



Improving pregnancy outcomes among high-risk mothers who abuse alcohol and drugs: Factors associated with subsequent exposed births



Therese Grant^{a,b,*}, J. Christopher Graham^b, Cara C. Ernst^b, K. Michelle Peavy^{b,c}, Natalie Novick Brown^a

^a University of Washington School of Medicine, Department of Psychiatry and Behavioral Sciences, 180 Nickerson St., Suite 309, Seattle, WA 98109, United States

^b University of Washington Health Sciences Administration, Alcohol and Drug Abuse Institute, 180 Nickerson St., Suite 309, Seattle, WA 98109, United States

^c Evergreen Treatment Services, 1700 Airport Way S., Seattle, WA 98134, United States

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ABSTRACT

Parental alcohol and drug abuse is a factor in approximately 15% of the cases investigated by the child welfare system and in approximately one quarter of cases with substantiated maltreatment. While substance abuse treatment is generally an essential component of child welfare family plans, a relatively low proportion of substance abusing mothers involved in the child welfare system complete treatment, which typically results in placement of their children in substitute care and the beginning of a new generation of adaptive problems. This longitudinal study explores whether loss of an index child due to substance abuse is associated with risk of a subsequent alcohol/drug-exposed birth in a sample of 795 substance-abusing mothers enrolled in the Washington State Parent–Child Assistance Program (PCAP). Results indicate that at program exit, over one-fifth of these women had a subsequent birth (SB) after the birth of their index child. Among these women, over half (i.e., 56.3% or 12.3% of the entire sample) used alcohol and/or drugs during the subsequent pregnancy. Consistent with our main hypothesis, the adjusted odds of having a SB were increased nearly two-fold for women who had the index child removed from their care. Furthermore, among mothers with subsequent births, the adjusted odds of having an *exposed* SB were increased three-fold if the index child had been removed from the mother's care. We discuss implications of our findings for child welfare policy and practices.

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1. Introduction

Maternal alcohol and drug abuse during pregnancy continues to be a serious social and public health concern (NIDA, 2011). The 2012 National Survey on Drug Use and Health reported that among pregnant women, 5.9% used illicit drugs, 8.5% consumed alcohol, and 2.7% drank alcohol in a binge pattern (Department of Health and Human Services, DHHS, Substance Abuse and Mental Health Services Administration, SAMHSA and Center for Behavioral Health Statistics and Quality, 2013). Prenatal alcohol and drug exposure adversely affects growth and development of the fetus and may put an exposed child at risk for a range of physical and neurodevelopmental problems that persist across the lifespan (Mattson & Riley, 1998; Nolan et al., 2005; Singer et al., 2002; Streissguth et al., 2004; Thompson, Levitt, & Stanwood, 2009). Postnatally, a birth mother with an untreated substance abuse disorder is likely to provide a home environment compromised by myriad problems associated with addiction (Conners et al., 2004; Grant et al., 2011; Lustbader, Mayes, McGee, Jatlow, & Roberts, 1998; Marsh, Ryan, Choi, & Testa, 2006).

Evidence from studies meeting standards of scientific rigor indicates that parental alcohol or drug abuse may be a factor in 50 to 79% of child welfare cases in which young children are removed from custody, and in approximately 25% of cases with substantiated maltreatment. Among investigated cases, the prevalence of parental substance abuse is lower (approximately 15%) (Testa and Smith, 2013; Young, Boles & Otero, 2007). In these cases substance abuse treatment generally is an essential component of child welfare family plans, with the aim of reducing risk to children by treating maternal addiction, improving maternal functioning, and if possible achieving family reunification (Smith, 2003). Unfortunately, treatment completion rates are low among women in the U.S., ranging from 32% for outpatient treatment (SAMHSA, 2009a) to 52% for short-term inpatient (SAMHSA, 2009b). Treatment completion rates vary according to how they are measured. Among substance abusing mothers who are involved in the child welfare system, rates that take into account completion of all treatment requirements (e.g., detoxification, inpatient, and intensive outpatient) range from 22% (Choi & Ryan, 2006) to 26.5% (Gregoire & Schultz, 2001). Choi, Huang, and Ryan (2012) report a higher rate of 56.5% in their investigation of rates for completion of only one treatment episode, however the ratio of treatment referrals to treatment completions is 0.34, indicating that only about one-third of treatment referrals were completed. One reason for seemingly lower rates of treatment

* Corresponding author at: University of Washington, 180 Nickerson St., Suite 309, Seattle, WA 98109, United States. Tel.: +1 206 543 7155; fax: +1 206 685 2903.

E-mail address: granttm@u.washington.edu (T. Grant).

completion among substance abusing mothers involved in the child welfare system may be that women with substance use disorders commonly have co-occurring psychological disorders (Choi & Ryan, 2007; Miles, Sviki, Kulstad, & Haug, 2001; Minnes, Singer, Humphrey-Wall, & Satayathum, 2008; Zilberman, Tavares, Blume, & el-Guebaly, 2003), which not only put them at risk for poor or disrupted parenting (Grant et al., 2011) but also increases the likelihood of substance abuse treatment dropout (Bernstein, 2000). When a mother who has delivered a substance-exposed infant fails to comply with her alcohol and drug treatment regimen, the likelihood of relapse or ongoing substance abuse increases along with the risk that if she does become pregnant she will have a subsequent substance-exposed infant.

We located only four published studies that examined recurrent childbearing among substance-abusing mothers. In a longitudinal study of 931 women in the child welfare system who were enrolled in an Illinois Title IV-E Waiver Demonstration project (Ryan, Choi, Hong, Hernandez, & Larrison, 2008), investigators found that 94% of the 151 subsequent substance-exposed infants born during the study period were the offspring of women who had had a prior substance-exposed infant. Another study found that among the 240 opioid- or cocaine-dependent pregnant women enrolled in a comprehensive substance abuse treatment program, 98.3% of the mothers previously had given birth to a child prenatally exposed to alcohol or drugs (Kissin, Sviki, Morgan, & Haug, 2001). In a related vein, Smith and Testa (2002) found that families involved with the child welfare system due to prenatal substance abuse ($N = 142$) were more likely to have subsequent allegations compared to families involved in the system due to other child maltreatment allegations ($N = 135$). This finding was largely attributable to mothers who had subsequent births with accompanying substance-exposed infant allegations. In fact, these researchers suggested that in their maternal sample a substance-exposed infant allegation may have predicted subsequent prenatal drug use. In a fourth study, Wright, Schuetter, Fombonne, Stephenson, and Haning (2012) examined postpartum outcomes, including family planning and childbearing. This was an observational study of 103 mothers who used methamphetamines prenatally and were enrolled in a perinatal addiction clinic in Hawaii. Controlling for other predictors, these investigators found that compared to mothers who retained custody of the index child, those who lost custody at or within six months of birth were nearly three times more likely to have a poor family planning outcome, defined as not using a family planning method postpartum or having a subsequent pregnancy within six months after the birth of the index child.

The purpose of the present study is to examine factors that predict subsequent births and subsequent alcohol or drug-exposed births among mothers enrolled in the Parent–Child Assistance Program (PCAP), a three-year case management intervention in Washington State. PCAP is well-positioned to examine this question because the program serves substance-abusing pregnant and parenting mothers throughout the state who have multiple other risk factors that contribute to disrupted parenting or loss of child custody (Grant et al., 2011). In particular, we expand on the limited body of research in this area by testing the hypothesis that women who have their youngest child removed by the state will be more likely to have a subsequent birth and more likely to have a subsequent exposed birth than women whose youngest child remains with them (i.e., is not removed). Further, because research on family reunification intervention services in mothers with substance abuse problems has demonstrated the benefits of comprehensive, multidisciplinary services (Choi & Ryan, 2007; Grant et al., 2011; Marsh, D'Aunno, & Smith, 2000; Newmann & Sallman, 2004; Suchman, Pajulo, DeCoste, & Mayes, 2006), we use multivariable statistical modeling to take into account substance abuse treatment and other community services received during the intervention. We surmise that mothers who fail to comply with their substance abuse treatment regimens both are more likely to have the index child removed and also are

more likely to give birth to another substance-exposed baby. We discuss the implications of our findings for child welfare policy and practices.

2. Methods

2.1. Overview

The Parent–Child Assistance Program (PCAP) is based on a framework of relational theory, motivational interviewing concepts, and harm reduction principles designed to help mothers replace risky behaviors with healthy adaptive ones (Grant, Ernst, & Streissguth, 1999; Grant & Huggins, 2013). Participants are paired with case managers (CMs) who develop a positive, empathic relationship with their clients, help them identify personal goals, and work with them to take incremental steps toward achieving those goals. CMs have a caseload of 16 families, conduct home visits approximately twice per month, connect women and their families with comprehensive community services, coordinate services among providers in this multidisciplinary network, and assure that children of parents participating in the program are in safe and stable home environments. CMs are highly trained and closely supervised by clinicians who are credentialed in the mental health, social work, or the chemical dependency fields.

2.2. Participants

Women are eligible to participate in PCAP if they: 1) are pregnant or up to 6 months postpartum; 2) self-report heavy alcohol and/or illicit drug use during the index pregnancy; and 3) are ineffectively (or not at all) engaged with community social services. Participants are referred to PCAP by community providers familiar with the intervention through brochures, presentations, and word of mouth (e.g., social workers, public health nurses). PCAP clinical supervisors review each referral for eligibility and contact women who meet the inclusion requirements.

A total of 1355 mothers were enrolled in PCAP from January 1, 1998, through June 30, 2008, at program sites in nine Washington State counties (King, Pierce, Yakima, Spokane, Grant, Cowlitz, Skagit, Clallam, and Kitsap). Of these, 261 (19.3%) did not complete the program because they disengaged or disappeared ($n = 117$), moved out of the area ($n = 60$), withdrew from the program ($n = 54$), died ($n = 14$), went into long-term incarceration ($n = 9$), or transferred to another intervention program ($n = 7$). An additional 156 (11.5%) participated in PCAP for three years but did not complete the exit interview (reasons included no-shows, could not be located, were too busy, and did not want to end PCAP). An additional 143 clients (10.6%) participated in PCAP and completed exit interviews, but their data are excluded from this analysis because they did not consent to use of their data for research purposes ($n = 40$); exited early (<30 months in PCAP, $n = 18$); were interviewed outside the 6-month post-PCAP follow-up window ($n = 3$); were enrolled under age 18, which precluded use of their data for research ($n = 19$); had a subsequent birth that occurred before the index child was removed ($n = 19$)¹; miscarried or had an index child who died ($n = 13$); transferred to PCAP from another program without an intake interview ($n = 9$); or had a fetal alcohol spectrum disorder (FASD) and were enrolled in a separate study ($n = 22$). [FASD, a medical condition caused by prenatal alcohol exposure, involves brain damage that impairs executive functioning and other cognitive skills. The mental health sequelae of FASD are diagnosed in DSM-5 as Neurodevelopmental Disorder associated with prenatal alcohol exposure, or ND-PAE.] Data from the remaining 795 participants provided the basis of this analysis. Institutional Review Board approval was obtained from the Washington State IRB. Informed consent was obtained from participants. A certificate

¹ This exclusion was necessary because the main purpose of the study was to examine whether or not child removal predicted first subsequent birth, so any subsequent birth necessarily had to come *after* removal (if there was one).

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