Factors Affecting Mother-Child Visiting Identified by Women with Histories of Substance Abuse and Child Custody Loss

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The influence of maternal substance abuse upon the placement of children in out-of-home care increased significantly in the 1980s and 1990s, affecting mother-child visiting in numerous ways. Content analysis of interview data from 15 mothers with histories of illegal drug use and child custody loss provides insight into five major factors that can promote or inhibit visiting: (1) mother's drug use and health status, (2) effects of visits on the child, (3) transportation, (4) scheduling/visit settings, and (5) support of others.

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Over the last two decades, parental substance abuse has become an increasingly significant factor in the placement of children in out-of-home care. For example, the prevalence of alleged substance abuse in one or both parents for cases investigated by child protective services in Washington state rose from roughly 30% to 40% between 1994 and 1997 (Marshall & English, 1999). An examination of records of 749 children in San Francisco placed into care in 1991 through 1992 revealed that 30% of parents had documented substance abuse histories (Takayama, Wolfe, & Coulter, 1998). When neglect was the reason for placement, the incidence of parental substance abuse rose to 51%. The Child Welfare League of America reported that 37% of referrals to public child welfare agencies in 10 states were related to problems associated with parental drug or alcohol use (Curtis & McCullough, 1993).

Literature Review

Studies that have focused on mothers with substance use histories have reported similar or even higher percentages of child custody loss than for parental substance use in general (Neuspiel, Zingman, Templeton, DiStabile, & Drucker, 1993; Raskin, 1992; Streissguth, Grant, Ernst, Phipps, & Gendler, 1994). Nair and colleagues (1997) found a 43.4% incidence when 152 mothers with histories of substance abuse were followed during their child’s first 18 months. Kearney, Murphy, and Rosenbaum (1994) noted in their grounded theory study that 69% of the 68 mothers who were active cocaine users reported losing temporary or permanent custody of their children.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) strongly encourages visiting between children and their parents who have temporarily lost child custody. Visits serve numerous purposes: they maintain family relationships, help families cope with changing relationships, empower and inform par-
ents, enhance children's well-being, help families confront reality, provide a time and place to practice new behaviors, promote accurate assessment, and provide a transition to home (Hess & Proch, 1993). Yet for a variety of reasons, visits do not always occur at the frequency suggested by court mandates, case plans, or agency protocols.

For example, in a five-year longitudinal study of children in New York City entering out-of-home care for the first time in 1966 ($N = 624$), Fanshel and Shinn (1978) collected data about parental visiting patterns over four time periods. These researchers noted a direct inverse relationship between the length of time the child was in out-of-home care and the number of parental visits. As the length of time in care increased, parental visits decreased. Furthermore, children who had the maximum number of visits permitted or frequent irregular parental visits during the first year were twice as likely to be discharged from care as those children who had fewer or no parental visits in the first year. Although the study cited reasons such as parental mental or physical illness, child neglect or abuse, and family problems as contributing to placement in care, the use of drugs or alcohol by parents was not explicitly examined. Fanshel and Shinn (1978, p. 85) "viewed parental visiting as highly important for the welfare of the children." Later studies have supported the inverse relationship between parental visiting and length of stay in out-of-home care (Mech, 1985; White, Albers, & Bitonti, 1996).

Proch and Howard (1986) reviewed 256 case records of children in out-of-home care in Illinois and noted that 70% of the records contained visiting plans. The authors found a strong connection between these written plans and the actual occurrence of parental visits and suggested that if more visits were written into a plan, perhaps more visits would occur. When Grigsby (1994) examined 46 cases of children in out-of-home care who were expected to be eventually reunified with their parents, he noted that only 13 (28%) of the cases explicitly documented parent-child
visits. Grigsby recommended that child welfare workers be educated about the importance of maintaining and supporting the attachment relationship between parent and child.

White and colleagues (1996) reviewed the records of 41 children under the age of 10 who were placed into out-of-home care for at least six months and then were returned to a parent’s custody. Of the 41 cases, 32 (78%) involved parental substance abuse. The researchers found a significant difference (p < .001), with more parents who had increased social worker (case manager) contact visiting their children than those parents who did not.

In an earlier study that also addressed case manager issues, Hess (1988) conducted 15 in-depth interviews with caseworkers from a variety of public and private agencies involved in child welfare services and policy. Using content analysis, she identified eight categories affecting caseworker considerations in planning the frequency of visits: 1) court orders and influence of others; 2) agency policy and norms; 3) agency resources; 4) placement-related considerations (including distance and foster parents’ schedules, reactions, requests, and cooperation); 5) case phase, case goal, and parental progress toward case goal; 6) children’s needs, requests, and characteristics; 7) parental needs, requests, and characteristics; and 8) parent-child relationship. As Hess noted, “Caseworkers reported the need to constantly balance conflicting needs, requests, and expectations. The most frequently mentioned conflict was balancing the parent’s right to frequent and increasingly unrestricted contact and the concern for the child’s physical and emotional well-being” (p. 320–321).

Child welfare workers in Hess’s (1988) study also noted that in general, children in out-of-home placements benefit from visits with their parents. Borgman (1985) provided objective support for this when he reported on 47 boys in a youth correction facility, noting that increased visits between youths and their parents were associated with less major misconduct by the youths. Cantos, Gries, and Slis (1997, p. 324) examined behavioral corre-
lates of two groups of children in out-of-home care and noted that "the children who were visited regularly were rated as exhibiting fewer behavior problems, especially problems of an internalizing nature (i.e., withdrawal, depression, anxiety) than the children who were visited irregularly or not at all." The authors noted that although some children may have increased externalizing behaviors after a visit, even these behaviors decreased somewhat with regular visiting.

The child's adjustment to out-of-home care and other factors are also important. For example, in a retrospective chart study of 23 children under the age of 3 in out-of-home care who had been referred for child psychiatric evaluation and consultation (Gean, Gillmore, & Dowler, 1985), children were noted to exhibit an increased amount of distressful symptoms following visits if visits were held in the parent's home, if the child already had been in several out-of-home care placements, or if the child's caregiver was opposed to or anxious about visits.

In summary, studies regarding visiting between children in out-of-home care and their parents have identified the significance of such factors as the frequency of visits, the incorporation of visits in the case plan, and the effects of visits on the child's behavior. The role of maternal substance abuse in visiting, however, has not been specifically addressed. As Benedict and White (1991) have noted:

Visiting is probably a proxy indicator for more complex relationships of parent, child, and agency... We know that regular visiting may imply commitment and ability to work with the agency toward a child's return home, but we have only anecdotal information about the parents who do not visit regularly. (p. 56)

The present study sought to identify factors that affect mother-child visiting when maternal substance abuse is a contributing reason to the placement of a child in out-of-home care.
Method

Content analysis of a larger qualitative retrospective exploratory study from three sites was conducted using interview data from 15 women with histories of cocaine or heroin use who had lost custody of one or more children (32 children total).

Participants

Women were recruited from three treatment programs from urban and rural areas and through referrals from prior participants. Inclusion criteria included self-report of child custody loss related to the use of heroin or cocaine. The majority of the 15 participants regularly received some type of public assistance (93%). Eleven women were Caucasian (73%), two were African American (13%), and one each was African American/American Indian and American Indian/Caucasian. Their average age was 30.8 years (range = 23–38), and they had diverse educational backgrounds, ranging from completing grade 10 to 2.5 years of college. At the time of the first interview, 80% of the women had abstained from drug or alcohol use for one year or less (range = 5 days–3 years), although drug or alcohol abstinence was not an inclusion criteria.

The average number of children lost to the mother’s custody was 2.1 (range = 1–4); 59% of the 32 children were between the ages of 3 and 11 at the time of custody loss. At the time of the initial interviews, 19% of the children had been returned to their mother’s custody (at least on a part-time basis), 41% of the children remained in temporary placement, and another 41% had been permanently placed out of their mother’s custody.

Procedure

Unstructured and semistructured interviews were conducted at the participant’s residence or treatment site. All interviews were audiotaped and transcribed, with the average recorded portion
being 61 minutes. Each participant received $20 compensation at the time of her initial interview. Follow-up interviews occurred with four women. The larger study (Kovalesky, 1997) used grounded theory methodology to analyze the interview data from the 15 women.

In the current report, content analysis (Downe-Wamboldt, 1992) was used to categorize excerpts that were related to visiting issues from the participants' transcripts. A total of 50 excerpts from the 19 interviews were identified. Of the 19 interviews, four contained no pertinent material on visiting issues. The number of excerpts related to visiting issues in the remaining 15 interviews ranged from two to eight in each interview.

An excerpt was defined as interview data that primarily focused on issues related to visiting. Once the content of the interview changed from this focus, the particular excerpt was considered complete. As the excerpts were identified, factors that either promoted or inhibited visiting between the mother and her child were developed and refined. Interrater reliability was established regarding category determinations.

**Results**

Five factors influencing visiting were identified from the mother's stories. These factors were: (1) the mother's drug use and health status, (2) the effects of the visits on the child, (3) transportation issues, (4) scheduling/visit setting issues, and (5) support for the visits by pertinent others.* Each factor, with supporting examples from the data, is discussed below.

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* Pertinent others were persons who had authority or influence over the mother's contact with the child and/or reunification with the child. Specifically, these persons included child welfare workers, foster or adoptive families, substance abuse treatment staff, family members of the mother, the child's father or his family, and legal persona such as attorneys, guardian ad litems, review boards, and judges. Although not applicable to this study, mental health therapists also can serve in the role of pertinent other.
Mother’s Drug Use and Health Status

The mother’s suspected or confirmed active drug use was frequently identified as a reason for visits not occurring. Sometimes it was pertinent others who imposed the visiting restriction; at other times, it was the participant herself. As one mother explained:

A few times I didn’t go see them because I was too loaded. That would just hurt really bad but I still didn’t get up and go see them.... My mom would tell me that she had talked to [the daughter] and [the daughter] wants to know when I’m gonna come see her and if I’ve left her. And I would still cry but I would still keep getting loaded.

Some mothers spoke of how the visits caused them such emotional distress that they relapsed following a visit. “Every time I’d go there I’d end up drinking or you know, something, because I wanted to take them back so bad.”

A few participants noted that their continued drug use was ignored or denied by relative caregivers. For example, one participant had informally given custody of her only child to her mother. This arrangement allowed the child’s mother to continue using drugs and to care for the child whenever she wanted. “He would stay with me for like a couple of days and...at night time when he would cry and stuff I just didn’t have the patience, you know. So my mom would come and take him from me.”

Participants also noted that their physical or mental health also inhibited visits with their children. One mother who had an active visiting program during the initial interview ultimately gave up custody of her two children because of her depression and concerns that she could not properly maintain her mental health and be a good parent simultaneously. Still another mother was hospitalized for lengthy periods for endocarditis related to her intravenous drug use. The mother’s inability to see her daughter during this time created additional stress for her.
Participants noted that when they were compliant with recommended activities, such as being active in a drug and alcohol treatment program, keeping health appointments, or pursuing safe and sober housing, pertinent others were more likely to support visits than when the participant’s lifestyle had not changed from the time of custody loss.

*Effects of the Visits on the Child*

The potential or actual effects of visits on the child were another factor in determining whether visits occurred. If these effects were perceived as beneficial, visits were encouraged. If potential or actual effects of the visit were perceived as unhealthy or unhelpful for the child, visits were more likely to be limited.

For example, mothers and pertinent others expressed concerns about whether a child would be upset after visits. One mother provided evidence of such an incident:

One time she was visiting me when I was living in my apartment. And the worker said, “Well, we need to get your coat on. It’s time...to go.” And she [the daughter] just threw a fit. “No. I’m not ready to go...I want to stay with mom!” You know, it’s like melt, melt.

The mother’s closing words indicate that even though her child was upset, the mother did not interpret the child’s behavior in a negative manner. Nor was it a deterrent to future visits. In fact, the child’s behavior reinforced to this mother that she was important in the child’s life. In contrast, another participant shared that she did not want her children to visit with her while she was in treatment because she thought the experience “would be harder” for the children than waiting until the mother had completed treatment.

One mother described how her children showed acting-out behaviors when visits did not occur following custody loss:

I went 40 days and didn’t have any contact with them.... My kids were having a very hard time adjusting. They
wouldn't eat, they were very withdrawn, angry, you know, hitting the other children in the household and really taking their aggressions out. So we thought it was best that if I just didn't have any contact and let them get adjusted with being in the foster care and then after a time, you know, work my way back into it. Now that I've done that, though, I can see that was totally wrong. I should have had contact from the very beginning. Because they felt abandoned....They didn't know if I was coming back.

This mother had voluntarily placed her two sons in out-of-home care, after a supportive child protective services (CPS) worker made numerous home visits encouraging the mother to seek treatment. In telling her story, the mother shared her initial concern about whether her children would be angry with her at their first visit. But not only were the children happy to see her, the mother received validation from one of them regarding her decision to pursue treatment. "After about an hour I took my oldest one to the bathroom...he just grabbed on to me and said, 'You're not mad anymore. I like that a lot better.'" This mother eventually regained custody and moved into rental housing near an after-care program.

Other children expressed concern for their mothers during visits, with some comments indicating role-reversal between parent and child. The mother who had informally given custody of her only child to her grandmother shared this vignette:

It got to the point where he [a 6-year-old] would say, "Get in the car, grandmom. Let's go find my mom." "Mom," he would tell me, "Mom, aren't you tired of being on the streets? I want you to come home."

Some mothers whose children had observed the mothers' drug-using behaviors hoped that through visits, the children could discuss these behaviors with them or with available professionals. For example, one mother of a 10-year-old girl was hoping that her daughter could spend the summer with her and participate
in the youth program at the transitional apartment complex at which the mother was now living. "She could go in with other kids her age and talk about how she feels about my drug use and how it affected her...I think she really needs that." This participant and others also shared concerns about how during visits older children would respond to new siblings in the mother's custody and whether the older child would feel misplaced or upset.

Another potential effect of visits on the child concerned the child's health. For example, one child suffered from chronic ear infections. Because of this, the foster parents limited visits, informing the mother that less traveling would be better for the child.

**Transportation Issues**

Getting to and from the visits was another significant factor affecting visits. Because of limited substance abuse treatment sites, some mothers had to travel hundreds of miles away from their homes to receive treatment. In other instances, the children had to be placed with relatives or in family foster homes that were often some distance away from the mother's treatment site or residence. One mother of three summarized some of these difficulties.

I had to go where they [the foster parents] live and at times my car broke down. And I didn't have a way out there. So because of that they switched it to where I have to see them at the CPS office with the worker. And you know, they like hold it against me that I missed those visits...It's not that easy to take a bus all the way to [xx] on the weekend when you're pregnant.

One mother who had voluntarily given up custody of her children but was initially too toxic to see them shared how proximity of treatment and the children was taken into account. "I went to see the kids. The CPS office was just right down the street ...[CPS]
transferred the kids from [one office to another] because I didn’t want the kids too far away.”

Having money for bus fares or gas and other car expenses was also vital for getting to and from visits. Likewise, women who spent considerable time getting to visits desired that the visits be proportionate to their travel time. One woman (who had delivered her child by cesarean section) traveled two hours one-way on a bus to visit with her baby. One day she arrived ten minutes late and so had only 50 minutes visiting with her child before the scheduled one-hour visit was terminated.

**Scheduling/Setting Issues**

The frequency of visits was also affected by the schedules of the mother, the child welfare worker or other visit coordinator/supervisor, and the child’s caregivers. Participants cited examples of busy or limited staff from child welfare offices who were not able to arrange and/or supervise visits. Several mothers told how their own busy schedules—often related to court mandates—interfered with visits. Some foster parents had work schedules and appointments for themselves or other children that interfered with visits. Trying to coordinate all of these schedules—the mother’s schedule with that of the child welfare staff and the child’s caregiver—could be a difficult task.

Sometimes arrangements for the child or the mother precluded visits. For example, one child was taken on a two-week-long vacation trip with the foster family. Several mothers were incarcerated or placed in treatment centers that prohibited contact with those outside of the facility for a specified time, thus restricting visits. Mothers of children placed in closed adoptions had no feedback or contact with their children.

**Support by Pertinent Others**

Pertinent others were those persons who had influence over whether the mother could see or be reunified with her child. For example, foster parents could provide much positive support for
the women. One mother who had voluntarily relinquished two children at birth and had two daughters in a state-supported family foster home told this story:

[The foster mother] lets her know who I am and that I am their mother. And it makes me feel really good. And it makes me feel really good that I got to meet the foster mom. This was the first foster parent that I’ve ever met...If they could manage to get me more visits they would. I do believe they would. Because...I’ve completed a parenting class. I’ve completed an anger management class. My drug evaluation recommends no treatment any more.

This story again exemplifies how one category of concerns can affect others, in this case, how support from pertinent others may be based on the mother’s situation (she is abstinent and building trust through compliance). But this story also suggests that scheduling visits may have been problematic.

Lack of support from the child’s caregivers for the mother’s recovery and visits with her child was also noted by some participants. One woman shared that her child’s foster parents seemed interested in adopting the child and that the foster parents had already informally changed the name of the child. Another woman whose youngest child was living with her ex-husband and his mother told how her intent to stay drug-free was threatened during an overnight visit: “At 4:30 in the morning I was woke up with an eight ball [fractional drug portion] sitting in front of my face...I didn’t use...I got up and left.” Another mother shared how her ex-husband wanted sexual relations in exchange for visiting her children.

Support from child welfare workers for mother-child visiting was also quite important. Some women realized that this support was often based on a mother building trust with her worker. As one mother described:

[The visits are] still done at the CPS office but she [the child welfare worker] comes and goes out of there....I take
my girls to the bathroom. I’m basically doing the mother thing now with them. [Interviewer: “So there’s trust there.”] Yeah. There’s a trust there...I’ve worked extremely hard for this trust.

Several participants shared how they believed the attitudes of pertinent others regarding persons who use drugs or certain drugs impacted visits. The child welfare worker “was against me at the beginning anyway because I don’t think she understands...heroin....If they were pills or something—alcohol—I think they would probably...be more acceptable.”

Another new mother whose baby was in a group home for infants experiencing opiate withdrawal shared how she felt uncomfortable during her visits to the home, which was 40 miles away:

I just felt like people were looking at me weird... I didn’t know a damn thing about babies. What do I do when she cries? And of course she’s addicted to methadone so she’s different from most newborns. I didn’t even know how to take her clothes off or change her diaper....I was afraid to ask because...I was already worried that they were thinking I was an incompetent mom.

This mother relapsed and eventually lost her parental rights to this child. At the initial and follow-up interviews (14 months apart) in this study, however, the mother was raising another child, was in a strong recovery program, and had secured stable housing.

Discussion

Although the factors in this study were determined independently of those identified by prior researchers, in retrospect some resemblance can be seen to those determinants identified by Hess (1988). For example, Hess’s category of Court Orders and Influence of Others has some crossover with this study’s factor, Sup-
port by Pertinent Others. Likewise, Hess's categories of Agency Resources and Placement Related Considerations share similarities with Transportation Issues and Scheduling/Setting Issues in the current study. Both studies identified aspects of the child and of the parent (in this study, the mother) as important factors.

Yet because of the timing and nature of Hess's study, specific influences of maternal substance abuse on mother-child visiting were not explicated by the sample of caseworkers in her study. In the current study, maternal drug use is a major factor. If treatment for the mother's substance abuse problem is not imminently available following child custody loss, the mother may find it difficult to maintain her abstinence for visits with her child. Indeed, visits were less regular for many of the participants immediately following custody loss, when the mothers' lives were unstable and the influence of drugs/alcohol was high. Even when the mother was abstinent, the typical visiting plan for most of the participants in this study with a child in nonrelative family foster care was one hour a week. Furthermore, as some of the participants noted, the visits themselves can elicit such strong emotional responses regarding the custody loss that a relapse can occur following a visit, jeopardizing future visits. Ready access to a counselor, 12-step sponsor, substance abuse treatment program, or other source of support seems essential to promote mother-child visiting.

Few participants in this study had support for child rearing from the child's father. Entering drug/alcohol treatment frequently involved giving up custody of a child to relatives or the state because the treatment setting did not allow mothers to keep their children with them. Although some mothers in this study were able to have their children with them in later phases of treatment, additional treatment settings that admit mother-child pairs could help break the pattern of visits/relapse/no visits frequently seen in this population. Unfortunately, many of these settings currently have waiting lists or can accommodate only young chil-
dren. Furthermore, little, if any, research has been done about the recovery status of mothers who have their children in treatment with them versus mothers who do not. Yet if results from prior studies are supported (Fanshel & Shinn, 1978; Mech, 1985; White et al., 1996), increased visiting between mothers and children, especially during the first year after custody loss, is expected to decrease the length of time that children spend in out-of-home care. Future studies also need to examine the impact of additional visits per week or visits of increased duration.

In the current study, as mothers restabilized their lives, other factors that could influence mother-child visiting sometimes appeared. For example, mothers with outstanding arrest warrants had to pursue dissolution of these warrants through court appearances or incarceration. Other mothers had to relocate to distant areas to avoid associates who continued to use drugs or alcohol. Such positive changes in the mother’s drug use and health status resulted in other conditions that negatively affected visiting, such as transportation problems and setting issues.

In addition to the sequential interaction among factors, participants also encountered concomitant interactions, such as between the mother’s drug use and health status and support by pertinent others, or between transportation issues and scheduling concerns. If one of the factors was addressed directly, sometimes another could be diminished. At other times it was necessary to directly address all identified factors.

Support by pertinent others for visits is essential for successful visiting. One way of providing this support is preparing parents, children, and caregivers for visits. Historically, a time was arranged for the child and parent to visit together, but not much attention was given to what would occur during those visits. Over the last decade, increasing emphasis on the content of the visits has occurred (Simms & Bolden, 1991). Loar (1998, p. 41) noted that “parents often have to learn how to play with and enjoy their child’s company during visits” for visits to be enjoyable for both
parents and children alike. Webster-Stratton (1992) and her colleagues have incorporated playing with children and praising children as the initial foci of their ongoing parenting program.

Support for pertinent others regarding mother-child visiting is also important. Case workers who have established trust with a particular mother, only to have the mother misuse that trust, need support from others to avoid developing a punitive approach toward all mothers with histories of substance use. A team approach about important decisions such as whether a mother can have unsupervised visits can prevent any one staff member from making a decision that can have negative outcomes. Although many cases already have numerous persons involved, case managers frequently have such large caseloads that getting input from pertinent persons and coordinating their recommendations is difficult and time-consuming. Encouraging smaller caseloads at budget hearings and other funding determinations is an ongoing struggle.

Furthermore, transportation, scheduling, and setting difficulties are also often related to the limits of operational budgets. Some local communities facing limited financial resources have developed volunteer programs to assist with both supervision and transportation for visits (Dore & Harnett, 1995). Some agencies are now using neutral locations for visits, outside of child welfare offices (Perkins & Ansay, 1998; Simms & Bolden, 1991).

The rising influence of substance use among mothers of children in care also necessitates that pertinent others become knowledgeable about addiction and recovery processes (Dore, Doris, & Wright, 1995). Scott and Campbell (1994) noted several obstacles impeding a family-centered approach by child welfare and drug and alcohol treatment staffs in Australia. Citing psychological, ethical, conceptual, professional, and organizational factors, the authors provide suggestions to promote family centeredness. Programs to assist child welfare workers, foster parents, and others in improving assessment and intervention skills also are becoming more widely available (e.g., Pride [Child Welfare League of America 1997]; Gregoire [1994]; Scott & Campbell [1994]).
Conclusion

The possibility of regaining or maintaining child custody can be a major motivating factor for women to seek treatment and comply with treatment recommendations (Carten, 1996; Corser & Adler, 1993; Kearney et al., 1994). Mother-child visiting is an essential step toward maternal primary caregiving of a child. Although visits are central components of temporary custody arrangements, practical issues often inhibit these visits from occurring on a regular basis. The factors identified in this study offer a preliminary way of reviewing cases to assess why visits may or may not be occurring when substance abuse is a contributing factor in the custody loss.

References


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