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Integrated treatment programs for pregnant and parenting women with problematic substance use: Service descriptions and client perceptions of care

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ABSTRACT

Integrated treatment programs comprehensively address the unique and varied needs of pregnant and parenting women with problematic substance use. Despite the growth of these programs and evidence supporting their effectiveness, a clear picture of services that comprise integrated treatment is lacking. To address this gap in knowledge, we explored the services provided by 12 integrated treatment programs in one Canadian province. We found that integrated programs routinely provided substance use and mental health services, yet there was marked variability in other supportive services that address other central needs of women, such as prenatal and primary care, therapeutic childcare, housing and transportation support. Using survey data, we further examined client perceptions of care within integrated treatment programs (N = 106) compared to standard treatment programs (N = 207), and thematically analyzed qualitative feedback provided by integrated program clients to gain insight into how services may or may not be promoting positive perceptions of care. We found that integrated treatment program clients perceive their care more positively than clients in standard treatment programs and services provided impact on these perceptions. Implications for treatment development and research are discussed.

1. Introduction

1.1. Substance use in pregnant and parenting women

While rates of substance use are higher among men than women (Keyes, Grant, & Hasin, 2008; Rush et al., 2008; Tjepkema, 2004; Wilsnack et al., 2000), evidence suggests that this gender gap has been narrowing over the past 20 years (Bloomfield, Gmel, Neve, & Mustonen, 2001; Holdcraft & Iacono, 2002; Keyes et al., 2008; McPherson, Casswell, & Pledger, 2004; Seedat et al., 2009; Steingrimsson, Carlsen, Sigfússon, & Magnússon, 2012). Notably, research has found that substance use in women peaks during their reproductive years (Cook et al., 2017). Recent data from the 2016 Canadian Community Health Survey indicate that the highest proportion of heavy drinking for women was among those aged 18 to 34, with 23.4% reporting that they are heavy drinkers (Statistics Canada, 2017). Similarly, in the United States, more than 50% of women of reproductive age use alcohol and approximately 13% use other drugs (McHugh, Wigderson, & Greenfield, 2014). These prevalence rates suggest that many of the women accessing substance use treatment may be pregnant and/or parenting. As such, consideration of the unique needs of this population in terms of engagement, retention, and provision of treatment is essential.

There are numerous, well-documented barriers that pregnant and parenting women experience that may hinder access to and engagement with treatment. Women with problematic substance use are more likely than men to have co-occurring mental health disorders, low social support, and current and/or historical experiences of physical and sexual abuse and trauma (Cook et al., 2017; Cormier, Dell, & Poole, 2004; Currie, 2001; Finnegan, 2013; Poole & Issac, 2001; Rush et al., 2008)—all of which can negatively impact on the treatment process and outcomes (Compton, Cottler, Jacobs, Ben-Abdallah, & Spitznagel, 2003; Grella, 1997; McKay et al., 2005; Moos, 2007; Project MATCH Research Group, 1997). Other barriers include the problematic substance use of significant others (Desrosiers, Thompson, Divney, Magriples, & Kershaw, 2015; Howell, Heiser, & Harrington, 1999; Jones, Tuten, & O'Grady, 2011), fears of judgment from care providers

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(Eggertson, 2013; Finnegan, 2013; Greaves & Poole, 2007; Stone, 2015), involvement of child welfare, financial and legal troubles, and lack of childcare (Cormier et al., 2004; Currie, 2001; Greenfield, Brooks et al., 2007; Grella, 1997).

Recognition of the unique needs and barriers of women who are pregnant and parenting women within the context of problematic substance use has led to the development of comprehensive or integrated treatment models (hereafter referred to as "integrated programs") that address these needs and challenges (Finnegan, 2013; Milligan et al., 2010).

1.2. Integrated programs for pregnant and parenting women

Integrated programs have been designed to provide services that address women's physical and mental health and social-economic well-being concurrently with substance use treatment, ideally at a single access point (Finnegan, 2013; Finnegan, Hagan, & Kaltenbach, 1991; Hume & Bradley, 2007; Milligan et al., 2010). Such programs seek to overcome the traditional fragmentation of services across sectors, and to engage women in a comprehensive and coordinated set of services that address needs within the unique context of their substance use. These principles are consistent with best practices for the treatment of women with problematic substance use, including the emphasis on promoting both maternal and child health and the development of healthy relationships (Currie, 2001; Greaves & Poole, 2007; Health Canada, 2006). Programs offer a variety of services, both on-site and through partnering agencies. In addition to substance use treatment, services may also address needs related to mental health, prenatal care, parenting and child development.

Meta-analytic evidence suggests that integrated programs are similarly effective in improving substance use compared to standard care. However, when examining outcomes relating to maternal mental health, attendance at prenatal visits, parenting and child outcomes, integrated programs are associated with superior outcomes (Milligan et al., 2010; Milligan et al., 2011a; Milligan et al., 2011b; Niccols et al., 2012). One challenge in interpreting these findings is the lack of a consistently identified theoretical and service model and associated heterogeneity in the services offered by integrated programs (Meixner, Milligan, Urbanoski, & McShane, 2016). Further, within the extant literature, there is troublingly little information about the service model and its delivery to support reliable replication (Henderson et al., 2012). Given the potential far-reaching benefits of integrated programs, clearly defining the integrated program service model is essential. This will aid in future research to identify active components of this treatment, set the stage for multi-site research, and advance efforts to more widely implement these programs.

To begin to address this gap in the literature, Meixner and colleagues (Meixner et al., 2016) worked with stakeholders involved in research, service provision, and policy to identify the key aspects of integrated care for pregnant and parenting women with problematic substance use. Using concept mapping methodology, several key processes and values were identified. Processes included accessible, holistic, and coordinated care for women and children that was tailored to specific and changing needs. These were embedded in a number of key values, including strength-based/focused, client empowerment, non-judgmental and non-stigmatizing attitudes, and valuing lived experience. While the results of this study were helpful in identifying key processes and values that underlie effective integrated care, a clear picture of services offered by integrated programs is lacking and is crucial for program development and evaluation.

1.3. Present study

To address these limitations, this study sought to further our understanding of the integrated program service model. A secondary exploratory objective was to broadly examine client perceptions of care in integrated programs compared to standard treatment. Particular attention was paid to aspects of the integrated program service model that women perceived as enhancing or hindering positive perceptions of care. Evaluating client perceptions of care in concert with current service models can facilitate the mobilization of findings into service delivery by identifying service areas that work effectively or may be in need of improvement (Rush & Project Team of the Ontario Drug Treatment Funding Program – Client Perception of Care Project, 2015). There has been little research on client perceptions of care within both integrated and standard treatment models. Most research has examined client perceptions of care solely within the integrated program, without a comparison treatment. Furthermore, the extant research, which largely utilizes qualitative methods, suggests that women perceive experiences in the programs positively, but provides less detail on the specific aspects of service provision that may underlie these positive perceptions. Therefore, to further understand the services comprising integrated programs, this study examined these programs in the Canadian province with the largest number of integrated programs to provide a description of services offered. Clients were additionally surveyed to gain an understanding of their perceptions of care, including the services that they perceived as supporting success, and their views on ways in which programs could be improved.

2. Materials and methods

The current study was undertaken as part of a mixed methods evaluation of integrated programs across Ontario, Canada (Milligan, Usher, & Urbanoski, 2017). All study procedures were reviewed and approved by the Research Ethics Boards at Ryerson University and the Centre for Addiction and Mental Health.

2.1. Service descriptions: participating programs

Of the 34 integrated programs in Ontario, we purposively selected 12 to represent the geographic diversity of the province, years of operation, program size, and client characteristics (including substances most commonly identified as problematic). Data on these characteristics were acquired from Ontario's Drug and Alcohol Treatment Information System (DATIS). Of programs contacted, no reply was received from three of the programs on our initial list. These programs were therefore replaced with programs with similar characteristics based on the initial selection criteria.

Ultimately, the 12 participating programs were located in both rural and urban areas, with populations ranging from < 50,000 to over 1 million (n = 3, pop. < 120,000; n = 5, pop. 120,000–300,000; n = 4, pop. > 300,000). Most (n = 9) had been in operation since 2003, whereas three had been in operation/funded as an integrated program since 2012. Unpublished data from the 2013–2014 fiscal year provided by DATIS indicate a range of 12 to 275 (M = 88.0, SD = 91.52) new client registrations for participating programs. Between June to November 2015, site visits were conducted at each of the 12 integrated program sites. Interview, survey, and questionnaire data were collected from integrated program stakeholders, including management-level staff, front-line staff, and clients. Programs were provided with a $100 gift card to a book/toy store for participation in the larger study and clients were provided with a $10 gift card for questionnaire completion.

2.2. Service descriptions: procedures

Service descriptions were compiled using two strategies. First, prior to each site visit, all participant programs nominated one staff member to fill out a survey to identify the types of services that they offered in-house and/or through a partner agency or organization. Second, using a structured guide, qualitative interviews were conducted with at least one management and one front-line staff person from each program to obtain information on service components, and the extent and processes