from partners as noted in the U.K. (Stanley et al., 2012) and Australia (Walsh, 2002). It has been proposed that the concept of 'readiness to change' understood in relation to alcohol and other drug use may be applicable in situations of family violence (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008; Humphreys, Thiara, & Skamballis, 2011); the process of intervention may, therefore, be an important factor in outcomes in relation to both substance use and family violence.

Various approaches to managing risk in child welfare have been recommended including improved engagement with parents (Darlington, Healy, & Feeney, 2010; Davies & Krane, 2006) and increased interagency collaboration in infant practice when maternal substance use has been identified (McGlade, Ware, & Crawford, 2012). The perinatal period has been referred to as 'a window of opportunity' in which women re-evaluate domestic violence (Pulido, 2001); many strive to become abstinent or, at the very least, to change their drug habits, as reported in Mayet, Groshkova, Morgan, MacCormack, and Strang (2008) and Radcliffe's (2011) U.K. studies. It is also a time when preparedness by mothers to be honest with health care providers, in the best interests of the infant, has been noted by Australian obstetric services (Phillips et al., 2005). The perinatal period may, therefore, be an ideal time to engage substance-dependent women in working towards an improved trajectory for themselves and their infants.

3. Method

3.1. The policy and practice context

There is no legal mandate in Australian legislation to support intervention with unborn babies but duty of care is considered imperative. Some child protection systems are able to receive reports for the purpose of support to expectant women but concern must be for the infant's wellbeing in the postnatal period (Mathews, 2008). Despite potential to intervene early in the development of problems, the Australian practice response to substance use in pregnancy is inconsistent with some hospitals notifying all newborn infants and others using discretionary powers. Child protection responses to infants deemed at risk prior to birth are similarly inconsistent (Wickham, 2009).

The present study was conducted in the State of Victoria which has mandatory reporting requirements for specific professional groups including the medical profession. Alternatively, reports can be made to community-based intake for vulnerable families not requiring a statutory response. Since the enactment of new legislation in 2007, Victoria has been able to formally receive notifications of unborn infants. In the absence of other concerns, substance is not considered sufficient grounds for notification in the pre or postnatal period. Victorian policy guidelines encourage health care providers to notify the statutory Child Protection service when women who have lost the care of previous children present at an obstetric service as this is considered a significant risk factor in child maltreatment. Case-planning meetings are generally held for all neonates considered at risk prior to discharge from hospital. Family Group Conferences are not mandated and are held at the discretion of Child Protection workers. The study was located at the Women's Alcohol and Drug Service (Women's ADS) at the Royal Women's Hospital, the state's largest provider of health services to pregnant women and newborn infants. Approximately 60 women access the service each year, half of whom who are brought to the attention of Child Protection in the pre or postnatal period on a case-by-case basis.

3.2. Research design

The overall aim of the study was to understand the trajectory for substance using women and their infants in the first 12 months of the infant's life and the role of the service system in responding to their needs. The research question addressed in this paper is: What risk and protective factors influenced outcomes among substance-exposed infants at infant age 12 months and how did the service sector, particularly the statutory child protection service, respond? The study was a mixed-method prospective case-study with two units of analysis: communication and collaboration between the Women's ADS and CP in the perinatal period and a twelve-month follow-up of individual women accessing the Women's ADS.

Data sources were:

1) The Women's ADS Client Assessment Tool which lists client demographics, psychosocial and risk assessment conducted by staff as routine intake procedure and case notes made after each contact with women accessing the service.
2) Structured interviews with Women's ADS counsellors to understand assessment of risk in infancy and corresponding referral pathways for each participating woman and her infant.
3) Structured interviews with CP workers to ascertain infant progress through the child protection system from notification to the making