Substance Abuse and Mental Health Services Administration
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Treatment Episode Data Set

The TEDS Report

May 9, 2013

Characteristics of Pregnant Teen Substance Abuse Treatment Admissions

Teenage pregnancy is a serious public health issue because of the risk for short- and long-term negative consequences for the mother and child.[1,2] Compared with pregnant adults, pregnant teens are at increased risk for having pregnancy-related complications, premature delivery, and delivering babies with developmental problems.[1,2] Pre- and postnatal health problems for both mother and child are compounded when the mother uses alcohol or drugs.[3] This is of particular concern for pregnant teens because they tend to recognize their pregnancies later than adult women; pregnant teens are more likely to engage in binge drinking and drug use early in their pregnancies.[4,5]

Research shows that when mothers use drugs during pregnancy, babies born to these mothers can exhibit signs of addiction at birth,[6] and long-term effects of maternal prenatal drug use have been observed in children at 6 years of age.[7] These problems can be amplified by other factors associated with teenage mothers, including poverty, homelessness, exposure to violence and crime, poor health, and lack of access to health care.[2,6] Substance abuse treatment provides an important opportunity to halt cycles of substance use and abuse among pregnant teens and, in turn, prevent or mitigate the short- and long-term impact of teen maternal substance use.

The Treatment Episode Data Set (TEDS) is a national data system of annual admissions to substance abuse treatment facilities that provides, among other things, information on pregnant teen admissions. This report uses combined data from 2007 to 2010 to describe female admissions aged 12 to 19 that were pregnant at treatment entry, hereafter referred to as "pregnant teen admissions."[8] Selected comparisons are made between these admissions and female teen admissions that were not pregnant at treatment admission ("other female teen admissions").

Note that TEDS is a census of all admissions to treatment facilities reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) by State substance abuse agencies.

IN BRIEF

- Between 2007 and 2010, about 57,000 female teen admissions aged 12 to 19 were admitted to substance abuse treatment annually; of these, 4.0 percent (an annual average of about 2,200 admissions) were pregnant
- Pregnant teen admissions were 3 times more likely than nonpregnant female teen admissions to report receiving public assistance as a primary source of income (15.0 vs. 5.3 percent)
- Of nonpregnant female teen admissions that were not in the labor force, 74.0 percent reported that they were students, whereas only 44.2 percent of pregnant teen admissions reported school as their reason for not being in the work force
- More than half of pregnant teen admissions (51.0 percent) reported using drugs or alcohol in the month prior to treatment entry

Because TEDS involves actual counts rather than estimates, statistical significance and confidence intervals are not applicable. The differences mentioned in the text of this report have Cohen's h effect size ≥ 0.20, indicating that they are considered to be meaningful.

Overview and Demographic Characteristics

Between 2007 and 2010, about 57,000 female teen admissions aged 12 to 19 were admitted to substance abuse treatment annually. Of these, 4.0 percent (an annual average of about 2,200 admissions) were pregnant.

More than half of both the pregnant teen admissions and the other female teen admissions were non-Hispanic White (53.4 and 59.4 percent, respectively) (Table 1). Pregnant teen admissions tended to be older than their nonpregnant counterparts. For example, 61.5 percent of pregnant teen admissions were 18 to 19 years old compared with 34.8 percent for other female teen admissions. Likewise, 2.9 percent of pregnant teen admissions were 12 to 14 years old compared with 13.2 percent for other female admissions.

In comparison with other female teen admissions, pregnant teens were less likely to have completed high school (34.7 vs. 51.0 percent) or to have received any college education (3.3 vs. 10.6 percent). These differences are notable in light of the finding that the pregnant admissions were typically older than the other female teen admissions. About 30 percent of admissions in both groups reported having no primary source of income support at treatment entry (33.9 percent for pregnant teen and 28.5 percent for other female teen admissions).[8] For admissions 18 years old or younger, this status means that their parents had no primary source of income. Pregnant teen admissions were 3 times more likely than nonpregnant female teen admissions to report receiving public assistance as a primary source of income support (15.0 vs. 5.3 percent).

Although similar proportions of both groups reported not being in the labor force (54.8 percent of pregnant teen admissions and 57.5 percent of other female teen admissions), the reasons for not being in the labor force differed.[8] Of nonpregnant female teen admissions that were not in the labor force, 74.0 percent reported that they were students, whereas only 44.2 percent of pregnant teen admissions reported school as their reason for not being in the work force. More than three quarters (77.6 percent) of pregnant teen admissions expected to pay for their treatment through government assistance, such as Medicaid, compared with 60.3 percent of other female teen admissions.[8]

Table 1. Demographic Characteristics among Female Admissions Aged 12 to 19, by Pregnancy Status: 2007 to 2010

Demographic Characteristic	Pregnant Admissions (Percent)	Other Admissions (Percent)
Race/Ethnicity		
Non-Hispanic White	53.4	59.4
Non-Hispanic Black	16.9	12.5
Hispanic	19.3	17.8
American Indian/Alaska Native	5.0	3.7
Asian/Pacific Islander	0.9	2.5
Other	4.4	4.2
Age		
Aged 12 to 14	2.9	13.2
Aged 15 to 17	35.7	51.9
Aged 18 to 19	61.5	34.8
Education		
Less than High School	65.3	49.0
High School/GED Only	31.5	40.4
Some College/College Degree	3.3	10.6
Primary Source of Income Support		
None	33.9	28.5
Wages/Salary	17.6	23.1
Public Assistance	15.0	5.3
Other	33.5	43.1
Employment		
Full Time	4.6	5.7
Part Time	7.6	11.5
Unemployed	33.0	25.2
Not in Labor Force	54.8	57.5
Student*	44.2	74.0
Expected/Actual Primary Source of Payment for Treatment		
Government Payments, Such as Medicaid	77.6	60.3
Self-Pay	7.9	12.3
No Charge	6.0	7.2
Other Health Insurance Companies	2.9	7.6
Blue Cross/Blue Shield	1.3	4.6
Other	4.3	8.0

* These admissions represent the proportion of teen treatment admissions that were not in the labor force because they were students. Other "not in labor force" categories include homemaker, retired, disabled, inmate of institution, and "other."

Source: SAMHSA Treatment Episode Data Set (TEDS), 2007-2010.

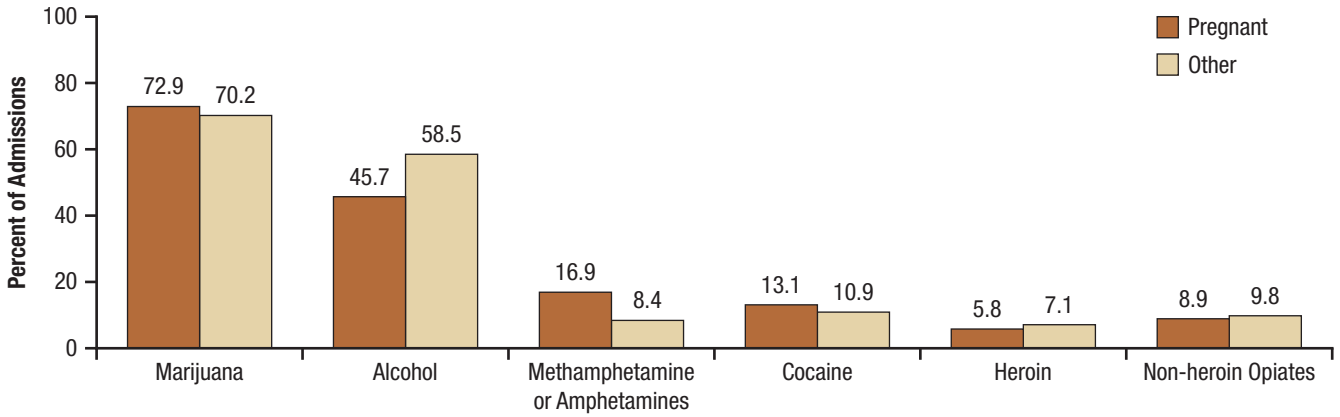
Substances of Abuse

Similar proportions of marijuana abuse were found among admissions in the two groups, with 72.9 percent of pregnant teen admissions and 70.2 percent of other female teen admissions reporting abuse of this drug (Figure 1). Pregnant teen admissions were twice as likely as other female treatment admissions to report abuse of methamphetamine or amphetamines (16.9 vs. 8.4 percent). Other female teen admissions were more likely than pregnant teen admissions to report alcohol abuse (58.5 vs. 45.7 percent).

Characteristics of Use

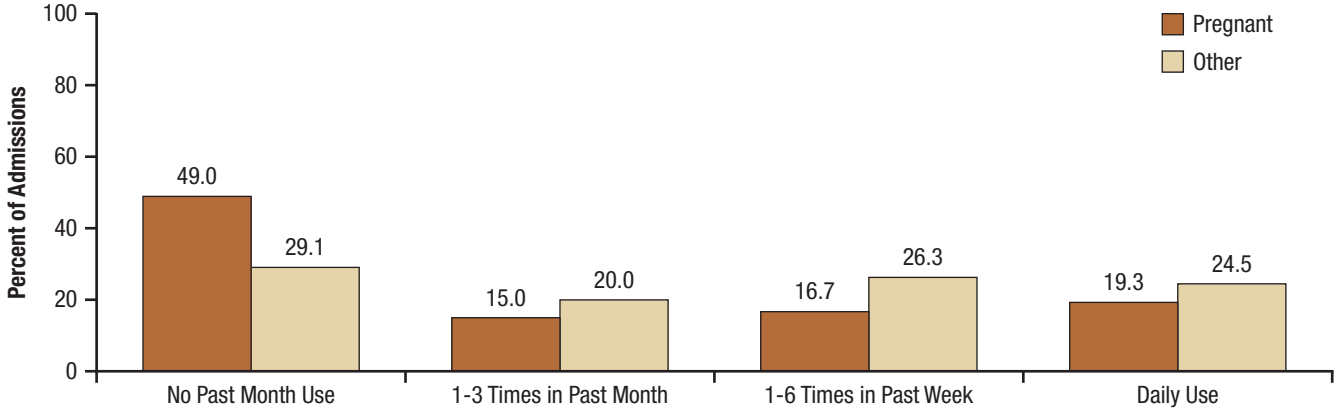
Differences were seen between pregnant and other female teen admissions regarding the frequency of substance use in the month prior to treatment admission (Figure 2). About half of pregnant teen admissions (51.0 percent) reported using drugs or alcohol in the month prior to treatment entry, which was substantially lower than that of other female teen admissions (70.9 percent). However, pregnant teens were about as likely as other teens to report daily use (19.3 vs. 24.5 percent).

Figure 1. Selected Substances of Abuse among Female Admissions Aged 12 to 19, by Pregnancy Status: 2007 to 2010



Note: Percentages will not sum to 100 percent because more than one substance of abuse can be reported at treatment entry.
Source: SAMHSA Treatment Episode Data Set (TEDS), 2007-2010.

Figure 2. Frequency of Substance Use in the Month Prior to Treatment among Female Admissions Aged 12 to 19, by Pregnancy Status: 2007 to 2010

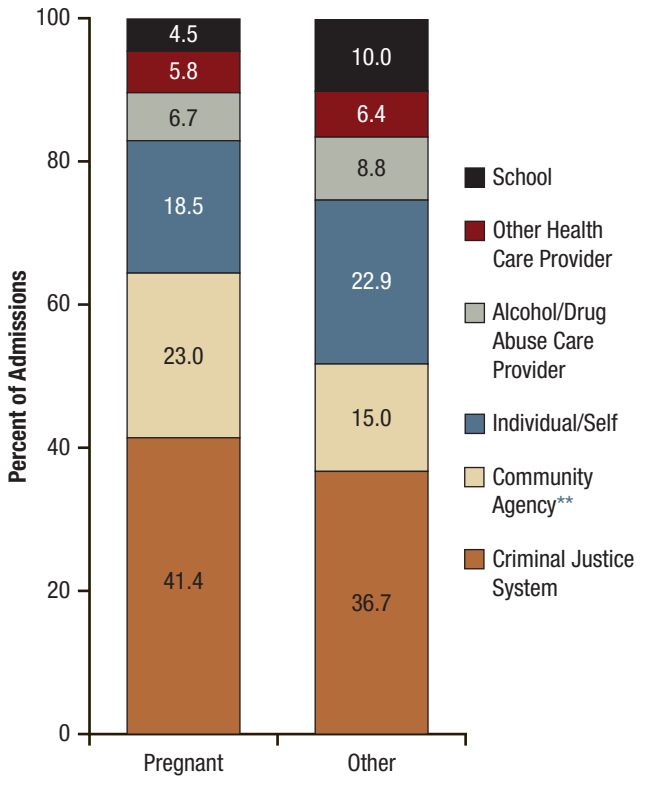


Note: Percentages may not sum to 100 due to rounding.
Source: SAMHSA Treatment Episode Data Set (TEDS), 2007-2010.

Referral Source

The most common referral sources for both pregnant teen and other female teen admissions were the criminal justice system, community agencies,[9] and individual/self-referrals to treatment (Figure 3). However, the proportions of admissions from these referral sources varied by the two groups of admissions. In particular, pregnant teen admissions were more likely than other female teen admissions to be referred to treatment by community agencies (23.0 vs. 15.0 percent). Other female teen admissions were more likely than pregnant teen admissions to be referred to treatment through the school system (10.0 vs. 4.5 percent).

Figure 3. Selected Sources* of Referral to Treatment among Female Admissions Aged 12 to 19, by Pregnancy Status: 2007 to 2010



* The percentages of pregnant teen admissions and other female teen admissions that were referred to treatment through employers or employee assistance programs (EAPs) were so small that they could not be graphically displayed; thus, the percentages do not sum to 100 percent.

** Referrals to treatment from community agencies include referrals from self-help groups, churches, and Federal, State, or local government agencies that provide social services.

Source: SAMHSA Treatment Episode Data Set (TEDS), 2007-2010.

Discussion

This report highlights many important differences between pregnant teen and other female teen admissions at treatment entry that have implications for both treatment and prevention programs (Table 2). With respect to treatment, more than half of pregnant teen treatment admissions reported drug or alcohol use in the month before treatment initiation, and one fifth indicated daily use.

Pregnant admissions to substance abuse treatment may require specialized medical services at treatment entry.[10] For example, pregnant teen admissions may need referrals to medical services for standard prenatal care; birth control counseling and parenting courses may be beneficial as well. Moreover, relapse prevention may be increasingly important as the pregnant teen reaches the end of treatment or pregnancy.[10]

Table 2. Summary of Differences Found between Pregnant Teen and Other Female Teen Admissions: 2007 to 2010*

Pregnant teen admissions were MORE likely than other female teen admissions to be or to report:

- 18 to 19 years old
- No past month use of any substance of abuse
- Government assistance (such as Medicaid) as the expected/actual primary source of payment
- Less than a high school education (0-11 years)
- Public assistance as a primary source of income support
- Methamphetamine or amphetamine use
- Referral to treatment from community agencies, such as self-help groups, churches, and Federal, State, or local government agencies that provide social services

Other female teen admissions were MORE likely than pregnant teen admissions to be or to report:

- A student
- 12 to 14 or 15 to 17 years old
- Having at least some college education
- Alcohol use
- Any past month use
- Referral to treatment from school

* The differences shown in this table have Cohen's h effect size > 0.20, indicating that they are considered to be meaningful.

Source: SAMHSA Treatment Episode Data Set (TEDS), 2007-2010.

Poverty was common among pregnant teen admissions, as indicated by the relatively high percentages of admissions reporting Medicaid assistance and reporting either none or government assistance as their primary source of income support. Taken together, these findings indicate that pregnant teens presenting to treatment face substantial economic problems that, coupled with their addiction, may impact their ability to become healthy, productive, independent adults in the long term. Ongoing psychosocial assessments for pregnant teen admissions may be important to identify needed services and resources that will in turn support their stability and recovery.[10]

Finally, the top substances used by female teen admissions, regardless of pregnancy status, were marijuana and alcohol. Prevention and intervention services may be particularly beneficial if they focus on these substances, especially given the documented misperceptions teens have about the risks associated with using them.[11] Public health campaigns directed toward teens may also profit from emphasizing both direct and indirect consequences of substance abuse, such as pregnancy, sexually transmitted diseases, and criminal justice system involvement.

End Notes

1. Gilbert, W., Jandial, D., Field, N., Bigelow, P., & Danielsen, B. (2004). Birth outcomes in teenage pregnancies. *Journal of Maternal-Fetal and Neonatal Medicine, 16*(5), 265-270.
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5. Rome, E. S., Rybicki, L. A., & Durant, R. H. (1998). Pregnancy and other risk behaviors among adolescent girls in Ohio. *Journal of Adolescent Health, 22*(1), 50-55.
6. Office on Child Abuse and Neglect, Children's Bureau, ICF International. (2009). *Protecting children in families affected by substance use disorders*. Retrieved from http://www.childwelfare.gov/pubs/usermanuals/substanceuse/index.cfm
7. Cornelius, M. D., Goldschmidt, L., Day, N. L., & Larkby, C. (2002). Alcohol, tobacco and marijuana use among pregnant teenagers: 6-year follow-up of offspring growth effects. *Neurotoxicology and Teratology, 24*(6), 703-710.
8. The following variables are TEDS Supplemental Data Set items: *Pregnant at Time of Admission, Source of Income Support, Detailed* "*Not in Labor Force*," and *Expected/Actual Primary Source of Payment*. Admissions data were restricted to those from States with reliably adequate response rates for *Pregnant at Time of Admission*.
9. Community agency or agencies include self-help groups, churches, and Federal, State, or local government agencies that provide social services.
10. Substance Abuse and Mental Health Services Administration. (2001). *Quick guide for clinicians based on TIP 2: Pregnant, substance-using women* (DHHS Publication No. SMA 01-3551). Rockville, MD: Author.
11. Substance Abuse and Mental Health Services Administration. (November 26, 2009). *The NSDUH Report: Perceptions of risk from substance use among adolescents*. Rockville, MD: Author.

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The Treatment Episode Data Set (TEDS) is an administrative data system providing descriptive information about the national flow of admissions aged 12 or older to providers of substance abuse treatment. TEDS intends to collect data on all treatment admissions to substance abuse treatment programs in the United States receiving public funds. Treatment programs receiving any public funds are requested to provide TEDS data on publicly and privately funded clients.

TEDS is one component of the Behavioral Health Services Information System (BHSIS), maintained by the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA). TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once. Information on treatment admissions is routinely collected by State administrative systems and then submitted to SAMHSA in a standard format.

There are significant differences among State data collection systems. Sources of State variation include the amount of public funding available and the constraints placed on the use of funds, facilities reporting TEDS data, clients included, services offered, and completeness and timeliness of reporting. See the annual TEDS reports for details. TEDS received approximately 1.8 million treatment admission records from 48 States and Puerto Rico for 2010.

Definitions of demographic, substance use, and other measures mentioned in this report are available in Appendix B of the annual TEDS report on national admissions (see latest report at http://www.samhsa.gov/data/2k12/TEDS2010N/TEDS2010NAppB.htm).

The TEDS Report is prepared by the Center for Behavioral Health Statistics and Quality, SAMHSA; Synectics for Management Decisions, Inc., Arlington, VA; and RTI International, Research Triangle Park, NC. **Information and data for this issue are based on data reported to TEDS through October 10, 2011**.

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