Title
Extrinsic barriers to substance abuse treatment among pregnant drug dependent women

Author
Jessup, Martha Anne

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Abstract

Extrinsic Barriers to Treatment Among Pregnant and Parenting Drug Dependent Women

Martha Anne Jessup

Drug use during pregnancy is a public health problem requiring gender-specific treatment and public policy that fosters treatment enrollment. Punitive actions against pregnant drug users, stemming from two decades of the U.S. War on Drugs, have led to the current pejorative social construction of pregnant drug users. Viewed as dangerous mothers whose behavior, reproductive choice and child custody should be constrained, these women often delay or avoid health care and substance abuse treatment. Poor enrollment in care has been construed as denial and cited as evidence of low motivation for recovery and good mothering. Concerns about drug testing, loss of child custody, arrest and incarceration have been noted as possible reasons for treatment delay. Others have suggested that socially located barriers contribute to drug dependent pregnant women's late entry, or no entry, into treatment.

The objective of this qualitative life history study was to examine patterns of treatment utilization and extrinsic barrier negotiation among 36 pregnant and parenting women. Participants were pregnant or had an infant under one year old and were enrolled in residential perinatal substance abuse treatment in public sector programs within northern California. One-time semi-structured interviews were conducted. Data analysis was guided by the analytic framework of Mandelbaum (1973) to describe dimensions, turnings and adaptations of participants during the time before initiating substance abuse treatment.

Results: Biological, socio-cultural and psychosocial dimensions of participants' care-seeking experiences were identified. The turning was pregnancy. Adaptations included protecting custody, preserving the family, talking to God and doing the right thing. Study participants identified fear of punitive actions from helping institutions and individuals as a major barrier to care. Other extrinsic barriers included substance abuse treatment program-based barriers, partners, the status of opiate dependency and the status of pregnancy. The majority (n=35) of participants sought prenatal care.

Findings describe the transformation of the therapeutic alliance and the gendered impact of the War on Drugs. Study participants' coping strategies suggest that the desire for child custody and concern for fetal and child well-being is a priority and motivates care-seeking despite extrinsic barriers perceived to be threatening to the women's safety and autonomy.

Kathryn A Lee

Kathryn A. Lee, PhD, Professor
Committee Chair

Table of Contents

Chapter One: The Social Construction of Perinatal Addiction

Chapter Two: Barriers to Treatment for Pregnant Drug Dependent Women

Chapter Three: Methodology

Tables

Figures

Chapter One

The Social Construction of Perinatal Addiction

Introduction

Advocates for pregnant drug dependent women and their children believe that perinatal addiction is primarily a health problem requiring gender-specific treatment interventions for the women and their children. National organizations of nurses, physicians and other professionals have endorsed policy statements calling for treatment and prenatal care in lieu of punitive sanctions for pregnant drug dependent women (American Public Health Association, 1990; American Academy of Pediatrics, 1990; American Nurses Association, 1991). Others who view perinatal addiction primarily as a form of deviant maternal behavior have proposed that the use of alcohol and drugs by pregnant women constitutes a crime known as "prenatal child abuse" worthy of prosecution and imprisonment (Coady, 1991).

This chapter examines the central forces in the construction of perinatal addiction in terms of how the problem is currently viewed by the public and by health professionals. These historical and political events which began in the late 1980's include renewed legal attacks on women's

reproductive rights, racism, the rise of the fetal rights movement, and the response of mass and scientific media. The convergence of these events that formed the context and background for this construction of perinatal addiction will be examined.

This polemic regarding the use of addictive drugs during pregnancy emerged in the United States at the peak of the Reagan/Bush War on Drugs. During that period, these historic events and movements collided, igniting a bitter and contentious reaction to the problem of perinatal addiction. These events defined and influenced current U.S. policies and health practices pertaining to the meaning and understanding of drug use during pregnancy and contributed to the creation of barriers to treatment for women who are drug dependent and in need of health care. This legacy produced punitive health and child welfare policy, negative professional attitudes and clinical practice, and questionable ethical stances toward drug-dependent women and their babies. The phenomenon of drug use during pregnancy is at the intersection of these turbulent forces, conferring a unique and solitary status upon drug dependent pregnant women. This recent metamorphosis of perinatal addiction from a public health problem into a primarily legal enterprise defines the social construction of this problem today.

Prevalence

Current prevalence data on the use of alcohol and other drugs by women in the United States come from two major sources, federal survey and empirical research. Federal data sources include the National Household Survey on Drug Abuse (NHSDA), the National Drug and Alcohol Treatment Unit Survey (NDATUS), the Client Data System (CDS) which examines treatment availability and utilization, DAWN (Drug Abuse Warning Network) data drawn from emergency room mentions of drug related morbidity and mortality, and the Center for Disease Control (CDC), which also examines and reports morbidity and mortality data. The other source of data is empirical and descriptive studies of substance abuse and perinatal treatment utilization and outcomes, focusing on women in medical, child welfare and HIV/AIDS related contexts of service provision.

Due to numerous dilemmas in data collection methodologies, not all persons with alcohol and drug problems are captured and accounted for in these traditional data sources. Agency-based data usually measure indicators of problematic drug use and therefore miss drug use per se; this may affect the validity of assumptions drawn from such data (van de Goor, et al., 1994).

In a 1993 re-examination of drug use self-report issues and the National Household Survey of Drug Abuse (NHSDA), the researchers found that women interviewees who had been pregnant between the 1984 and the 1988 survey were more likely to deny ever having used drugs, while those women who were pregnant at the time of the survey were more likely to be honest about their use of drugs in the past (Harrison, Haaga & Richards, 1993). The stigma of self-report may also deter pregnant women from revealing substance use especially if there are consequences to that report, such as criminal prosecution or child welfare actions (Grella, 1996; Hans, 1999).

Health care providers' lack of knowledge about addiction or reluctance to query patients about this "sensitive" subject can also deter accurate estimates of use among pregnant women in obstetric care settings (Chappel & Schnoll, 1977). Hospital data are frequently based on urine toxicology screens, known to be biased because only those women thought to be users are tested (Hans, 1999). This has led to overestimates of drug use among women of color (Chasnoff, Landress & Barrett, 1990), though it is acknowledged that drug use occurs in all ethnic groups and classes as well as in both genders in America (Hans, 1999). While racialized stereotypes of drug users characterized the War on Drugs, research has shown that

statistical data were also vulnerable to racialized analyses of drug use patterns of cocaine. In a re-examination of NHSDA data by Flewelling and colleagues (1991), after adjusting for numerous demographic variables, including socio-economic status, the difference in use rates of cocaine between African Americans and Whites was not significant. Prior to the adjustment, African Americans were four times more likely than Whites to use crack cocaine (Rouse, Carter & Rodriguez-Andrew, 1995).

Studying an in-treatment population is also problematic. While these data are clinically useful, they do not numerically account for, nor describe the experiences of pregnant drug-using women who are not in treatment. Though not examined as yet, significant differences are likely to exist between in-treatment and out-of treatment drug dependent pregnant women. In addition, the federal household survey does not specifically count pregnant women, homeless persons, immigrants, or incarcerated persons as a separate category (Lillie-Blanton, Anthony, & Schuster, 1993). Among women who are incarcerated, 40% report use of illicit drugs in the month preceding their arrest (Snell, 1992) and homeless women are more likely than the general population to have a substance abuse related problem (Smith, North & Spitznagel, 1993). Pregnancy is not noted in any of the

other sources of federal data.

The 1995 Household Survey on Drug Abuse estimated that 6.1% of the US population had used an illicit drug in the past month. Of that 12.8 million, 4.3 million (29.7 % of the drug using population) were women of childbearing age (14-44 years) and reported use of an illicit drug in the previous month (HSDA, 1995). In that study, rates of heavy use of alcohol were comparable for White (1.6%), African American (1.5%) and Hispanic women (1.0 %). For alcohol-related deaths, African American women's mortality rates (6.8 per 100,000) exceed those of White women (2.7 per 100,000). For other drug related deaths, African American women die at a rate of 3.9 per 100,000 compared to White women at 2.9 per 1000,000 (USDHHS, 1994).

NDATUS providers reported on treatment utilization by women in 1992, noting that 53% of all private and public providers had specialized programs for all women and only 29% of providers had programs for pregnant women (Rouse, Carter & Rodriguez-Andrew, 1995). According to the Client Data System (1992), 28% of admissions to publicly funded programs were women; women comprised 40% of admissions for cocaine addiction and greater than 50% of all admits for sedative and tranquilizer

addiction. It is not known how many of these women were pregnant at the time of treatment.

In a national survey of hospitals, it was estimated that 5.5% of women used some illicit drug at some point in their pregnancies (NIDA, 1992). Alcohol and tobacco were used most frequently, at rates of 18.6% and 20.2% respectively (NIDA, 1996). A similar hospital-based study conducted in California in 1992 noted an 11.4% rate of use of alcohol and illicit substances by pregnant women (Vega, Kolodny, Noble, Hwang & Boles, 1993), while a 1989 Illinois study documented a 9% rate of illicit substance use among women enrolled in prenatal care in rural and urban, private and public settings (Chasnoff, 1989a).

Profile of Pregnant Drug Dependent Women

The majority of women in treatment for substance abuse problems are women of childbearing age. These in-treatment women are known to have high rates of violent trauma experiences, sexual assaults and other forms of traumatic stress (Thompson & Kingree, 1998; Amaro, Fried, Cabral & Zuckerman, 1990; Munzenmaier, Meyer, Phil, Struening & Ferber, 1993). A portion of these substance using women also have co-existing mental health problems which may impede their ability to enroll in treatment

programs or may contribute to poor rates of retention (Grella, 1994; Brown, Huba & Melchoir, 1995). Wilmore (1995) described facets of alcohol and drug dependent women's lives in noting that they have stressful family, financial, and legal problems. Many addicted women enrolled in federally funded treatment programs have no vocational skills, poor self-esteem, fewer sources of social support and numerous physical health problems.

The use of smokeable or "crack" cocaine (named for the crackling sound it makes when combusted) by pregnant women is associated with extensive maternal, fetal and neonatal morbidity. Pregnant women who use cocaine during pregnancy have an increased risk for preterm labor and delivery, malnutrition, stroke, heart attack, transient stimulant induced psychosis, abruptio placenta, spontaneous abortion and miscarriage, sexually transmitted diseases, HIV/AIDS, and hypertension as well as other less acute medical and psychological complications (Richardson & Day, 1991; Slutzker, 1992). With exposure to cocaine, the fetus and newborn are at risk for prematurity, state disorganization, reductions in interactive behavior, low birth weight, neurological deficits, feeding problems, learning and behavior problems, gastro-intestinal, cardiac and eye anomalies (Lutiger, Graham, Einarson & Koren, 1991; Neuspiel & Hamel, 1991). Beyond these personal

medical problems associated with alcohol and drug use and dependency, other problems include the disruption of families, exposure to violence and community disorganization, emotional pain and suffering and child abuse and neglect (Barth, Pietrzak & Ramler, 1993).

This description of pregnant drug dependent women presents a picture of lives deeply affected by internal and external stressors. For drug dependent pregnant women, for example, the process of getting to prenatal care and substance abuse treatment can be extremely challenging. "Getting there" takes place in a socially constructed context often fraught with numerous barriers which include lack of child care and transportation, lack of social support for treatment, fear of loss of custody and fear of prosecution. While seeking treatment is challenging due to the addicted persons' intrinsic barriers (Beckman & Amaro, 1986; Thom, 1986; Takeuchi, Leaf & Kuo, 1988), facing extrinsic barriers such as these is also daunting. In addition to traditional barriers encountered by both males and females, pregnant addicts have obstacles that are gender related and focused on their reproductive capacity and expected mothering role. Therefore, the desire/action to seek treatment takes place in a context of extreme need and

dependence on crucial health care services amid the ubiquitous and real possibility of legal action.

In the following description of the social construction of perinatal addiction, "meanings that congeal" (Casper, 1998) around perinatal addiction are explored in order to understand the contextual experience of seeking treatment, as well as the forces contributing to the current status of this phenomenon in the U.S. These forces are deeply intertwined, yet the imprint of each one is visible and enduring on perinatal addiction in the U.S. today.

The War on Drugs and the Impact of Racism

Federal Policy and the War on Drugs

It is estimated that approximately 6% of women admitted to prison are pregnant (Snell & Morton, 1994) and that the majority of women entering jails are there for drug-related charges and are women of child-bearing age, many of whom have two or more dependent children (Jessup & Nantambu, 1994). The period of intense punitive focus on pregnant drug-using women occurred in the center of what has become known as the War on Drugs. While this "war" was aimed primarily at the users of crack cocaine, it was the mainstay of federal policy to control illicit substance use during the

Reagan and Bush administrations. It may also be viewed in the history of the U.S. as the latest in a long series of drug scares. Table 1.1 presents the historical perspective on drug scares in the U.S. and was adapted from Reinarman & Levine (1997).

Table 1.1

Drug Scares in the United States (Reinarman & Levine, 1997)

Anti-opium legislation	1870's
Harrison Narcotic Act	1914
Prohibition (18th Amendment)	1920
Marijuana Tax Act	1937
Marijuana Scare	1960's-1970's
Crack Cocaine Scare	1986-1992

As described by Duster (1997), this anti-drug user campaign also dramatically altered incarceration rates as well as mandatory sentencing patterns in the U.S. The punitive effects of the War on Drugs have been shown to fall disproportionately on poor people and, in particular, on minorities. Duster also notes that, due to the exclusive focus of the War on Drugs on the "street-level seller," the numbers of African Americans incarcerated during this period grew dramatically. In the U.S. the prison population (state and federal) grew from 330,000 to 804,000 and federal drug convictions increased 213% from 1981 to 1991 (Bureau of Justice

Statistics, 1992; Clark Foundation, 1992). In most cities African Americans constitute only 15-20% of drug users, yet they account for 50-65% of all persons arrested for drug crimes (Flanagan & McGuire, 1990; NIDA, 1990). By 1997, the rate of imprisonment of women had drastically increased from the previous decade (National Women's Law Center, 1995). Duster (1997) discusses the "selective aim of the artillery in the war on drugs" as the cause of these racial imbalances. Differential sentencing for possession and sales of powdered cocaine (used and sold predominantly by Whites) as opposed to crack cocaine (mainly used and sold by African Americans) has also been noted (Duster, 1997; Meierhoefer, 1992).

The Impact of Racism

Individual and institutional racism. Individual racism and institutional discrimination are significant contributors to the criminalization and current social construction of perinatal addiction in the U.S. By 1994, criminal prosecution of pregnant drug using women had occurred in 34 states (Chavkin, Breitbart, Elman & Wise, 1998). The majority of the more than 200 women prosecuted in the past 15 years in the U.S. for "prenatal child abuse" have been women of color (Jos, Marshall & Perlmutter, 1995; Kolata, 1990).

It is important to examine how race discrimination is bound to the prosecution of pregnant addicts in the U.S. because of the implications for social justice and also because of the inherent unequal delivery of care that results from this prejudicial treatment. Some believe that racialized prosecution of pregnant drug dependent women is simply part of a larger on-going attack and marginalization of minorities in the U.S. in general (Roberts, 1997; Reinarman & Levine, 1997). Yet, it is also necessary to examine more closely the unequal delivery of health care as a result of this policy of selective prosecution. In this section, evidence of race discrimination and drug testing as a form of racial profiling and the policy implications will be discussed. Examples of social and health services interactions from the micro/clinical or individual level to the macro/institutional level will be examined (Feagin & Feagin, 1996).

Racism is defined as an "ideology that considers a group's unchangeable physical characteristics to be linked in a direct, causal way to psychological or intellectual characteristics, and that on this basis distinguishes between superior and inferior groups" (van den Burghe, 1967, p.11). Feagin and Feagin note, "...in a racist ideology, real or alleged characteristics are linked to cultural traits that the dominant group considers

undesirable or inferior" (1996, p.7).

Understanding individual racism is useful in examining clinical patterns of differential urine screening and reporting of drug dependent women for legal action. However, to understand the role and impact of these dynamics in health care services delivery, it is more relevant to scrutinize patterns of institutional racism. Feagin and Feagin describe institutional racism as: "direct institutionalized discrimination [which] is [an] organizationally prescribed or community-prescribed action that by intention has a differential and negative impact on members of subordinate racial and ethnic groups" (1996, p.20). A number of the prosecutions of pregnant addicted women, most notably at the Medical University of South Carolina (MUSC) are the result of institutional discrimination. In the case of MUSC, "direct organizational discrimination" consisted of a written policy created by the medical center and the police which indicated that pregnant women in the *public clinics only* who tested positive for cocaine would be arrested and incarcerated. The "differential and negative" effect included the arrest and incarceration of more than forty pregnant women in the public clinic and none from the private obstetric practices of the same institution. The Medical Director of the neonatal intensive care unit at MUSC stated "[The

program is] a thinly veiled discrimination…against poor Black women" and the hospital's general counsel, in a letter to a South Carolina assistant district attorney noted "…the other weakness in this program is that the main prosecutions have been against Black indigent women" (Siegel, 1994, p.16).

Drug testing. While the term "War on Drugs" has generally referred to actions by the U.S. criminal justice system against the drug user, as noted above, the rapidly growing technology of drug testing allowed health professionals and health care institutions to conduct their own clinically based war on drugs. Another example of institutional discrimination is the common usage of subjective indicators (e.g. "she looks like a drug user") for urine toxicology testing on pregnant women in hospital settings.

The late 1980's was a period of growth for the body fluid analysis industry and innovations in urine, hair and meconium testing were being widely promoted as reliable drug detection methods (Jain, Meyer, Moore, Tebbett, Gauthier & Vidysagar (1993); Lewis, Moore, Leikin & Koller, 1995; Maynard, Amoroso and Oh, 1991). While universal testing was generally considered cost prohibitive (except for HMOs), toxicology testing of pregnant women and infants who appeared as though they might have a drug problem was strongly advocated. However, selective identification of

patients for drug testing without objective criteria for testing led to a finding of racism in this practice. In a Florida study of discrepancies in reporting to health authorities after positive drug screens, Chasnoff and colleagues (1990) determined that although the prevalence of drug use during pregnancy between White and African American women was similar, African American women were ten times mores likely to be reported to health authorities than were White women ($p<.0001$). This racial difference in reporting persisted even when the data were analyzed by type of health care the women received. In this study, poor women were also more likely to be reported. Cocaine use among wealthy women is documented (Matchan, 1990), yet these women have not received the same scrutiny as poor women delivering in public sector hospitals. While the practice of indiscriminate drug testing had been criticized for some time, the Chasnoff (1990) study provided this important example of racial profiling. This empiric data signaled the need for objective criteria for drug testing.

The state of California also attempted to rectify the practice of discriminatory drug testing and its negative effects with the passage of Senate Bill 2669 (1990). This important legislation had three mandates: 1) a positive infant toxicology screen at delivery is not sufficient in and of itself

to generate a report to child welfare authorities; 2) any indication of maternal drug use should lead to an in-depth assessment of the patient and 3) reports to law enforcement are prohibited if the planned child welfare report consists of parental substance abuse and the resultant inability to care for the child as the only risk to the child.

The aforementioned examples of institutional discrimination continue today. In several states, positive maternal drug tests requires a prima facie report to child welfare authorities (Chavkin, Breitbart, Elman & Wise, 1998) and numerous centers of obstetric care in California practice subjective drug testing just as they did pre-SB2669. However, leaders in the treatment of prenatal addiction cite the need to remain clear on the preferred clinical application of these tests: "…the subversion of medical tests for other than medical purposes directly related to the clinical care of the patient destroys the value of the test and compromises the role of the physician" (Schnoll & Karan, 1989, p. 2384).

A model of race and health outcomes. In an attempt to examine the impact of these types of practices on health, Williams has described a theoretical model and notes "…race is a complex multidimensional construct reflecting the confluence of biological factors and geographical origins,

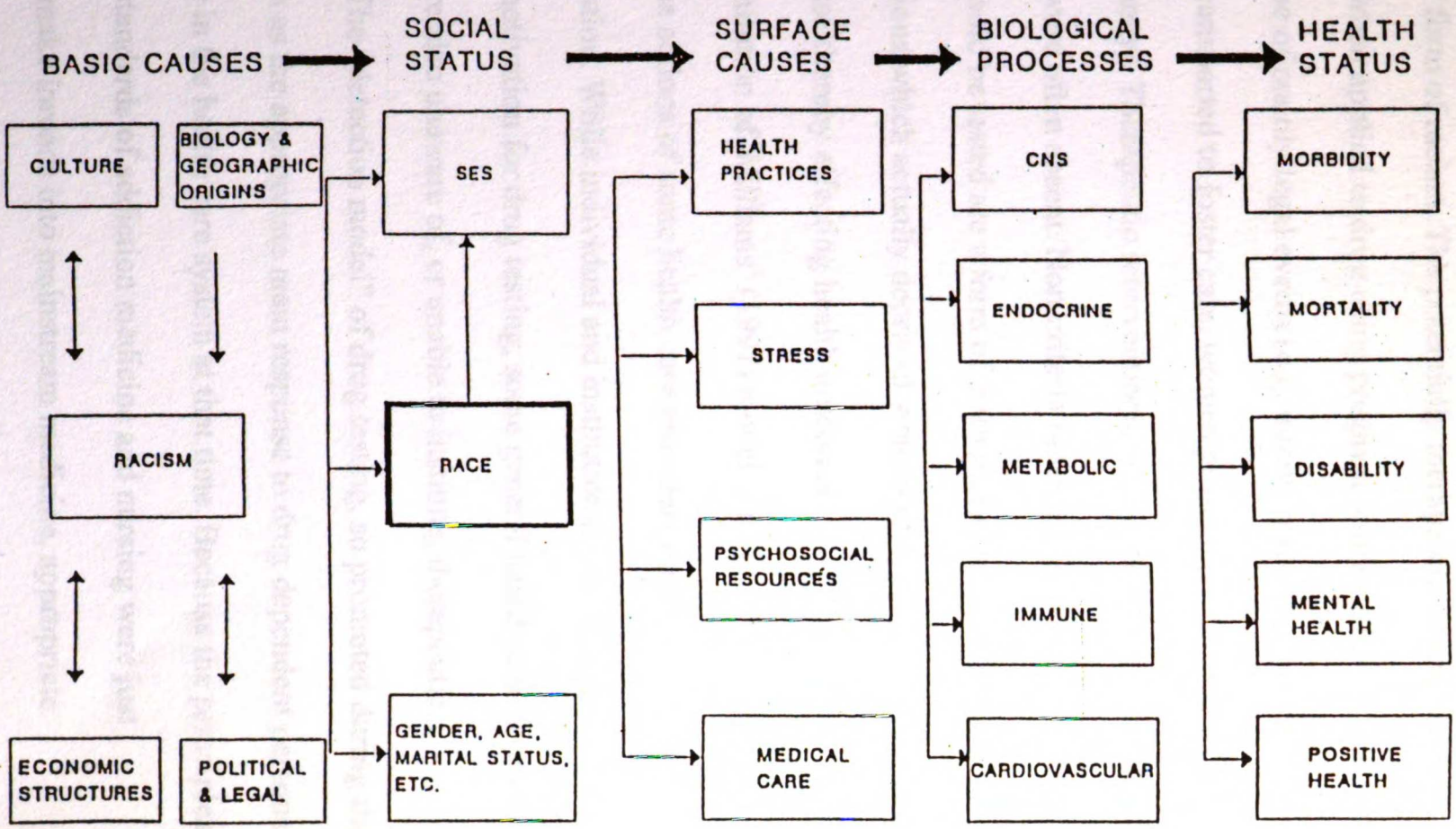
culture, economic, political and legal factors, as well as racism" (Williams, 1997, p.327). This model proposes that cultural and societal forces are the main determinants of differences in health status. In the model, basic causes are the "factors responsible for generating a particular outcome" and surface causes are "related to the outcome, but changes in these factors do not produce corresponding change in the outcome" (Williams, 1997, p. 327). Figure 1 depicts the interaction of racism with multiple other social, institutional and individual factors and designates extrinsic elements in the model (including race and racism) as major determinants of individual health outcomes.

While no research exists examining the impact of punitive actions on the health of pregnant drug dependent women, Williams' model has meaning in this examination of the historical event of the War on Drugs and pregnant drug dependent women. Applying Williams' model to the phenomenon of perinatal addiction, the potential for prosecution suggests that racism and political and legal forces (as basic causes) are the most significant determinants of health outcome for this population.

Williams (1997) also notes that the effects of institutional racism are more difficult to evaluate, yet regarding health outcomes, it is the more

Figure 1. A Framework for the Study of the Role of Race in Health

Note. From "Race and health: Questions and directions," by D. Williams, 1997, Annals of Epidemiology, 7, p. 238.



consequential form of racism. The potentially therapeutic intervention of drug testing, when applied to drug using pregnant women of color, led to a whole sequelae of mainly legal events (e.g. infants placed into police custody and transported to foster care, women prosecuted for drug use during pregnancy). Therapeutic interventions, such as the offer of treatment and support, were often absent. Non-criteria based subjective assessments about who should be tested are a form of institutional racism and can be viewed as actions which actually deprived women of appropriate treatment for their disease thereby affecting health outcomes.

One limitation of Williams' (1997) model is its inability to fully account for the actions of some health care providers during the historical period in question. While individual and institutional racism account for some of the motivation for drug testing, some general health care services providers were also unaware of, or unable to institute, therapeutic alternatives. The "detection model" of drug testing, so promoted during the War on Drugs as the appropriate main response to drug dependent persons, found a home in the health care system at that time. Because the principles and practice standards of addiction medicine and nursing were just beginning to make inroads into mainstream medicine, appropriate

therapeutic interventions with alcohol and drug dependent persons were essentially unknown and unimplemented in obstetric care settings. Yet, a question remains about why health care providers in so many settings allowed such an essentially punitive model to prevail. Williams insightfully recommends that "the characteristics of providers and the health care system" be examined in order to fully understand forms of discrimination in health care settings (1997, p.329).

Prosecution and the Social Climate

During the War on Drugs, the majority of drug using pregnant women who were prosecuted were users of crack cocaine and they were charged with a variety of drug-related offenses. While this was the drug of choice among urban African American women of childbearing age, the policy of detection and prosecution for the use of this drug is racially selective as cocaine is the drug of choice among urban, impoverished African Americans (Garcia, 1993). It should be noted that during this period, aggressive punitive action was also taken against women whose primary drugs of abuse were other than cocaine. Methamphetamine was the drug allegedly used by Pam Stewart, who was arrested in California and charged with child endangerment (Schachter, 1986). In Wyoming in 1990, Deborah

Pfannensteil (who was pregnant) was arrested in an emergency room (ER) and charged with felony child abuse due to the presence of alcohol on her breath. She had sought care in the ER due to an assault by her husband in a domestic violence attack (Goodman, 1990). At the Medical University of South Carolina, the aforementioned arrest-and-incarcerate policy for pregnant women, initiated in 1989, was aimed only at detecting cocaine in maternal and infant urine.

By 1995, thirty-four states reported that pregnant drug dependent women had been prosecuted in their states and this represented an increase of twelve such states since 1992 (Chavkin, Breitbart, Elman & Wise, 1998). Types of criminal charges against pregnant drug using women included criminally negligent homicide, felony child endangerment, child abuse, failure to follow physician's advice, delivery of a controlled substance to a minor via the umbilical cord, involuntary manslaughter, vehicular homicide, assault with a deadly weapon (smokeable cocaine), contributing to the delinquency of a minor, and endangering the life of a fetus (Paltrow, Moss & Crockett, 1990; Garcia, 1997). Roberts states, "Race… provided the backdrop of hostility toward Black mothers that made prosecuting pregnant women permissible" (1997, p.154).

Fundamental to the War on Drugs and legal interventions against drug using pregnant women was the changing role of government. During the Reagan/Bush years and finally in the Clinton administration, the decline of the welfare state and emergence of a "new" conservative ideology had occurred. Petchesky (1981) describes this phenomenon:

> ...what has given the New Right both ideological legitimacy and organizational coherence has been its focus on reproductive and sexual issues. If there is anything "new" about the right wing in the United States, it is its tendency to locate sexual, reproductive and family issues at the center of its political program. (p. 207).

This anti-choice and "pro-family" ideology came to influence politicians, local law enforcement and national policy formulation during this period of time. The "power elite," as originally identified by Mills (1956), began to speak out about pregnant drug dependent women and in so doing, began to solidify sectors of opinion on the issue. Table 1. 2 provides a chronological record of the rancorous and discriminatory tone of statements by these influential persons.

Table 1. 2

Shaping Public Opinion on Perinatal Addiction

"When you have a baby taking up space, it is dangerous and expensive…at its worst, it makes it difficult to get a sick baby in the hospital…" **Physician**, New York Times, 1986.

"This is a willful, harmful act when they take drugs…maybe we should hold back their Medi-Cal or food stamps…" **Physician chief of obstetrics**, 1988

"The newest, a bio-underclass, a generation of physically damaged cocaine babies whose biological inferiority is stamped at birth…the dead babies may be the lucky ones."
C. Krauthammer, Washington Post, 1988

"…the crack epidemic floods the nation's hospital nurseries with hundreds of thousands of drug-addicted newborns…" **S.F. Chronicle**, 1989

"Mr. President, in all the ugly drug lore of modern America, surely the most sordid and terrifying story is that of the exploding child abuse through the umbilical cord…metastasizing through our Nation…threatens costs that will drain health care…writhing in pain in their cribs, they suffer literally the agony of the damned." **Senator Pete Wilson**, 1989

"Proponents of a woman's right to abortion should not weaken their powerful argument in favor of a woman's right to control her body." **Alan Dershowitz**, 1989

The part of their brains that "makes us human beings, capable of discussion or reflection.. has been wiped out." **J. Howard**, pediatrician, UCLA, late 1980's

"…crack babies who won't ever achieve the intellectual development to have consciousness of God."
John Silber, President of Boston University, 1991.

"…substance abuse by a pregnant women is the moral equivalent of child abuse…the condition of these children, and their agony is a grievous offense against the basic values we hold so dear…"
Louis Sullivan, Secretary, US DHHS, 1990.

"They snorted, smoked and shot their way through pregnancy. Their babies were born medical disasters…"
Northwest Magazine, Portland, Oregon, 1990

"Many of these mothers are unreachable. We have no reason to believe they'll become more adequate parents in the foreseeable future." **D. Besharov**, American Enterprise Institute, 1990.

"Given that her fetus is viable, the fetus has certain rights that the public has a legitimate interest in protecting..." **Judge, Wisconsin,** taking protective custody of a 36 wk. fetus and mother, 1995.

" I am sick and tired of these girls having these bastard babies on crack cocaine, and until they change the law, the law they gave me, it said I could put them in jail." **Judge, So. Carolina** , 1997.

During the summer of 1990, at the height of national concern about perinatal addiction, a law-enforcement conference was held in Chicago on legal strategies for the prosecution of pregnant women who use drugs. The conference was entitled "Substance Abuse Infants: A Prosecutorial Dilemma" and was sponsored by the Cook County State's Attorney and the National Center for Prosecution of Child Abuse (NCPCA). The objective of the meeting was to gather law enforcement professionals from around the country to discuss legal interventions that could be used to deal with the problem of drug using pregnant women. The NCPCA noted in its report of the conference, "Prosecutors have a positive and important role to play in developing and implementing strategies to combat parental drug abuse. That role should include fund-raising efforts to increase treatment resources, legislative and community advocacy to focus attention on drug treatment and drug-affected children, and creative use of the justice system to encourage treatment and children at risk" (NCPCA, 1990, p.7).

Conference participants, in defense of legal interventions against pregnant women, noted that it "was not the charging decisions that disrupted families and communities, but the behavior that proceeded it" (NCPCA, 1990, p.8). A number of the legal intervention protocols proposed at the

Chicago conference depended on the essential collaboration of health professionals as partners in reporting substance-abusing women to child welfare and legal authorities. For example, one program known as the APB ("Addicted, Pregnant and Busted") Program created by the District Attorney's office in the second judicial district of New Mexico, legally required drug-using pregnant women to attend prenatal care at the university hospital and "comply with all directives given" (APB Program, 1990, p.1). This probationary program, devised for the purpose of diversion from incarceration for drug offenses, apparently also included open communication between the hospital prenatal caregivers and the New Mexico district attorney's office.

Health care providers. Prosecutors are the initiators of legal interventions against pregnant drug users. However, prosecutors remain unaware of these cases in medical settings until they are contacted by health professionals, social workers, or child welfare agencies. A significant number of these cases of prosecution came to the attention of legal authorities due to positive drug screens and because physicians, nurses and social workers made the call. In the majority of prosecution cases thus far, the positive drug test and the contact by the health professional were the

catalysts for punitive action. The moral and ethical dilemmas imposed upon health care providers by these punitive policies drastically and permanently change the traditional role of helper when pregnant addicts are their patients (Chavkin & Breitbart, 1996). This policy severs the extended arm of hope and obstructs the ability of helpers to help and the women to have any opportunity for authentic treatment. Research and clinical anecdotal evidence also suggest that reports by health professionals and prosecutions "enhance the flight from care" (Poland, Dombrowski, Ager & Sokol, 1993; English, 1990; Whiteford & Vitucci, 1997; USGAO, 1991).

Treatment access. It has also been noted in analyses of treatment utilization that appropriate culturally-specific and gender-specific substance abuse treatment was non-existent in many of the communities where these prosecutions took place (Chavkin, 1992; Whiteford & Vitucci, 1997; L. Paltrow, personal communication, October, 1996). The availability of treatment is directly related to pregnant women's utilization of treatment. In the context of perinatal addiction, access to substance abuse treatment, while also an outcome measure of epidemiological research, is also then a "political idea [in which] access can be defined as all of the public policy, legal, social, and related considerations that surround the entry or use of

personal health services by population groups" (Clark, 1983, p.6). In this light, lack of access to substance abuse treatment in areas where prosecutions have occurred underscores the observation that the political will to punish was present, while the will to treat was not.

Women's Reproductive Rights

The Intersection with Perinatal Addiction

The struggle for reproductive rights for women in America has primarily focused on the legal right to abortion and other health care services indicative of reproductive freedom. Perinatal addiction intersects with traditional definitions of these rights in a slightly different and unique way. Recent challenges to women's reproductive rights in the domain of perinatal addiction cases have largely focused on: 1) legal actions against pregnant women substance users which criminalize maternal behavior (prosecutions, incarcerations, differential probation and parole conditions); 2) reproductive coercion (e.g. forced sterilization, implantation of Norplant) which has attempted to selectively control and oppress women; 3) breaches in confidentiality; 4) violations of equal protection and 5) punitive actions which may constitute cruel and unusual punishment (Connally & Marshall, 1991). These areas will be addressed in the following section.

Cases of Prosecution

People v. Stewart (1987). In 1987 in San Diego, California, Pamela Rae Stewart sought prenatal care at seven months in her pregnancy and was told she had a high-risk obstetric condition known as abruptio placenta. Several weeks after the diagnosis and after allegedly being advised by her physician to stay on bedrest and to avoid sexual intercourse and street drugs, she returned to the hospital with acute uterine hemorrhage and precipitously was delivered of her infant son via cesarean birth. The baby was born with brain damage and was sustained on a ventilator for five weeks, at which time he died when life support was removed. As a result of a report to authorities made by the infant's neonatologist, Ms. Stewart was subsequently arrested and charged with child endangerment in the death of her infant son (J. Ganz, personal communication, October, 1999; Schachter, 1986). This case caught the attention of the nation as it focused on maternal behavior during pregnancy and how the state attempted to use an unlawful application of child abuse statutes in its case against Stewart (Paltrow, 1992). Social and political forces in America propelled the Stewart case to center stage in a new twist on the debate about women's reproductive rights—prenatal drug use and reproductive health.

The charges against Stewart were eventually dropped as the judge ruled that the alleged "crime" did not fit the statute of child endangerment under which Stewart was charged. However, the judge did note that the state legislature "could, under certain narrowly defined circumstances, restrict the actions of pregnant women" (Los Angeles Times, 1987) thus allowing for the possible primacy of the rights of the fetus. This case, while legally unsuccessful, defined a social climate in America relative to our collective attitude and response to women addicts. This punitive climate then allowed for the emergence of substantial interest and actions that sought not only to impinge on the reproductive rights of these women, but also to incarcerate them for gender-specific crimes.

Shortly after the Stewart ruling in 1987, a conservative lawmaker in southern California introduced a bill to criminalize drug use during pregnancy. Since 1988, approximately twenty such bills calling for the creation and punishment of a crime called "prenatal child abuse" have been introduced before the state legislature in California; none have yet been ratified into law. However, six states have recently enacted laws which recast health care providers into law enforcement persons vested with the mandatory duty to report drug-using women to criminal and child welfare

authorities (Teare, 1995). In most cases, authorities then move to impose further punitive sanctions and remove infants to foster care, actions which can only happen when criminal and child welfare authorities are notified by health care professionals privy to the results of drug testing of the mother and the infant.

United States v. Vaughn (1988). The case of Brenda Vaughn, a pregnant woman in Illinois, illustrates a trend toward gender-based sentencing in perinatal addiction. Ms. Vaughn had pleaded guilty and been convicted of second-degree theft for forging $700 in bad checks. During the interim time before sentencing, Ms. Vaughn tested positive for cocaine and was ordered to jail for the duration of her pregnancy. In the judge's comments, fetal protection was explicitly noted as the reason for her incarceration (Associated Press, 1989).

Ferguson v. City of Charleston (1993). Perhaps the most notable case of prosecution of pregnant drug dependent women occurred in South Carolina beginning in 1989 at the Medical University of South Carolina (MUSC). In a collaboration between MUSC and the Charleston police department, a policy called "The Interagency Policy on Cocaine Abuse in Pregnancy" was implemented. The policy consisted of arrest and

incarceration of pregnant women who presented for prenatal care and tested positive for cocaine. The policy was implemented only in the public prenatal care program at MUSC; private patients were immune from the effects of the policy. It is estimated that some 42 women were incarcerated in Charleston jails from 1989-1993 (Roberts, 1997). Additionally, some of these women were diverted from jail and detained in an inpatient psychiatric unit at MUSC. Psychiatrists there successfully used the civil commitment statutes to detain pregnant drug dependent women in the psychiatric unit (i.e., in the assessment of danger to self or other, the fetus became the "other"). In addition to numerous foster placements of infants and rupturing of families that occurred in this case, the actions of MUSC demonstrated on a much larger scale how health professionals could collaborate with law enforcement to punish pregnant addicts for their actions in an attempt to protect the "unborn." It also should be noted that MUSC's "Interagency Policy" was particularly aimed at the use of cocaine.

The demographics of drug use by women of childbearing age in Charleston at the time (1989-1993) were that African American were the primary users of smokeable (crack) cocaine. During the time of the Interagency Policy, there was never any action against a pregnant woman for

the use of alcohol or another illicit drug during pregnancy. In a research medical journal article about program "results" after one year of the MUSC policy, the authors of the Interagency Policy consistently refer to the program as aimed at reducing cocaine use and they report only cocaine positive drug screens (Horger, Brown & Condon, 1990). Given the well-documented and toxic effects of prenatal use of alcohol (Streissguth, Landesman-Dwyer, Martin & Smith, 1980; Abel, 1984), MUSC's claim of concern for the fetus as their main motivation loses credibility in light of their single-drug (cocaine) approach. Additionally, the MUSC case is especially disturbing because of its impact on interpretations of appropriate medical care standards, the silence of nurses and physicians working in and around such a program, the absence of informed consent for human subjects research, and violations of long-held federal protections of confidentiality. Appendix A includes copies of the letters from the Solicitor General and MUSC to pregnant patients, an open letter to patients from the Department of Obstetrics and Gynecology, and the final warning letter which was served to patients after a positive urine test for cocaine. The documents were intended by MUSC to serve as informed consent, yet they fall short of the legally mandated requirements of consent in a research context

(International Council of Nurses, 1997).

In October of 2000, the United States Supreme Court heard the case of Ferguson v. City of Charleston. In late March of 2001, the Court voted 6 to 3 in favor of the plaintiffs noting that the MUSC Interagency Policy was in direct violation of the Fourth Amendment. Frietsche, co-counsel for the plaintiffs, noted: "Today's decision is a victory for all women who are now assured that the Constitution protects their privacy when seeking prenatal care" (Center for Reproductive Law and Policy, 2001).

While these cases are only three examples of prosecution, they are significant for the obvious enormous impact on the lives of these individual women. Yet, a greater impact on thousands of drug dependent women who heard and read about these cases cannot be measured. This chilling effect on the motivation of drug dependent women to seek prenatal care and substance abuse treatment may be the greater negative and far-reaching effect of such public policy.

The Rise of the Fetal Rights Movement

Fetal Protection

Among issues surrounding perinatal addiction is the legitimate concern for the well being of the fetus. Alcohol and other drugs can

negatively affect the developing fetus at any point during gestation. Severity and type of impact depends on the chronicity of maternal addiction (Sanchez, 1992), amount and type of substances consumed, route of administration, individual genetic predisposition and pathophysiology (Pagliaro & Pagliaro, 1997), and male genetic contributions (Yazigi, Odem & Polakoski, 1991). Due to these drug-induced effects on the fetus, maternal abstinence during pregnancy is clearly a reasonable and appropriate objective. An appropriate public health response to perinatal addiction has been described as one in which treatment and advocacy are offered and health and social services systems are coordinated to serve these women and their children (Haack, 1997). Advocates for pregnant addicted women and legal experts have noted that the only way to actually "reach" and thus protect the fetus is through the mother in the context of a public health approach. This model of treatment also has the effect of initiating recovery and its inherent benefits for the woman. However, other models of fetal protection, without these long-term beneficial elements for the mother and children, have been proposed and instituted.

The prosecution of pregnant drug users came about at a time when the fetal rights movement in the United States was at its peak (Gallegher, 1987).

Women's right to abortion, secured by the Supreme Court in 1973, was under attack from right-wing political groups as well as fundamentalist Christian organizations. Fetal protection has often been the stated motivation for government in punitive actions to "take responsibility" for the fetus when the drug addicted mother is perceived by the state as unable to do so. This conflict between the state's duty to protect the fetus vs. woman's right to bodily integrity is at the heart of the debate over solutions to the problem of perinatal addiction. Currently eight states in the U.S. define child abuse or neglect as inclusive of prenatal use of substances: Florida, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, Oklahoma and Utah (ACOG, 1990).

In 1997, the Supreme Court of South Carolina sentenced Cornelia Witner to eight years in prison when traces of cocaine were detected in her urine after delivering her son in 1992. Ms. Witner served 18 months of the sentence when she was released because the court agreed to the re-hearing of her case. In the re-hearing, the Court ruled that a viable fetus is covered by the state's child abuse statutes. That decision resulted in Witner's re-incarceration and necessitated the abandonment of her four year-old son. This ruling set a precedent in effectively "opening the door for a new wave of prosecutions in South Carolina" (Roberts, 1997), holding that criminal

prosecution of pregnant women for substance use during pregnancy is a legal and legitimate practice. Roberts (1997) notes the ubiquitous role of race in these particular prosecutions: "The criminal regulation of pregnancy that occurs today is in some ways unprecedented. Yet it belongs to the continuing legacy of the degradation of Black motherhood...the prosecutions are better understood as a way of punishing Black women than as a way of protecting Black fetuses" (p.154).

The Status of the Fetus

Due also in part to advances in fetal surgery, Casper (1998) notes that the social status of the fetus underwent significant change in the 1980's:

> Like the oversized fetus in 2001: A Space Odyssey, fetuses are increasingly portrayed as free-floating and larger than life. Where fetuses were once confined to anonymity and invisibility inside pregnant women's bodies, the fetus has now gone solo...in the new cultural discourse, fetuses are increasingly represented as free agents with their own needs and interests and even their own doctors and lawyers (p.16).

Control of Maternal Behavior

As technologies such as fetal surgery and other intrauterine interventions developed, the implications of these advances in terms of the potential for physicians and other health professionals to control maternal behavior also began to emerge. In a 1982 case study (Mackenzie, Collins & Popkin, 1982) of an alcoholic pregnant women entitled "A Case of Fetal Abuse?" the authors note:

> ...measures of fetal health such as ultrasound and hormone determinations are becoming increasingly sophisticated and promise to provide more and more data...these measures will be examined with reference to specific aspects of maternal behavior" (p.700).

The psychiatrist authors discuss multiple methods of "restraint and control" of the pregnant woman, review the legal limits of civil commitment of the mother in order to protect the fetus and yet fail to ever mention treatment of maternal alcoholism as a therapeutic option.

In another article on the role of physicians in preventing fetal harm, Beresford (1994) describes the role of "...protecting the unborn" and he notes: "In this role, physicians become agents of the social order." This author describes an array of actors in this process including "legislative

bodies, courts, other public agencies, physicians and lawyers, operating in a sometimes seamless web" (p. 251). It is noteworthy that the pregnant woman as the central actor in this story of fetal protection is never mentioned. This absence of the woman/mother in this dialogue and in depictions of the fetus has been described by Rapp: "sciences like 'perinatology' focus on the fetus itself, bypassing the consciousness of the mother, permitting [the] image of the fetus as a separate entity" (Rapp, 1990).

In judicial actions of fetal protection, drug dependent women have been sentenced to prison for the duration of their pregnancies (Associated Press, 1989) and non-pregnant drug dependent women have been ordered to have Norplant implantation (Lewin, 1990). In Orange County, California today, a grassroots organization created to prevent the birth of drug exposed babies, will pay any female drug addict $200 to be sterilized. Other cash-for-contraception offerings include an agreement to have Norplant implanted or to utilize an IUD or Depo-Provera (B. Harris, personal communication, 1998). The website of this organization states "Drug addicts are no different than the rest of us in a sense that they are also motivated by money" (C.R.A.C.K., 1999) (see Appendix B).

The Lay Press

Media portrayals of perinatal addiction create and reinforce negative public impressions of drug dependent pregnant women and their babies. During the late 1980's and early 1990's, the tragic consequences of maternal addiction received much attention in the popular press, often in unbalanced portrayals of the women as horrific and abusive mothers and the infants as biologically inferior future criminals (Coles, 1993). The items noted in Table 1. 3 provide some examples of the tone of media coverage during this period.

Table 1. 3

Shaping Public Opinion: Headlines of 1984-1990

"When Pregnant Women Use Drugs, Victim is the Unborn Child"	SF Chronicle, 1984
"Crack Users' Babies Crowding Hospital Nurseries"	New York Times, 1986
"FAS: Intrauterine Child Abuse"	S.D. Journal of Medicine, 1986
"When A Pregnant Woman Endangers Her Fetus"	Hastings Ctr. Rep., 1986
"Pregnant Drug Users Pose Dilemma"	The Californian, 1988
"Pregnant Addicts Raise Question: Rights of the Unborn"	LA Times, 1989

Table 1. 3 (Cont'd.)

"Born To Lose"	Wall Street Journal, 1989
"A Vicious Assault on the Unborn Child"	New York Times, 1990
"Crack Cocaine Addicts and Their Tragic Babies"	SF Chronicle, 1990
"An Ethical Quagmire for Doctors: Drug Babies"	Med.World News, 1990
"Crack Children in Foster Care"	Children Today, 1990
"Punishment &Treatment Need Not be Mutually Exclusive Choices"	Children Today, 1990

While there is no doubt that very tragic outcomes do occur among women and infants exposed to cocaine, the mass media played down the disease aspect and treatment, often emphasizing extreme deviance in descriptions of the women. The New York Times proclaimed that pregnant drug users were "creating a whole new generation of innocent addicts" (Brody, 1988) thereby implying that there are guilty addicts, namely the pregnant addicted women themselves. A nurse caring for drug-exposed infants in New York City commented during this period: "The most remarkable and hideous aspect of crack cocaine seems to be the undermining of the maternal instinct" (Trost, 1988).

Blame and the Pregnant Drug User

In the printed and spoken reproduction of contentious and even racist speech on the topic, the tone and style of media coverage of perinatal addiction took on the power to forge public opinion. George Lakoff, a cognitive linguist, states that the way in which an issue is framed has great power because it connects to values held by the public (Lakoff & Grady, 1998). In a discussion of these "framing effects" in public discourse, Iyengar (1991) describes attributions of responsibility that "powerfully influence self-images, evaluations of other people and self-arousal" (p.9).

Attribution is a compelling theme in discussions of maternal responsibility and fetal well-being. In the debate on perinatal addiction, two *responsibility themes,* embedded in perinatal addiction, emerged in the media. One theme concerned government responsibility (punishment vs. treatment) and the other concerned maternal responsibility (good vs. bad mothering). No empirical studies have been done on the framing effects of media portrayal of perinatal addiction, however, this perspective implies that judges, policymakers and health professionals' opinions and actions on this matter were also affected by media coverage of the cocaine "epidemic."

Attitudes of Health Professionals

Health professionals have close and even intimate contact with drug dependent women as caregivers during one of the most significant moments in a woman's life. Health professionals' attitudes contribute to the quality of the therapeutic alliance with the drug dependent woman. Attitudes about addiction may not only affect the therapeutic relationship, they may delay the diagnosis of the disease (Chappel & Schnoll, 1977). In addition, providers may not diagnosis addiction unless they believe they are able to provide help for their patients (American College of Obstetrics and Gynecology Technical Bulletin, 1994).

Physicians and medical students, for example, have very little formal education regarding alcohol and drug problems and must rely on professional journals as well as colleagues and professors for information about addiction. One 1987 study of attitudes among chiefs of maternal-fetal fellowship programs showed that 46% supported judicial intervention or incarceration during pregnancy and 25% supported "state surveillance" of women in their third trimester of pregnancy (Kolder, Gallagher & Parsons, 1987). Another similar survey of pediatric and obstetric programs noted that of the 162 respondents, 28% favored foster care placement of drug-exposed

infants and 31% supported involuntary drug rehabilitation for the women (Pelham & DeJong, 1992).

Scientific Media

Of particular interest in the medical media coverage of maternal cocaine use is the bewildering failure to attend to scientific standards in research results as they appeared in journals in the late 1980's and early 1990's. Coles (1993) explains that in the rush to report perinatal effects of cocaine use, scientific methods as well as previous empirical research on drug effects was ignored:

> Not only has a media myth been created but there have been a number of effects that are damaging...women have been arrested or have been afraid to seek prenatal care because of fear of arrest. Children have been labeled with the pejorative term "crack baby" ...and this label will affect attitudes toward them in negative ways...the credibility of medical and clinical research in this area has suffered in the eyes of many observers (p.290).

Koren et al. (1989) conducted a study of research articles submitted to a prestigious medical journal for publication. In a provocative discussion of the "bias of the null hypothesis," findings from this study demonstrated that

articles with positive findings of cocaine-related problems were six times more likely to be published than those with findings of no effects. Yet, Mayes and colleagues (1992) cite numerous methodological problems with published research on the problem of maternal cocaine use and infant exposure. These include ill-defined study populations and questionable generalizability of results, "misclassification of users," inexact definitions of amount and trimester of use during pregnancy, lack of examination of other prenatal influences in addition to the drug, and a pervasive entanglement of environment and biological effect of cocaine in determining causality.

During these early years of research on cocaine-exposed babies, small sample size was also characteristic of the published studies on neonatal cocaine exposure. Table 1.4 lists some representative articles of this type that appeared in the scientific literature from 1988-1990.

In a 1989 article regarding respiratory pattern abnormalities in infants prenatally exposed to cocaine, the authors state that the study was initiated because 10 of 66 infants at two different maternal drug treatment sites had died due to SIDS (Chasnoff, Hunt, Kletter & Kaplan, 1989). While the authors were reporting data from a different sample, the anecdotal claim of increased risk for SIDS among cocaine-exposed infants was quoted and

Table 1. 4

Summary of Empirical Research on Perinatal Cocaine Use/Exposure 1988-1990

Authors/Yr	Sample	Findings	Study Limitations
Chasnoff, 1989	n=70 newborns	↑rates of IUGR, prematurity, microcephaly, perinatal morbidity	sample bias; no control group; confounded variables
Chasnoff et al., 1989	n=50 infants	respiratory abnormalities	flawed attribution of causality; sample bias; confounding variables; polydrug use not controlled
Doberczak et al., 1988	n=39 newborns	abnormal EEGs	confounded variables; sample bias; prenatal drug use undocumented
Fulroth et al., 1989	n=86 newborns	microcephaly/growth retardation	polydrug use & poverty not controlled ; sample bias; unreliable control group re: drug use; prenatal drug use undocumented
Horger et al., 1990	program eval.	↓ in cocaine + tox screens	no data analysis; reported 7 mos. of data; no IRB oversight; sample bias
Hume et al., 1989	n=20 fetus/newborns	abnormal state behaviors	unblinded examiners; sample bias; polydrug use not controlled or documented; ethical issues

widely disseminated. That brief introduction (the stated impetus for the study under consideration) omitted any discussion of potential sample bias, confounding variables such as maternal methadone dose, substantial tobacco

dependence in the mothers or continued use of illicit heroin among the women enrolled in methadone maintenance.

Numerous methodological problems also plagued this prospective study on respiratory abnormalities. Infants were divided into two groups: 32 infants of cocaine-using women (also addicted to and possibly still using heroin and legally prescribed daily methadone) and 18 infants of women on legally prescribed daily methadone and possibly still using heroin. Findings included a "higher incidence of cardio-respiratory pattern abnormalities in infants prenatally exposed to cocaine than among infants with methadone or no prenatal drug exposure" (p.583). However, these findings are confounded by lack of a drug-free control group as well as contamination by polydrug use of both groups. The reliability of the results of this study also are limited due to the probable under-reporting of drug use in the drug-using subjects as well as the lack of documentation of amount of cocaine use by trimester in this study. The small sample size further limits the generalizability of the findings. Additionally, the standard care for pregnant opiate dependent women during the years of this study was daily prescription of 40-60 mg of methadone (Ostrea, Chavez & Stryker, 1978; NIDA, 1979). The doses of methadone in the methadone group were much lower than that, and likely

resulted in methadone under-medication.

Under-medication of methadone may have led to the experience of withdrawal symptoms and possible return to heroin use in order to achieve a homeostatic narcotic effect. If this was the case, it is also likely that the women and in turn the fetuses, were undergoing periods of opiate intoxication and periods of acute withdrawal. Speculation of a relationship between prenatal use of opiates and SIDS (Rosen & Johnson, 1988) and a relationship between opiates and decreased fetal movement (Archie, Lee, Sokol & Norman, 1989) were documented at that time, yet neither these, nor a smoking-related alternative hypothesis, was raised in this study. The claim of a higher rate of SIDS in cocaine-exposed infants has not been replicated by other researchers (Bauchner & Zuckerman, 1990; Kandall & Gaines, 1991).

In a descriptive study of 39 newborns prenatally exposed to cocaine, transient clinical and EEG abnormalities were reported by Doberczak and colleagues (1988). Though the authors state "only those infants born to mothers using cocaine were included in our study" (p. 354-355), this was determined by maternal and infant urine testing at the time of birth, which does not account for drug exposure throughout the pregnancy. This study,

also confounded by documented alcohol use (and probable polydrug use) of the mothers, found that 17 of the 39 infants had abnormal EEGs at birth. Eleven of these resolved by the second week of life and the remainder resolved from 3-12 months of life. The findings of this study are meager and could potentially be explained by intrauterine ethanol exposure, although there is no attempt to control for alcohol or demographic factors, such as poverty. Combinations of "environmental and constitutional risk" (Bernstein & Hans, 1994) have since been reported as especially potent determinants of neonatal outcome in opiate exposed children (Hans, 1989), yet these elements of risk were not considered individually or in combination in this study. The small sample size also limits generalizability to all addicted women's newborns.

The 1990 evaluation of an intervention program for pregnant cocaine dependent pregnant women at MUSC is in many ways representative of the flawed and inconclusive science that was published in these early years of the War on Drugs (Horger, Condon & Brown, 1990). Separate and apart from previously noted legal concerns regarding the program itself, numerous serious ethical and methodological issues about the published research outcomes from this program arise. In concert with the county prosecutor and

the city of Charleston police department, the Interagency Protocol (IP) required pregnant women who tested positive for cocaine use to participate in substance abuse treatment or risk arrest and incarceration and potential subsequent loss of custody of their children.

The published findings of the program evaluation attempted to substantiate the success of the program in a description of three areas: 1) a description of the arrests and incarcerations; 2) a claimed reduction in the number of cocaine-positive urine tests among women delivering at MUSC and 3) an accounting of the number of all women delivering at MUSC before and after the implementation of the program. The authors claimed that the program reduced the number of cocaine-positive urine tests without deterring women from care. Beyond this claim, there was no further analysis or discussion of the data. There was also no discussion of the possibility of sample bias or biased application of the testing criteria. Neither did the authors consider that women may have delivered at other sites or that woman may have ceased drug use as their due date approached. Because this protocol was only interested in detecting cocaine, the design of this program was inherently flawed as it only attempted to intervene upon African American women cocaine users in a highly coercive and unique

circumstance. This was an additional ethical concern that undermined generalizability to all addicted women. There was no discussion of a control group in the study and there also was no attempt to control for confounding variables that may have affected the results.

The program utilized human subjects and was promoted as a research project, yet the authors made no mention of informed consent; due to police reports filed, confidentiality was not maintained (violation of 45 CFR § 46.101[b]). One of the authors later publicly noted that the program was coercive: "a program that used not only a carrot, but a real and very firm stick" (Condon, 1995, p. 6). In the 1990 study, there was also no mention of the medical or social outcomes of the women or their infants, or any mention of addiction treatment enrollments or completions, with the exception of a statement regarding the number of women arrested and jailed. The authors described an intervention program with the goal of "fetal protection, not maternal prosecution" (Horger, Brown & Condon, 1990, p. 530) and noted "...the threat of exposure and arrest does appear to be a deterrent to cocaine use" (1990, p. 530).

It should also be noted that this article was published only seven months after the policy was implemented and therefore the validity of the

results is questionable. Although it was noted in this publication that "...the role of this program in improving perinatal outcome will be reported after 12 month's data collection...." (p. 531), no such article or further data ever appeared in the scientific media. Though scientists and others concerned about ethical and legal aspects of this program may easily discredit this research, unknown damage was done in terms of publishing and then promoting this approach as an attempt to control the cocaine problem. Charles Condon, one of the authors of this study and the county prosecutor in Charleston, had presented this paper in July of 1990 at a national training conference for prosecutors in Chicago (NCPCA, 1990), three months prior to the publication of this article. In 1998, five years after the coercive elements of the Interagency Policy were removed, substance abuse treatment workers in South Carolina still believed that drug dependent women were crossing the state line into North Carolina to deliver their babies (Bragg, 1998).

In a quasi-experimental study of fetal and newborn behavioral state organization, Hume and colleagues (1989) reported on a methodology for the prediction of disorganized behavioral states in the fetus that claimed to predict abnormal newborn behavior in 13 of their sample of 20 cocaine-

exposed infants. Through the use of fetal sonography (a technique of questionable validity for fetal behavioral state), maternal and infant chart reviews and neonatal behavioral assessments, it was concluded that "all 13 fetuses who had abnormal fetal state behaviors were abnormal in state organization as newborns" (p.688). The authors also noted that the disorganization of newborn behavior seemed to be associated with the amount of the mother's cocaine use during pregnancy, even though "the relationships were not statistically significant" (p.688).

This study, however, had numerous methodological flaws. Examiners of the newborn (two of the authors) were not blinded to the fact that they were examining cocaine-exposed infants. There was no mention of controls for smoking, polydrug or alcohol use. Sample bias was introduced due to the small sample size and the fact that the twenty cocaine-using women were not randomly selected, but volunteered for the study. There was no drug screening throughout the pregnancies of the sample subjects to validate the women's reports of their use; use was determined only through interview by the primary author at the time of the study. Although the procedure was explained in detail, there was no presentation of supportive data regarding the validity or reliability of the sonographic fetal well-being assessment

technique. Of the ten possible medical-obstetric complications, only IUGR was positively associated with maternal use of cocaine ($p<0.01$). A final flaw of this study was suspected contamination of the control group as this group consisted of 2,210 women in the same obstetric service who were not tested for the presence of drugs, but whom the authors claim were "not known to abuse cocaine." The major problems with this study are the use of an unvalidated assessment instrument, the potential for uncontrolled confounding effects of other prenatal influences and the absolutism of the authors in their attribution of the findings to maternal cocaine use alone. Of ethical interest was the fact that the study team followed these twenty women cocaine users throughout their pregnancies, yet no mention of treatment, abstinence or therapeutic intervention was raised. This would be of interest to health care providers and researchers if only for the confounding events or status that treatment and sobriety might have conferred.

In a prospective descriptive study of 86 infants whose mothers used heroin and/or cocaine, Fulroth, Philips and Durand (1989) postulated that the concurrent use of both drugs has a synergistic effect on the behavior of the newborn. The intent of this study was to determine if toxicological testing of

both mother and infant would improve detection of drug exposure and to describe the newborn effects of both drugs, as well as the synergistic effects of this dual drug use pattern. Mother-infant pairs were divided into four groups: cocaine-only (35 pairs), heroin-only (14 pairs), cocaine and heroin (17 pairs) and a no-drugs-detected (with history of prenatal cocaine use) group (20 pairs). The authors observed newborn status and the emergence and course of withdrawal and measured infant withdrawal with the Finnegan scoring system and tested all pairs' urine at birth. Only 50% of the urine tests were concordant, mother to infant, and cocaine and heroin appeared to be synergistic in causing "abnormal behavior of withdrawal." Similar methodological flaws existed in this study as in others conducted in this same time period and reviewed here, including: 1) not controlling for the effects of smoking, marijuana or methamphetamine; 2) conducting urine tests at delivery only and therefore not measuring actual exposure during pregnancy; 3) sample bias due to method of sample selection, which was identifying subjects with a "history of maternal drug use" (p.905) through self-report of the mother or "suspicion of maternal drug use" (p.905) as defined by the authors; 4) not discussing or controlling for effects of poverty and 5) the control group consisted of 1,021 infants born at the same delivery

site to mothers who were "thought to be drug free" (p. 905), though none of these maternal infant pairs were drug tested.

Additionally in this study, there was no control for alcohol exposure. In discussing the finding of decreased head circumferences in the cocaine-only group of infants, the authors state "...newborns with fetal alcohol syndrome also have a small head circumference and a low birth weight. However, the urine drug test results in the cocaine group were negative for alcohol..." (p. 909). This conclusion is flawed in that a urine test was done only at the time of birth, clearly not an inclusive measure of the entire forty weeks of a pregnancy when alcohol consumption sufficient to cause this finding could have occurred. Also, the Finnegan scoring system, standardized and validated on opiate exposed infants (NIDA, 1979) was not intended for, and has not been standardized on infants exposed to other drugs. Thus, while the scores on the heroin-only group may be considered reliable, the scores of the other groups are suspect and their meaning unclear.

Finally, the Chasnoff (1989) study of 70 cocaine exposed infants represents a prototype of the articles of the time under consideration here. It is a curious mix of statements of causality and a lack of rigor in its scientific

method. While a discussion of the findings of this study is important, a consideration of the tone of this article is equally relevant to a perspective on the scientific media's contribution to the social construction of perinatal addiction. There is a tone of emotional urgency and negative stereotypical language in this article. As an introduction to the science of the article, Chasnoff shares with the reader the fact that there have been "close to 1,500 calls" to the "Cocaine Baby Hotline," a help-line set up at the site of the study, the Perinatal Center for Chemical Dependence at Northwestern University Medical School. These calls were from men and women "concerned about the effects of substance abuse on the unborn child" (p. 24). In an examination of the accompanying data, however, there were actually an average of 2.7 calls per day across a seven state area surrounding Chicago during the previous 18 months. In this article, Chasnoff's selection of the words "unborn child" and "cocaine baby" calls up the image of the disempowered fetus. This use of terms was not the standard of the day (most publishing scientists use the word "fetus") and in this context, while subtle, meaning congeals around these words.

Chasnoff's (1989) study involved 70 infants whose mothers used cocaine in the first trimester (100% of subsample) and throughout pregnancy

(60% of the subsample). A control group of 70 women from the ambulatory care clinic, similar by demographics but thought to be without a history of drug use, served as the control group (total n = 140). Findings on the cocaine-exposed infants include a greater frequency (value not explicitly noted) of meconium staining at birth, increased incidence of premature labor (unknown if followed by premature delivery), and a lowered mean gestational age among the cocaine-exposed infants as compared to the non-drug controls (exact data not reported). Eight infants in the cocaine group exhibited congenital anomalies and two infants in the cocaine group experienced cerebral infarcts prior to delivery. Even though there was a small sample and numerous confounding variables in this study, Chasnoff affirmed causality when he stated: "The perinatal cerebral infarction noted in two infants is a severe example of the morbidity associated with intrauterine exposure to cocaine" and in the same article, "Two infants in the cocaine group suffered a perinatal cerebral infarction *related to their mother's cocaine use*..." (p. 29) (emphasis added). These statements were made even though there was at the time no empirical evidence for cocaine causing cerebral infarcts in infants. The study is also vulnerable to the recurrent

problem of no control over the polydrug use of the women; yet attributions of cocaine as the causing agent were consistently made in this article.

The Re-evaluation of Prenatal Cocaine Exposure

In 1992, scientists and advocates for pregnant drug dependent women and their children began a re-examination of earlier research conducted on cocaine-exposed infants, some of which has been discussed in the previous section. In describing the wave of early research and the punitive climate that resulted, these authors characterize the research and punitive events of this period (1987-1992) as a "rush to judgment" (Mayes, Granger, Bornstein & Zuckerman, 1992, p. 406). The authors called for accurate estimates of the actual prevalence of perinatal addiction and noted that the existing research on infants at that time was "far too slim and fragmented to allow any clear predictions about the effects of intrauterine exposure to cocaine on the course and outcome of child growth and development" (p.406).

Beginning around 1991, the lay media revisited the issue of the integrity of the research on cocaine babies. One prominent neonatal researcher noted at that time: "The research around cocaine has been very poor. Most of the early observations turned out not to be true" (San Jose Mercury News, 1991). Other researchers began to publish findings which

moderated the effects of cocaine on newborns (Zuckerman & Frank, 1992; Lester & Fronick, 1994; Hurt, Brodsky, Braitman & Gianetta, 1995) and even suggested that factors other than drug exposure itself may account for the negative outcomes that had previously been described in scientific media and the press (Lutiger, Graham, Einarson & Koren, 1991; Napiorkowski et al., 1996; Arendt, Angelopoulos, Salvator & Singer, 1999).

In 2001, Frank et al noted: "... among children up to 6 years of age, there is no convincing evidence that prenatal cocaine exposure is associated with any developmental toxicity different in severity, scope, or kind from the sequelae of many other risk factors" (Frank, Augustyn, Knight, Pell and Zuckerman, 2001, p. 1621). These authors note that research findings, once specifically suggestive of cocaine effects, are now more likely to be the result of prenatal exposure to alcohol, tobacco and marijuana as well as the quality of the home environment.

Researchers also challenged the common practice of infant drug testing without confirmatory testing of a positive result when citing prevalence studies. In a unique discussion of neonatal drug testing, authors determined that radioimmunoassay testing without confirmatory drug testing can produce false positives, thus adversely inflating estimates of prevalence

of cocaine exposure in newborns (Henderson et al., 1997). Finally, numerous studies now suggest that neonatal exposure and outcomes vary greatly and that there may be a dose-response relationship (Chiriboga, Brust, Bateman & Hauser, 1999; DeLaney et al., 1996). While there are still grave consequences to some prenatally exposed infants, cocaine does not now appear to not be the wholly destructive drug it was earlier claimed to be (Lyons & Rittner, 1998).

Conclusion

While this remarkable legacy of perinatal addiction is implacable in terms of its past history and its impact on select health and social policy, this historical examination also serves the purpose of looking forward to the potential for change in beliefs and practices as well as in the political process that has defined the availability of treatment for pregnant drug dependent women today. Simultaneous to the events that occurred from 1987 to the present, researchers and advocates continued their work to define strategies of gender-specific treatment that improve the lives of drug dependent women (Brindis, Clayson & Berkowitz, 1997; Howell, Heiser & Herrington, 1998; Strantz & Welch, 1995; Messer, Clark & Martin, 1996). In spite of the negative portrayal of perinatal addiction primarily as a legal problem,

progressive and therapeutic interventions continue to be developed and communities continue to organize around the notion of addiction as a biopsychosocial disease wherein recovery for the women and their children is possible.

As these on-going research and advocacy activities unfold, we are lead to another set of questions about drug dependent women and how best to facilitate treatment for these women and their children. Among those questions is the issue of treatment readiness and elimination of the barriers to treatment that women face. While there is a significant amount of empiric research on barriers (Cunningham, Sobell, Sobell, Agrawal & Toneatto; Isenhart, 1994; Longshore, Hsieh & Anglin, 1993), there is very little that is specific to pregnant drug dependent women. None of the currently existing research has specifically queried pregnant women about the barriers they encountered in seeking drug treatment.

Chapter Two

Barriers to Treatment for Pregnant Drug Dependent Women

Introduction

The process of identification and location of barriers to treatment for drug dependent pregnant women can enable researchers, policymakers, program developers, care providers and advocates to work toward a reduction or elimination of barriers in order to enroll more women into treatment. While other extrinsic forces such as legal or family coercion, limited treatment system capacity and regional and national drug policy also act upon the process of treatment entry, increasing early voluntary treatment enrollment is a necessary focus of research on treatment barriers for this population. In the case of pregnant drug dependent women, it is research that has not yet been fully implemented.

Examination of extrinsic barriers to treatment for individuals and populations can lead to increased admissions and may reveal areas of needed action relative to clinical intervention and policy development. Gender-specific treatment for alcohol and drug problems is associated with decreased morbidity and mortality and decreased economic costs to society (Svikis et al., 1997; NORCU, 1994; Kronstadt, 1990). As findings

accumulate about the effectiveness of treatment in general, participation in substance abuse treatment by women emerges as the overall goal of knowledge development in the area of reduction of extrinsic barriers.

For pregnant drug dependent women, the process of entering treatment is affected by ease of access to treatment, by factors in the social environment and by particular psychological dynamics and motivational stance conferred by pregnancy and impending parenthood. The purpose of this chapter is to examine research literature and theoretical models that have relevance to the process of pregnant drug dependent women's negotiation of extrinsic barriers to alcohol and drug treatment as a part of the overall process of treatment readiness. This chapter provides a discussion of the significance of examining these barriers for pregnant drug dependent women, reviews the literature on extrinsic barriers to treatment and prenatal care, and discusses gender-specific treatment for pregnant and parenting women. Two relevant theoretical models of barriers to treatment are also examined.

Making Ready for Treatment: The Women and the Social Context

Drug Dependent Women

A 1989 national survey of 36 perinatal hospital-based services found

an 11% incidence of maternal illicit drug use at delivery (Chasnoff, 1989). In a study of perinatal substance exposure conducted in California in 1992, an overall rate of substance use of 11.35% (n = approximately 607,000 births in California) among women presenting at delivery was detected. Approximately 6% of women in jails are incarcerated for drug-related offenses and the majority of these are women of childbearing age with two or more dependent children (Snell & Morton, 1994; Jessup & Nantambu, 1994).

Pregnant drug using women have multiple needs and life experiences that make seeking treatment and encountering barriers especially challenging. Women who abuse alcohol and other drugs are often involved with alcoholic/addicted men and these male partners often play a pivotal role in women commencing and continuing their use of mood-altering chemicals (Amaro, Zuckerman, & Cabral, 1989). Families affected by alcohol and drugs are often isolated from community, religious and other social activities (Kumpfer, 1987). The perinatal substance abuser may also suffer from unresolved grief and loss due to the loss of a previous child either through miscarriage, stillbirth, neonatal death or child welfare removal (Raskin, 1992).

Women with alcohol or other drug dependencies are also at risk for HIV infection and AIDS from sharing contaminated needles and unsafe sexual practices. The Centers for Disease Control and Prevention (1994) notes that women are predominantly infected through injection drug use (48%) or transmission from an infected heterosexual partner (36%). Of cases of AIDS in adolescents that are heterosexually transmitted, 91.5% are among girls. Vertical transmission of HIV from mother to child occurs at a rate of 20-30% and the majority of pediatric cases of AIDS in the U.S. are the result of perinatal transmission. Women of color are disproportionately affected by AIDS. In the U.S., the rate of AIDS cases among African American women is 13 times higher than among White women; among Hispanic women, the rate is 6 times higher than among White women (Blank, Mofenson, Willoughby, & Yaffe, 1994).

Other researchers have noted a specific link between addiction and history of trauma, violence, and co-existing mental illness. In-treatment populations of addicted women are known to have high rates of past sexual, physical and psychological abuse (Gil-Rivas, Fiorentine, & Anglin, 1996). Violence toward women drug users and women with drug-using partners is common (Amaro, Fried, Cabral, & Zuckerman, 1990). Among women with

alcoholism or other drug dependencies, there is also considerable co-morbidity with depressive symptoms and other mental health disorders including post-traumatic stress disorder (Wilsnack & Wilsnack, 1995; Fullilove et al., 1993). The population of addicted women has numerous problems and often require intensive case management, material assistance and advocacy in order to negotiate the system of prenatal care and substance abuse treatment in the public sector.

The Social Context of Perinatal Addiction

In this discussion of extrinsic barriers to treatment and theoretical approaches to the phenomenon, it is important to appreciate the power of the current social construction of perinatal addiction. The theme of deterrence is embedded in the treatment-seeking experience for pregnant women, solidified by fifteen years of the federal War on Drugs and the resultant vilification of addicted persons in general and pregnant drug dependent women in particular. This metamorphosis of perinatal addiction from a public health problem into a primarily legal enterprise has had significant impact.

In some settings, pregnant users of cocaine who sought prenatal care have been arrested and incarcerated (Bragg, 1998). In other settings,

pregnant women have been prosecuted for a variety of gender-specific crimes associated with the use of mood-altering chemicals (Paltrow, 1992). Others have suffered severance of parental rights as a result of detection of illicit drug use (Siegel, 1994) and the legal use of methadone in the context of bona fide methadone maintenance treatment (S. Castillo, personal communication, March 27, 2000). In some communities, there is no treatment of any type, or there is inappropriate treatment, which discourages a pregnant woman from seeking care.

With the rise of the cocaine epidemic in the United States a decade ago and the intrusion of government into women's reproductive health, the social construction of perinatal addiction changed immutably in 1987. In San Diego that year, a pregnant drug dependent woman was criminally charged with child endangerment in the death of her infant son as an alleged result of prenatal drug exposure and maternal behavior (Schachter, 1986). As discussed in more detail in the previous chapter, this case and over 250 other cases of "prenatal child abuse" in the United States since 1989, have led to a profound and contentious controversy about drug dependent pregnant women. Other forces contributing to the criminalization of pregnant women's drug use include the rise of the fetal rights movement, renewed attacks on women's reproductive

rights, methodologically flawed scientific findings, and negative lay media. These forces inflamed negative public opinion about female drug addicts and incited frightening public and judicial reactions to the problem (Chavkin, 1989; Kolata, 1990; Teare, 1995). Court-ordered Norplant, incarceration, sterilization and daunting revisions in child welfare law are some of the policies proposed and carried out in order to resolve the problem of illicit drug use during pregnancy ("Child abuse charge", 1990; Pollitt, 1990; Cole, 1990). This controversy, which affects policymakers and providers of addiction treatment, prenatal and pediatric care, is a polemic characterized by a conflict between the balance of interests of the fetus/infant (rights of the unborn) and the interests of the woman (right to bodily integrity; confidentiality and privacy rights). In this highly charged context then, the importance of determining extrinsic barriers to treatment, including an examination of the role of punitive public policy, is highly relevant.

Extrinsic Barriers to Treatment

In order to locate barriers in the process of treatment readiness, it is important to explore the relationship of the two. Theoretically, the larger construct of treatment readiness has been construed as an individual's motivational status in terms of levels of acknowledgement of a problem and

desire to take action by seeking, entering and staying in substance abuse treatment (DeLeon & Jainchill, 1986). Treatment readiness has been depicted as the type and quality of the individual stage of change as it exists along a change continuum (Miller & Rollnick, 1991) and as having stages that are differentiated by degree of willingness and action (McConnaughy, DiClemente, Prochaska & Velicer, 1989). Readiness as an ability has also been defined as largely determined by the social context (Allen, 1994). Treatment readiness has been correlated with retention (Joe, Simpson & Broome, 1998; Siddall & Conway, 1988; Ingersoll & Haller, 1995) and relapse (Strantz & Welch, 1995) and also relates to treatment-matching and patient placement criteria (Gastfriend & McLellan, 1997; Hoffman, Halikas & Mee-Lee, 1987; Hoffman, Halikas & Mee-Lee, 1991). Brown and colleagues (2000) have also described "steps of change" in a model of treatment readiness in women. The authors suggest that the "help-seeking behavior of substance abusing women may reflect a hierarchy of readiness in women based on the immediacy or time urgency, of their treatment issues" (p. 231).

The dimensions of treatment readiness however, are not necessarily discreet or independent domains with clear conceptual boundaries. For

example, in reviewing literature on intrinsic barriers to treatment, such as motivational status, perceived need for treatment, and the concept of treatment utilization, it is notable that these concepts are closely linked and often describe behavioral and psychological responses to perceived extrinsic barriers (Longshore, Hsieh & Anglin, 1993; Isenhart, 1994; Rollnick, Heather, Gold & Hall, 1992; Cox & Klinger, 1988).

In order to examine the literature on pregnant drug dependent women, treatment barriers are discussed in terms of the negative and restraining effect on a woman's ability to enroll in treatment (see Table 2. 1).

Table 2. 1

Barriers to Treatment for Drug Dependent Pregnant Women

Intrinsic Barriers	Extrinsic Barriers
motivational status	program characteristics
self-perceived need for treatment	social stigma
help-seeking behaviors	fear of prosecution, loss of custody
co-morbidity	punitive public policy
fear	racism
	prenatal care access
	transportation
	child care
	family/spousal resistance
	physical abuse

The category of extrinsic barrier serves to sort empiric research on barriers, differentiating objective social contextual barriers from psychological person-located barriers.

Extrinsic barriers to treatment may be located in the health service system or embedded in the social and family relationships of the drug dependent women. Extrinsic barriers described in literature on health care in general include time, distance, cost, availability, organization of services, discrimination and provider-consumer relationships (Melnyk, 1988). For drug dependent persons, other barriers may include socially constructed attitudes and myths about drug dependency, an inability to obtain goods or services which therefore prohibit treatment participation (e.g. transportation, childcare) or lack of knowledge about, or confidence in, the treatment system and its effectiveness (Grant, 1997).

Program characteristics, which may be a barrier to entry, include the very presence or absence of a program in a community, the modality (outpatient, hospital inpatient, day treatment, etc.), content of treatment services offered, staff attitudes (Beckman & Kocel, 1982), and pre-admission requirements. These requirements, which could be barriers to treatment include a 48+ hour sobriety requirement, daily phone calls to the

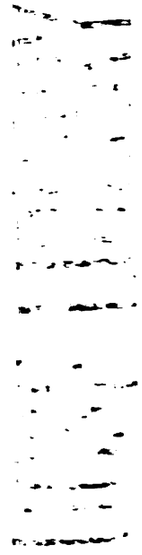
program to demonstrate motivation, extensive documentation of health insurance coverage and citizenship or mandatory participation of family and significant others as conditions of admission.

Punitive public policy, such as gender-based judicial actions, prosecutions or inequitable child welfare actions (Marsh & Miller, 1985; Vogeltanz & Wilsnack, 1997) may also serve as barriers to treatment for drug dependent women. It should also be noted that punitive public policy, while considered an extrinsic barrier, can result in fear, an intrinsic barrier. Objective realities, such as punitive legal and treatment policies and child welfare laws, generate fear and anxiety in pregnant drug dependent women and therefore, fear and punitive public policies are linked experientially in the lives of these women. A social constructivist perspective recognizes this phenomenon's social origins as a contextually induced fear, rather than a fear originating in individual psychopathology or neurosis. Yet, within this contextual backdrop, fear is nonetheless placed in the intrinsic category precisely because of the highly personal impact wrought by punitive policies.

There are important reasons to delineate barriers to treatment for pregnant drug dependent women. The overriding purpose of identifying and

increasing understanding of extrinsic barriers is to facilitate early-in-pregnancy entry to treatment for alcohol and drug dependent women. When drug dependent women enter treatment early in the course of their pregnancies, significant decreases in mortality and morbidity for the women and their infants occur (TPMG Bulletin, 1995; Camp & Finkelstein, 1995; Brindis, Clayson & Berkowitz, 1995). However, in some treatment-intervention samples, even though medical and social complications were reduced through the women's participation in treatment, only one third of the drug dependent women entered treatment during pregnancy and many (49%) entered late in the third trimester (Brindis, Clayson & Berkowitz, 1995). In another study of treatment-seeking HIV+ drug dependent pregnant women, it was noted that 62% (n=21) entered the treatment program in the third trimester (Svikis, Gorenstein, Paluzzi & Fingerhood, 1998). The provision of social services and early prenatal care is an essential part of nursing and interdisciplinary guidelines and policy statements on the health care of drug dependent pregnant women (American Nurses Association, 1991; American Society on Addiction Medicine, 1989; American Academy of Pediatrics, 1990), yet specific strategies to induce drug dependent women to enter care earlier have not been examined empirically.

Additionally, even though women historically use health care services more than men, women continue to be under-represented in public sector alcohol treatment programs based on the presumed prevalence of alcohol problems among women (Weisner & Schmidt, 1992). In this regard, examining barriers to treatment may also affect treatment providers' traditional perspectives about so-called "denial and resistance" among active drug using women, which may actually be valid gender-specific concerns that cannot be ignored. Addicted women have valid concerns about family, children, housing and their futures that must be dealt with prior to entering treatment.



Recent changes in child welfare legislation and dependency court policy in California and nationally have renewed pressure on substance dependent women to enroll and complete treatment rapidly relative to child welfare timetables. Because of this policy of "concurrent planning," child welfare agencies must plan for the potential severance of parental rights while also pursuing a plan for possible reunification with parents (California Department of Social Services, 1998). Therefore research on effective strategies for expediting women into treatment is critical in facilitating

compliance with child welfare agency agendas and for family maintenance and reunification, as well as recovery and survival.

In the life of drug dependent women, pregnancy has been described as a "window of opportunity" for successful interventions and participation in treatment due to enhanced motivation on the part of the women (Daley, Argeriou & McCarty, 1998). As noted by Curry (1989), some high-risk pregnant women have to be actively recruited into prenatal care. These gender-specific approaches can be used to test strategies for program development and recruitment of clients.

For pregnant women, it is important to engage in the discussion of barriers within a perspective that holds gender as a definitive aspect of these barriers. Socially imposed and personally assumed roles, economic status and power, ethnicity, relationship dynamics, women's responsibilities for children and childcare, reproductive health status, child welfare issues, and sexism contribute to the current social construction of perinatal addiction.

Insensitivity and devaluing of ethnic and cultural values, customs, beliefs and traditions may act as barriers to treatment for drug dependent women of color. Women of color will not be attracted to programs that focus on "individual pathology" without an appreciation of the historical, social

and environmental pressures and forces they face (Taha-Cisse, 1991; LaDue, 1991; Mora & Gilbert, 1991).

Discussions on barriers to treatment for drug dependent women in the scientific literature are largely anecdotal; few are reports of empiric research. The empiric research that exists is quantitative in nature. There are virtually no "thick descriptions" of women's lived experience told in their own voices relative to their stories of readying for treatment and the extrinsic barriers they face in that process. Additionally, it is important to note that research on barriers to treatment is not same as research on the question of "what makes women enter treatment." The question of motivations for treatment may enhance knowledge about barriers to treatment, yet they are separate lines of inquiry.

Extrinsic Barriers to Treatment for Drug Dependent Persons

Descriptive research on extrinsic barriers to alcohol and drug treatment for dependent persons in general cites finances, transportation, childcare, discouraging persons, and attitudes toward alcoholism treatment as barriers to treatment (Stark, Campbell & Brinkerhoff, 1990; Grant, 1997). Empiric research on barriers for drug dependent persons is limited. Some of the research on barriers for addicted persons in general tends to conflate the

concept of barriers into the concept of early treatment dropout or problems in retention once enrolled in treatment. In this way, early dropout is construed as a barrier to continued treatment, rather than a barrier to entering treatment at all. The following review of the literature on barriers to addiction treatment is summarized as a Table in Appendix C.

In their study of attrition prevention, Stark, Campbell and Brinkerhoff (1990), randomly assigned 117 callers (46% females) to an outpatient treatment program to one of four experimental conditions. One of the variables in the conditions included a verbal inquiry about possible barriers that might prevent the person from appearing for their intake interview. Participants in the study either received 1) an immediate appointment plus a barriers dialogue; 2) instructions to come as soon as possible plus the barrier dialogue; 3) immediate appointment only or 4) instructions to come as soon as possible. Participants given the immediate appointment kept their intake appointments at a higher rate than participants whose appointments were delayed. The barriers dialogue had no effect on client behavior. Gender differences in result were not reported and barriers were not discussed in depth, but researchers noted that immediate entry to treatment, when the caller is most motivated, is a strategy to reduce barriers and "improve

clients' motivation for treatment"(p. 73).

Another comparative cohort study of help-seeking among alcohol and drug abusers was conducted to examine barriers to treatment for three groups: 192 alcohol and drug users in outpatient treatment; 92 self-change alcohol abusers who claimed resolution of a drinking problem without treatment (abstinent and non-abstinent solutions) and 62 untreated active alcohol abusers (Cunningham, Sobell, Sobell, Agrawal & Toneatto, 1993). Using a Likert-type scale of structured "reasons questionnaires" and additional reasons added by the subjects, 11 treatment delay factors emerged. The no-treatment group (resolved without treatment or still with active problems) was more likely to report not entering treatment because they wanted to handle it alone or because they did not perceive their drinking as a problem. This group also rated the stigma associated with a diagnostic label of alcoholism as being more influential in their decision to not seek treatment compared to the in-treatment outpatient group.

There were serious flaws in this study that limit the significance of their findings. The close-ended questionnaire limited the possible choices of reasons for not seeking treatment and, although the authors asked for other reasons, the pre-selected possible reasons did not even include common

reasons cited in the literature for why individuals seek treatment such as medical consequences, relationships, employment, legal reasons or family pressures to quit (Weisner, 1986).

A similar qualitative interview study of barriers to treatment for women who became sober without formal treatment, was conducted by Copeland (1997). Exclusion criteria included any participation in formal treatment, including detoxification, and greater than five Alcoholics Anonymous meetings within the first year of sobriety. The 32 women were primarily White (95%) and well educated (86% high school graduates). Copeland found that women avoided formal treatment programs for four primary reasons: perceptions that they were very different from the usual women who use treatment programs, the expense, lack of childcare, and what the women believed was the inappropriateness of the available treatment models.

In a related study, differences between drug dependent women who had ever been in treatment and those who had never been in treatment were examined. In this correlational study of women drug users in New York City, interviews were conducted with 459 informants from three sources: a city prison, a residential treatment center and directly from the street (Faupel

& Hanke, 1993). The dependent variable in this study was treatment experience, dichotomously defined as yes or no. The independent variables included age, education, employment, race, marital status, presence of children, impact of drug use, criminal histories and number of lifetime arrests.

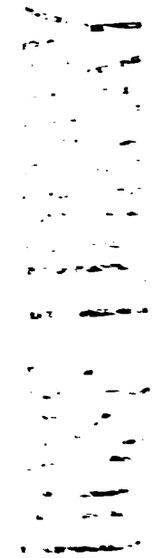
Through bivariate analyses and logistic regression, the influence of each independent variable to treatment entry status was examined as was the likelihood of each of the independent variables contributing to treatment entry while controlling all other variables in the model. Findings of significance revealed that women who had been in treatment were 4+ years older than those never in treatment; women who had been in treatment began their drug using careers at a significantly earlier age (14.4 years) than those never in treatment (15.2 years); the number of arrests was significantly related to treatment entry in that women who had been in treatment had a greater number of arrests on average (6.7 arrests) than those who had never been in treatment (3.1 arrests) (standard deviations not published). Among these respondents, women with children were significantly more likely to have participated in treatment at some point in time.

Faupel and Hanke's (1993) study was important for the identification

of demographic characteristics of women that relate to never seeking or receiving treatment, suggesting that barriers exist related to those significant variables. These clinically important findings have implications for policy development also, as they highlight the need for interdisciplinary approaches to recruitment of specific populations (i.e. younger women who are earlier in their careers of addiction, women who are first and second time arrestees, and untreated women with drug problems who have children and could be identified as at-risk drug users by child welfare authorities). Though this was a descriptive study, one problem was the absence of a theoretical framework, which would have clarified the motivation for the study design and possibly informed the discussion of the findings. Additionally, there was no attention to history of coercion as a means of entering treatment, which would have been crucial to examine in light of the treatment recidivism among the women in this study. These researchers also failed to ask about factors such as personal relationships which may have prevented the women from ever entering treatment; treatment sabotage by significant others has been described as a significant barrier to treatment entry (Beckman & Amaro, 1986).

In an examination of one type of treatment sabotage by families and

friends, Beckman and Amaro (1986) conducted a study of 67 White women and 54 White men in alcoholism treatment facilities in two California counties. Informants were recruited by program staff for interviews within one week of entry into treatment. Data included measures of self-esteem, health-related attitudes, social isolation, locus of control, severity of alcohol misuse and treatment history, level of social support, and childcare responsibilities. Selected variables were based on the theoretical model of alcohol treatment utilization (Beckman & Kocel, 1982). This model proposes that individual predisposing factors, personal enabling traits, social enabling characteristics and structural features of treatment determine women's abilities to secure and use treatment services.



Multivariate discriminant function analysis was used to examine differences by gender. The researchers found that women clients had less social support for entering treatment than men, and women were fairly likely to have had opposition to treatment from their friends and families. Opposition to the males entering treatment occurred in only one of the 54 males as compared to all 67 females. The authors attributed the opposition to women entering treatment to societal stigma. However, in order to more fully understand the opposition women encounter, their roles among families

and friends must be examined. These respondents were also not queried about fear of legal consequences or fear of loss of custody even though 79% of the women and 76% of the men were parents of at least one child. Sample selection in this study was also problematic in that interviewing persons in treatment excludes information from persons who never made it to treatment and barriers that impeded entry remain unknown. Interviewing alcohol and drug dependent persons not in treatment would be an important source of data about opposition from families and friends.

In a study of waiting lists and the impact on treatment entry, a retrospective analysis was conducted on factors that correlated with pre-intake dropout (Festinger, Lamb, Kountz, Kirby & Marlowe, 1995). The study included 235 client callers to an urban cocaine outpatient treatment program. A backward logistic regression was conducted on the dependent variable (showing up for the scheduled intake appointment) and thirteen independent variables, including caller characteristics (gender, age, city of residence) and days between initial phone contact and scheduled appointment, referral source, time since last cocaine use, other reported drug use, gender of assigned counselor, gender of operator taking the call and whether the client or someone else made the call. Of the 235 clients (68%

males and 32 % females), 136 (58%) did not show up for their appointments. The gender of shows vs. no-shows was not provided. The only independent variable of significance was number of days between initial phone contact and scheduled appointment; the fewer the days, the more likely the client was to keep the appointment.

Within the context of treatment then, system-induced delay was a barrier to entering treatment. Although participants were clients with cocaine as the primary drug of abuse, these findings suggest that prospective clients who have to wait to see a counselor will be at risk for no-show. There may also have been other determinants of pre-intake dropout for the sample in this study, such as psychiatric co-morbidity, medical complications, or other factors affecting motivation. Follow-up calls to determine a stated reason for the no-show could have further validated these results; notation of the gender of the shows and the no-shows should be included in any replication of this study.

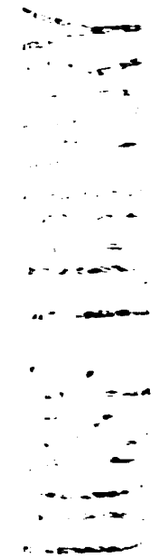
In a descriptive study of gay men and lesbians, treatment barriers included internalized and social homophobia, fear of coming out, low numbers of gay staff in treatment programs, and client perceptions of program staff's lack of ease in talking about HIV and AIDS related issues,

which included safer sex strategies (Cabaj, 1989). Barriers to continued recovery for opiate dependent persons may include vulnerability, dramatic mood swings and disordered thinking among individuals who are in the process of detoxification (Wermuth, Brummet & Sorenson, 1987).

Tam, Schmidt and Weisner (1996) noted a significant extrinsic barrier to treatment in their description of large bureaucratic institutions (criminal justice and social welfare) that interact with problem drinkers and yet do not utilize smaller community-based systems as referral sites for these persons. The authors suggest that making it to treatment is influenced by where persons with alcohol problems present in the public sector. They also suggest that early intervention programs should co-locate in these large agencies in order to target this particular population of drinkers. Women with alcohol problems have also been noted to be more likely to use treatment programs with aftercare and services for children, preferring those with extensive support services and child care (Beckman & Amaro, 1986).

The stigma of alcoholism and gender differences in obtaining help for alcohol problems was the subject of a descriptive study of 25 men and 25 women referred to an outpatient alcohol clinic in England (Thom, 1986). In this study, respondent perceptions of barriers to help-seeking and

demographic data were gathered. Women were much more concerned than men about the stigma of addiction, which caused them to delay asking for help from physicians for many years. Women were also significantly less likely than men to identify their drinking as the main source of their problems. Involvement with a drinking partner added significantly to the difficulty of the women in designating their problems being due to alcohol, as partners minimized and even discouraged them from seeking help. A critical intervention suggested by the results of this study is family education by primary care providers in order to reduce barriers associated with stigma and reinforce family relationships. This study, while limited in its discussion of the meaning of these barriers to the study participants, nonetheless provides more insight into barriers encountered by individuals who did eventually enter treatment.



It must be assumed that there are differences between in-treatment and out-of-treatment samples of drug dependent persons and, in this regard, Thom's (1986) findings have limited applicability to the latter group. The author does make the important point that primary care providers should do more to facilitate recovery in their patients, particularly among women. This was suggested because of the additional finding that women had difficulty in

seeing themselves as problem drinkers who should get help for their alcohol problem; yet, these women were able to go to their primary provider with other non-alcohol related complaints. Thom's findings are similar to the findings of Willmore (1992) and Amaro and Hardy-Fanta (1995) who described the stigma of addiction, role dissonance for drug dependent women who are mothers, and limited social and spousal support that make it more difficult for women to seek treatment.

An often-cited article on barriers to treatment for alcoholic women describes the impact of three barriers: negative myths about women's recovery, the impact of sex-role stereotyping and lack of knowledge by providers (Vanicelli, 1984). Vanicelli simultaneously described an author-conducted field experiment on attitudes toward women alcoholics, a meta-analysis of treatment outcomes for women and men alcoholics (1952-1980) and anecdotal evidence from her clinical practice. In the field experiment, the author conducted a two-day workshop for 45 members of alcohol treatment agencies of a mid-western state and also collected "various kinds of data" (p. 30). Participants were asked to list typical male and female problems likely to be encountered in an alcohol-dependent client seeking treatment. The major outcome of this field experiment was that program

staff viewed female clients as having a poorer prognosis for recovery than males. The author cited medical literature from 1948 to 1964, wherein the popular belief was that women alcoholics were more abnormal and inherently had poorer prognoses (Karpman, 1948).

In what Vanicelli (1984) describes as a "meta-analysis," scientific literature from 1952-1980 was reviewed. To be included, a study had to have three or more subjects and psychological counseling or medication used with a drinking-related outcome measure. While no in-depth discussion of the findings was presented, a mere counting of the positive and negative outcomes for women as compared to men showed no evidence to support that women with drinking problems had a poorer response to treatment than men. The meta-analysis methodology used in this study was problematic. At a minimum, an estimation of the population effect size, the means and the standard deviations for each study in the meta-analysis should have been included: furthermore, the design for the statistical analysis was not reported at all. However, Vanicelli's work is important as an early contribution to understanding sex-role stereotyping and the impact of sexism upon scientific research about alcoholism. The significance of this work, though dated and methodologically flawed, is compelling. She suggests that treatment staff

attitudes and unsubstantiated myths may act as barriers to successful completion of treatment and recovery for women.

Barriers for Drug Dependent Pregnant Women

Messer, Clark and Martin (1996) conducted a descriptive correlational study using a convenience sample of 182 drug-using women in the natural setting of a prenatal clinic. They compared those who accepted substance abuse treatment when offered (acceptors n = 93) and those who declined the offer of the same services (decliners n =89). Treatment acceptance status was the dependent variable and the eight independent variables included age, education, marital status, number of children, race and the level and type of use of substances, substance use by partner and parents and experiences of violence in their own lives.

They found that African American women who smoked during pregnancy, women who drank at all during pregnancy, and women who drank significantly more alcohol per month (mean of 9.9 drinks per month compared to decliners' 5.6 drinks per month) were more likely to accept treatment. Women who accepted treatment were six and a half times more likely to use some type of illegal drug during pregnancy than women who declined treatment. Additionally, women who accepted treatment were three

times more likely to be African American compared to women who declined treatment. Importantly, historic validity is questionable. It is also noteworthy that 78% of the pregnant women who reported cocaine use accepted treatment.

Messer and colleagues (1996) conducted their study at a large urban health department in North Carolina. However, at the Medical University of South Carolina (MUSC) in Charleston, at the same time as this study, there was a policy of arrest and incarceration of pregnant cocaine dependent women when they presented for prenatal care and tested positive for cocaine metabolites. Due to a civil lawsuit on behalf of the African American women arrestees and extensive media coverage, the policy at MUSC was a very high profile issue at the time of this study. However, there was no discussion of that issue as a possible confounding contextual variable in the choice process of these women subjects, an oversight in interpretation of these findings. This could explain the very high rate of enrollment in treatment among African American women in the study. Although the study setting was described as a prenatal care setting, it was not possible to determine if the prenatal care clinic had an integrated substance abuse track or if the prenatal clinic was separate from the substance abuse treatment component. A detailed description of the setting could allow for evaluation of the extent to which

the program was experienced as threatening, easy to enter or client-friendly.

One serious concern about the design of this study is the sample selection process and the method of offering treatment. It is merely noted that the subjects were identified "through the screening process as being in need of substance abuse treatment services" (Messer, Clark & Anderson, 1996, p.407). There was no discussion of the exact diagnostic or other inclusion criteria and so an element of possible investigator bias was introduced. The group of acceptors may have resembled a stereotypical profile of a "person needing treatment" from the subjective perspective of the investigators. Though there were White women enrolled in the study (White women n = 68; African American women n = 114) with equally serious histories of drug use and consequences from their use, the issue of why there were so many more African American women acceptors than White women acceptors remained unaddressed. Differences in the approach to offering treatment or differences in attitudes toward the participants based on ethnicity or a feeling of greater concern about the use of illegal substances, may explain the ethnic difference in treatment acceptance rates. Differences in treatment entry may have been due to the possibility of racial stereotyping. It is possible that the White women did not accept treatment

because they were not viewed as equally in need of treatment, or that a lack of urgency about their problem was unconsciously communicated to the women by the researchers. This concern is noted as a recent finding from interviews with women in a pilot qualitative study on barriers to treatment (Jessup, 1999).

In a descriptive study of fear of prosecution and the resultant "flight from care," 142 low-income women were interviewed 2-5 days postpartum to ascertain their attitudes regarding the possible effects of punitive legislation aimed at drug-using pregnant women (Poland, Dombrowski, Ager & Sokol, 1993). Women who delivered at a large urban city hospital participated in a one-hour interview with open-ended and fixed choice questions. The authors over-sampled women with little or no prenatal care in an attempt to match a sample of women who would be more likely to use illicit drugs (i.e. those with inadequate care). African American women constituted 85% of the respondents; 30% of the total sample received inadequate amounts of prenatal care and 15% (n = 21) admitted use of illegal drugs during pregnancy.

Of the 21 women in the sample who used drugs during pregnancy, 13 stopped use before the third trimester and four "sought treatment

unsuccessfully" (Poland, Dombrowski, Ager & Sokol, 1993, p. 201), however the authors provide no additional explanation. Of the drug-using women, 47.6% received inadequate prenatal care compared with 27.5% of the non-using sample. Respondents were queried as to whether a punitive law against pregnant drug users would make women in similar circumstances more or less likely to get prenatal care, test for drug use and seek drug treatment. For all three questions, the majority of respondents felt that women would be less likely to carry out all three tasks if a punitive law was in effect. One weakness of this study is that rates of positive and negative responses were not given. The authors reported that "Comments made in response to these questions indicated, in general, that substance using women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of children" (p. 202).

The findings of this study, however interesting, have questionable validity (Poland, Dombrowski, Ager & Sokol, 1992. The responses would be more informative if the sample was entirely drug using pregnant women and if it was in response to an actual situation. However, as the authors noted, they attempted to conduct the study in a state where there is such a punitive law and postpartum women who were known to use drugs refused

to participate in the study because they feared incrimination. These findings suggest that the threat of prosecution and loss of custody may be significant extrinsic barriers to treatment for this population, and further research is required. In their instrument that measures the overall construct of treatment readiness, DeLeon and Jainchill (1986) refer to these negative deterrents in the domain of "circumstances" and include the potential for personal loss and fear.

Drug dependent pregnant women are more likely to have partners who are drug abusers and to be the victims of physical violence than are non-drug-using women (Amaro, Fried, Cabral & Zuckerman, 1990). In a study of the impact of violent trauma among 96 low-income pregnant substance abusers, Thompson and Kingree (1998) noted that 72% had experienced sexual assault, 67% had experienced physical assault and 68% had experienced indirect violent trauma. Individual and family violence deters women from accessing support services, and specifically for rural women, belief in traditional gender roles and family ties may be a barrier to leaving the violent home environment (Fishwick, 1993). While more recent research has described active processes used by women prior to leaving a violent relationship (Merritt-Gray & Wuest, 1995; Curnow, 1997), seeking help,

including treatment for a substance abuse problem, could be negatively influenced by a male partner who is a batterer and a substance abuser (Amaro, Fried, Cabral & Zuckerman, 1990; Gorney, 1989). Treatment intake approaches that inquire about such barriers to entry and continued participation can encourage women to identify barriers in order to enhance retention (Namyniuk, Brems & Carson, 1997).

Extrinsic Barriers to Prenatal Care

A decline in attendance at prenatal care clinics, associated with cuts in federal spending, occurred in the 1980's. In that decade, the "percentage of women who obtained late (care beginning in the third trimester) or no prenatal care increased from 5.1% to 6.4%." (York, Grant, Gibeau, Beecham & Kessler, 1996, p.281).

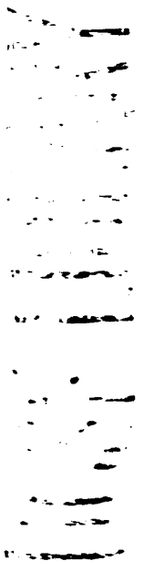
Poverty (Lia-Hoagberg, et al., 1990), low levels of education (Poland, Ager & Olsen, 1987) and inadequate childcare can also be extrinsic barriers to prenatal care (Schorr & Schorr, 1988). Barriers to prenatal care among low-income African American women include social, economic, cultural, demographic and attitudinal factors as determinants of women's decisions to seek prenatal health care (Sanders-Phillips & Davis, 1998). Racial discrimination and loss of cultural identity can be additional factors in

failure to seek health care (Williams, 1997).

Poland, Ager and Olson (1987) examined non-financial barriers in a descriptive study of 111 postpartum women (84.6% African American; other ethnic groups not mentioned) with varying amounts of prenatal care. They identified six socio-cultural factors that contributed to the amount of prenatal care received by the women. The sample consisted of women with no prenatal care and those who received spotty to adequate antenatal care in the prenatal clinic of the study site hospital. The women were interviewed 2-5 days postpartum with open-ended and fixed-choice questions. Subjects were interviewed about experiences, attitudes and beliefs, help-seeking behaviors from the time the women thought they were pregnant through the time of delivery, attitudes toward health care providers, and experiences of labor and delivery. Informants' responses were analyzed through content analysis and converted into four predefined categories with ordinal scales of adequate care, intermediate care, inadequate care and no care (undesignated by number of visits). Scaled responses that failed to reach an inter-rater agreement level of .90 by rank order correlation of the categories were deleted from the analysis.

Comparisons among the four categories on selected variables were

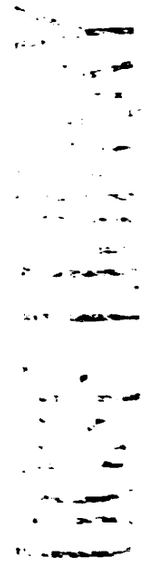
made using a one-way analysis of variance (Poland, Ager & Olson, 1987). Six variables were shown to account for 49% of the variance in amount of prenatal care. These six variables included insurance type, attitudes toward health professionals, delay in telling others about the pregnancy, perception of importance of prenatal care, attitudes about being pregnant and delays in suspecting pregnancy. Limitations of this study include the homogeneous sample and the fact that the study was limited to one urban setting. Also in a correlational study of this nature, it would seem important to ask the respondents how they felt about participating in prenatal care, not only the reasons for not attending frequently. Replication of this study should include qualitative data to understand the dynamics of these correlates of inadequate prenatal care.



Barriers to prenatal care for women members of Medicaid managed care groups were described by Gazmarian, Schwarz, Amaker and Powell (1997). From 42 patients and 22 providers in separate focus groups, the authors identified transportation, lack of knowledge of the managed care system and substance abuse as barriers to prenatal care. Substance abuse was considered a barrier to prenatal care by patient participants due to fear of incarceration if drug use was disclosed. In this study, many of the pregnant

focus group participants were former or current drug users. Additional barriers to prenatal care mentioned in this study included poor treatment by clinic office staff, lack of rapport with providers, lack of education, lack of childcare and limited clinic hours. Denial of pregnancy and resultant delay in seeking care was also mentioned by provider participants as a barrier for teen patients.

In another descriptive study of barriers to prenatal care for high-risk, impoverished populations, researchers noted that fear of incarceration and loss of custody were mentioned by women who participated in their focus groups (Leppert, Partner & Thompson 1996). Lack of insurance, cultural insensitivity, lack of transportation, long waiting times and inconsistencies in providers were noted by focus group participants. They also described the deterrent effect of fearing punishment that might be inflicted if substance abuse or mental health problems were detected by providers.

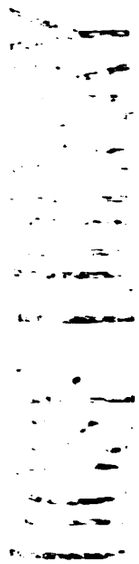


Gender-Specific Treatment

The purpose of this discussion on gender-specific treatment (GST) is to examine the outcome data on models of treatment in order to review the evidence and to understand the differences between traditional models of treatment and GST. Such an examination allows then for discussion of the

validity of GST as a clinical standard and as a policy goal. This review may also illuminate what the elimination of extrinsic barriers could potentially mean for early treatment enrollment and improved maternal and child outcomes. This discussion is also relevant because program characteristics are often included as an extrinsic barrier to treatment in the theoretical models discussed in the next section of this paper.

It should also be noted that there is much variation in the actual content and therapeutic approach of programs in the field of addiction treatment at large. GST programs and other programs also vary in terms of type of modality, length of stay, admission criteria, staffing qualifications, staff-to-client ratios, philosophies and emphases of treatment, level of in-program segregation, isolation vs. contact with family, use of medications, reliance on medical interventions and inclusion or exclusion of spirituality and religiosity as therapeutic tools.



Models of culturally specific and culturally competent treatment programs for pregnant and parenting women have also been developed and described (Uziel-Miller, Lyons, Kissel & Love, 1998; Poitier, Niliwaambieni & Rowe, 1997; Rowe & Grills, 1993; Nardi & Rooda, 1996; Aguirre-Molina, 1991). While descriptions of cultural perspectives and issues in the treatment

of addicted men and women of color are numerous in the scientific literature (Pãerez-Arce, Carr & Sorenson, 1993; Christie & DeBerry, 1994; Westermeyer, 1995; Foulks & Peäna, 1995), empirical research on treatment outcomes for drug dependent pregnant women in programs identified as culturally specific is exceedingly sparse. A review of outcome data from GST programs follows because the majority of research on drug dependent women who are pregnant and parenting is located in the literature on GST, rather than the literature on culture and ethnic-specific drug treatment programs for women.

Description

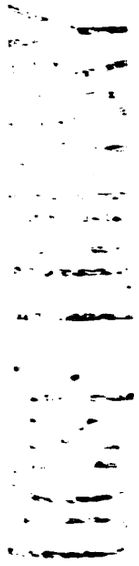
GST of alcohol and drug dependency in women is treatment that is reflective of, and responsive to, the needs, roles, status, psychological issues, culture, and economic status of women. GST takes into account that all activities and components of an addiction treatment program intending to provide therapeutic and recovery-oriented services for women must be consciously designed in order to maximize access, retention and improved outcomes in measures of recovery for women.

GST may be provided in the context of a co-educational treatment program, as a "track" of services, or in the context of programming for women

only. With the track model, the modality may be a therapeutic community, methadone maintenance or other outpatient program. Women-only programs of GST include residential, intensive day treatment or the recovery home, where recovering women live (sometimes with their children) and work with relatively minimal supervision. Traditionally, GST has included services for children as well as for women. Appendix D lists the components of comprehensive care for drug dependent women who are pregnant or parenting. While there is no standard requirement for a certain number of services, GST programs encompass some or all of these components either by in-house provision, interagency agreement or referral.

GST is thought to have greater effectiveness in the treatment of alcoholism and other drug dependencies in women because of improved outcomes, more appropriate client-to-service matching (Bartholomew, Rowan-Szal, Chatham & Simpson, 1995; Camp & Finkelstein, 1995; Copeland, Hill, Didcott & Biggs, 1993; Strantz & Welch, 1995) and the finding that women in mixed-sex groups talk less, are more likely to be interrupted and use language that is less assured (Swacker, 1975). Reed and Liebson (1981) conducted a prospective descriptive study of African American and White women who entered either a traditional program or a GST demonstration programs in the

late 1970's. They noted correlates of program choice based on multiple variables that included social support, previous treatment attempts, child custody, income and education, involvement with social or health services, drug abuse patterns and consequences. The significance of this study was the suggestion that GST programs attracted the most marginalized addicted women who would otherwise not be in any treatment at all. Critical to the field of women's addiction treatment were findings related to past and current sexual, physical and psychological abuse (Bollerud, 1990; Herman, 1992; Fullilove et al., 1993; Hien & Levin, 1994; Thompson & Kingree, 1998). More recent models of GST now attempt to address these life-defining issues (Moseley, 1996). With more attention to the needs of pregnant and parenting women, comprehensive models of GST focused on infant care and women's roles as mothers have been implemented and evaluated (Brindis, Clayson & Berkowitz, 1995).



Rationale

It is then in this context of heated public debate about the fate of drug dependent women and their children, that researchers and advocates return again to the critical need for treatment that is appropriate for, and responsive to the needs of, women and children. GST, non-existent in many of the

communities where these prosecutions took place (L. Paltrow, personal communiction, October, 1996), is the obvious humane alternative to punishment for the treatment of this bio-psycho-social disease. In the context of a society that does not prosecute pregnant addicts, GST is a viable alternative to punishment. In the context of a society that is conflicted and punitive about the treatment of this population, GST becomes an imperative to allow for the best possible outcome. GST has been cited as a critical part of the health and policy response to the problem of drug dependent women and their children (APHA, 1990; AAP, 1990; ANA, 1991). Advocates, including nurses, physicians, lawyers and policymakers, suggest that without GST to help these women, we become willing to punish what we are not willing to treat.

Research on GST

Finkelstein (1993a) found that barriers to addiction treatment increased for pregnant women and women with young children. These barriers include a lack of community-based resources, fragmentation of care and services, and non-supportive attitudes of providers about the special issues of women. These and other extrinsic barriers tend to be reduced or eliminated in programs and communities that provide and support gender-specific models of treatment

provision, thus allowing more women to enter treatment.

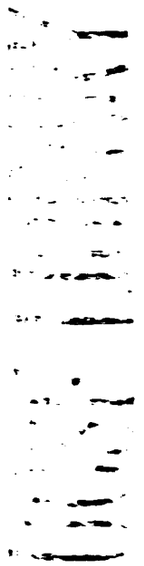
Ample empiric evidence demonstrates the efficacy of treatment for alcohol and other drug dependencies (Shepard, Larson & Hoffman, 1999; Gerstein & Johnson, 1994; Harwood, Thomson & Nesmith, 1994; Hubbard, Craddock, Flynn, Anderson & Ethridge, 1998). However, it is necessary to note that empiric research on the clinical effectiveness of GST is limited currently evolving.

Although the majority of studies on GST effectiveness are quasi-experimental or correlational, rather than clinical trials, findings suggest that select measures of abstinence, treatment participation and health are improved for women and their children. Reports on GST appear in the scientific literature as theoretical works, reviews of the literature, descriptive and outcome-based empiric research. Outcome-based empiric research on the effects of GST, the subject of this review, is limited in number and scope. While the most significant studies are included in this review, they are representative of the totality of empiric research on the effectiveness of GST and are presented here as a map of the major research currents about GST today. While the context for service provision is historically explicitly feminist, women's needs in treatment are focused largely around their

reproductive capacity and parenting role. Investigations on the topic of GST can be organized by emphasis into one of three categories: 1) GST vs. Traditional Program; 2) GST Only (No Control Groups) and 3) Effect of Entering GST With Children.

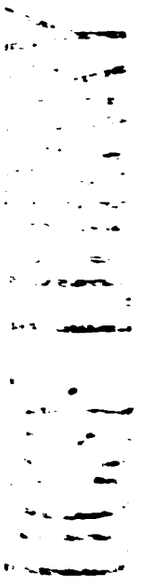
GST vs. traditional program outcomes. Mandel, Schulman and Monteiro (1979) examined the experiences of women addicts in a feminist awareness group within a co-educational therapeutic community. Implementation of the support group resulted in "some gains in self-esteem and self respect...freer communication among some of the women, increased interest in good nutrition, exercise, and protection against venereal disease and unwanted pregnancies" (p. 595). While the absence of statistically based outcome data is a serious flaw, this report is of historical significance as it represents one of the early gendered departures from traditional program design and illustrates one of the initial ways that female staff in one traditionally male model of treatment attempted to respond to the needs of women. Clinical observations and suggestions for adapting the model were also provided. A report such as this is limited in its empiric value, but it nonetheless made a substantial contribution to the beginnings of theoretical development of GST models.

Stevens, Arbiter and Glider (1989) proceeded along a similar path by conducting a two-year prospective study of retention and dropout rates after implementing their intervention, the "female-based therapeutic model" in a therapeutic community. After major programmatic changes (including allowing women clients to enter with their children, conducting women's groups and hiring a female program director and staff), these authors found significant changes. There was an increase in female clients' length of stay, the disproportionate numbers of males and females began to even out and success of treatment increased significantly for females and males. While not specifically measured, these authors related the increased "success" in treatment of both sexes with the newfound abilities of the women clients to feel safe and to practice emotional disclosure. Although correlational data were absent in this report, the findings retain clinical significance because of such substantial and positive changes in attraction and retention of women in the program.



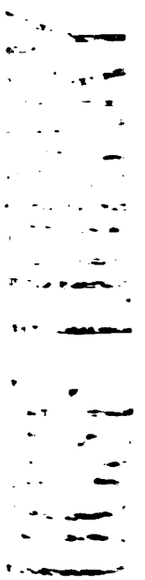
In another similar model of program enhancement, improvements in clinical outcomes were also noted for pregnant opiate dependent women in a methadone program (Chang, Carroll, Behr & Kosten, 1992). In a departure from the usual male model of services provision of methadone maintenance,

this enhanced GST model consisted of weekly prenatal care, frequent urine drug screen tests, relapse prevention groups and on-site therapeutic childcare for six women. They had less illicit substance use, got more prenatal care and had heavier birth-weight infants compared to the six non-enhanced control participants. There may have been sample bias in this study as perhaps only highly motivated women elected to participate in the enhanced model. However, this model of care was not only responsive to the women's specific need for childcare, but was among the first to identify the "one-stop-shopping" model as having potential benefit for women with complex needs such as opiate addiction and pregnancy. Future investigators replicating this study could improve validity with a larger sample size.



Copeland and Hall (1992) compared client characteristics for those women attending a "specialist women's treatment" program with women attending two "traditional mixed-sex" programs. This study, among the first to empirically identify sexual abuse as a specific recovery issue for drug dependent women, also marked the beginning of valid empiric research on the treatment needs of women and barriers to treatment for women. The women who enrolled in the women's specialist program were more likely to have young children, to be lesbian and to have experienced sexual abuse as a child.

As a result of this study, these authors suggest that poor retention for women in mixed sex programs may be related to the "failure of the services to address gender-specific issues such as sexual orientation, history of sexual or physical abuse and failure to nurture a sense of empowerment in a safe and supportive environment" (p. 1294). This study confirmed earlier beliefs of feminist advocates for GST that if the services were relevant for women, they would enroll and be retained in treatment. Even though by 1992 many drug dependent women were clients of child protective services agencies, one important omission from the study was discussion of the legal status of the women to determine how mandated vs. voluntary participation correlated with these findings. Since this report was published during the height of the "cocaine baby" epidemic and conducted from 1989-1990, this was a critical omission.



In a randomized field experiment of postpartum drug dependent women, Strantz and Welch (1995) examined correlates of retention and completion among voluntary and involuntary participants in two types of outpatient GST tracks. Treatment type (intensive enhanced day treatment) and custody of children predicted greater retention in treatment; very few psychosocial variables were found to predict length of stay. Findings from this

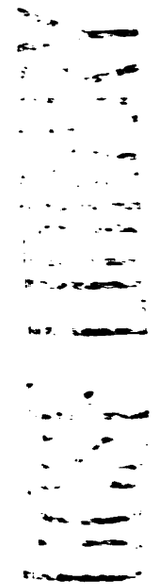
study have validity for postpartum drug dependent women due to the homogeneity of the sample, the large sample size (n = 292), and the analysis of multiple variables potentially correlated with treatment retention. The use of 18 different psychometric instruments provided a very extensive analysis of possible psychosocial correlates, which were not found to be statistically significant in predicting length of stay. Being in a positive all-day environment with their children minimized the importance of complex psychological treatment readiness variables and emphasized the importance of relevant and accessible direct services.

The relevance and effectiveness of specific perinatal-focused programs within a coed program has been noted by outcomes which included retention in treatment and drug-free urine screenings (Egelko, Galanter, Edwards & Marinelli, 1996). These investigators also found that women who entered treatment when pregnant experienced significant improvements in retention and drug-free urine results compared to those who entered treatment postpartum. Findings from this study reinforce the common wisdom that pregnancy represents a "window of opportunity" for interventions for drug dependent women; these authors cite pregnancy-specific programming rather than gender-specific programming as the needed program emphasis.

A more highly developed model of pregnancy-specific interventions and programming suggests that a multi-systems approach integrated into a GST program as a track of a coed program can improve outcomes for inner-city pregnant cocaine dependent women (Egelko, Galanter, Dermatis & De Maio, 1998). This multi-systems approach encouraged reunification with the biological child, aggressive outreach to families and friends for positive social support, and the presence of the infant with their mother in all-day treatment activities. While controversial in child welfare circles that seek to separate the addicted mother from the child, these findings suggest that drug dependent women have more strengths inherent in their families and communities than previously known. This approach attempts to address the "real-life" post-treatment situations they will return to upon discharge.

GST-only program outcomes. In a quasi-experimental study of 81 women enrolled in community-based methadone maintenance (MM), the effect of frequent participation in a six-week assertiveness training and sexuality group for women was examined (Bartholomew, Rowan-Szal, Chatham & Simpson, 1994). At admission, a self-rating scale for psychological and social functioning and motivation was obtained and a 20-item pre- and post-test questionnaire to assess knowledge on the content of the

specialized group presentations was administered. Frequent participation in the special program on reproductive health, assertiveness training and sexual health resulted in an increase in self-esteem and knowledge among opiate dependent women. Level of participation was also positively associated with length of time in treatment after completing the workshops. Since women were self-selected for participation, several groups were examined. Socio-demographic variables and drug use patterns were contrasted for women enrolled in MM but opting not to participate in the workshops, women attending one to three sessions, and women attending four to six sessions. There were no significant differences among the groups. This finding again reinforces the utility of GST and extends its usefulness into another co-ed modality, that of MM, historically a setting where little more than minimal federal requirements of daily dosing, mandatory prenatal care and regular random urine testing have been conducted.



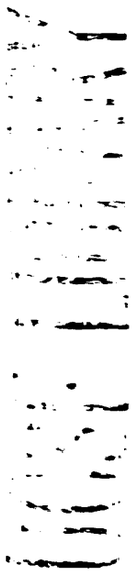
Regarding pregnancy-specific interventions, Camp and Finkelstein (1997) describe pre- and post-test results on measures of self-esteem and parenting confidence and knowledge among 170 pregnant and parenting women with the implementation of a parenting component in two women-only residential programs. There were improvements in self-esteem, infant

attachment, parenting knowledge and self-confidence measures. These improvements are clinically significant in addition to being statistically significant because they are known to be associated with decreased risks for child abuse (Williams-Peterson, et al., 1994). A strength of the intervention, then, may be a safer and higher quality of parenting. This study failed to measure outcomes longitudinally, which would have strengthened the findings.

Research on a women-only therapeutic community (TC) program supported the finding that for women the "longer the stay in treatment, the better the outcome" (Stevens & Arbiter, 1995). Through an analysis of female treatment completers and dropouts, this one well-known principle of retention in treatment was asserted for women as well. While this finding among rural TC program participants is clinically important, the small sample size of the completer's group ($\underline{n}$ = 13) threatens validity of the findings in this study. Other variables, such as potential extrinsic barriers to program continuation and future treatment enrollment need to be examined in order to understand the relationship between barriers, retention, length of stay and re-enrollment.

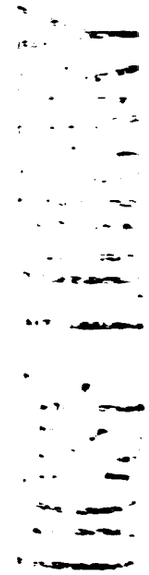
One retrospective program evaluation, notable for its large sample size of 2,600 female drug clients, was conducted on a comprehensive seven- site

model program of services for drug dependent pregnant and parenting women (Brindis, Clayson & Berkowitz, 1995). Perhaps one of the most highly developed models of GST, the "Options for Recovery" programs were unique in that they included a" family-oriented paradigm...a synthesis of the social and medical models into a hybrid bio-psycho-social model" (Brindis, Clayson & Berkowitz, 1995, p. 5). Quantitative and qualitative maternal and child health outcomes included treatment completion, family maintenance and reunification, and participant satisfaction. As a four-year state-sponsored treatment initiative, this study demonstrated that with interagency collaboration, GST could be successfully provided on a large scale. The model allowed for geographic, cultural and philosophic diversity while still preserving and effectively employing the main elements of GST. Of particular note was the finding of healthy outcomes among children born to Options for Recovery mothers. Healthy outcomes were operationalized as 89 % gestational age at birth $\geq$ 35 weeks, 77% with birth-weight > 2500 grams, 87% with absence of congenital anomalies, and 73% with physiologic systems unaffected by substance exposure.



The benefits of GST then, apply not only to the women, but also to their infants when the women have access to, and participate in, a program such

Options for Recovery. With its highly developed model of GST and clear emphasis on parenting and child health, this program became the exemplar for an important policy point as well. With comprehensive models of treatment for women, benefits also extend to their infants and children. And when provided with appropriate treatment, women enroll and stay in treatment. As a therapeutic alternative to punitive sanctions, treatment options such as this can be a major determinant in the long-term health and well-being of mothers and their children.



The effects of entering GST with children. Lack of childcare and separation from children have often been noted as treatment barriers for women as well as factors in treatment drop-out (Moise, Reed & Connel, 1981). The U.S. Southern Regional Project on Infant Mortality reported that 54% of drug dependent women surveyed stated that lack of childcare had prevented them from entering treatment. In rare cases, however, GST for parenting women has included the provision of on-site childcare in outpatient programs or the opportunity for women to enter residential treatment with their children.

In an experimental design to evaluate treatment retention and other outcome variables, Hughes and colleagues (1995) randomly assigned 53

participants in a perinatal substance abuse program to residential treatment without their children (n = 22; standard group) or with their children (n = 31; experimental group). The majority of the subjects were African American high-school dropouts and most cited cocaine as the primary drug of abuse. Using survival analysis methods, it was determined that 77% of the experimental group remained residents in the program after three months as compared to 45% of the standard group (L=9.94; p<.005). After all subjects had left the program (30 months), it was determined that length of stay was significantly greater for the women who participated in treatment with their children (300.4 days ±242.3 S.D.) than for the women in treatment without their children (mean=101.9 days ± 93.7 S.D.; t = 2.83; p <.05).

In a four-year prospective study of women entering residential treatment with or without their children, a convenience sample of 130 women was examined to evaluate the effects of the presence of children on women's retention (Szuster, Rich, Chung & Bisconer, 1996). Of the sample, 47% had children with them and 53% did not. Controlling for demographic variables (age, number of children, duration of drug use, previous treatment and others), women admitted with their children had significantly (p=.0000) better (6.2 mos.) retention than did the women admitted without children (2.6 mos.).

While these findings are interesting, careful analysis of differences in program content between groups with and without children in both studies should be examined for their relationship to retention. Though common wisdom has always suggested that childcare and dual placements of the women with their children were "best" for the women and their children, program context responses to other needs (housing, safe seclusion) and treatment performance (quality of the treatment alliance, psychiatric co-morbidity, staff attitudes and clinical skill) should also be examined. As suggested by Copeland and colleagues (1993), if other program elements are not controlled for in study design, it could be reductionist to attribute length of stay in GST programs to childcare services alone. Treatment mandated by child welfare services may also produce outcomes that differ from those wherein purely voluntary treatment participation occurs, as may have been the case in the study by Szuster and colleagues (1996).

Barriers to Treatment: Theoretical Models

The process of entering treatment is accompanied by challenges unique to drug dependent women who are pregnant. Theoretical models assist in understanding the dynamic movement of drug dependent women in relation to entering treatment and provide a stance from which to view

negotiation of barriers by these women. The purpose of this discussion is to examine the relevance and significance of concepts from 1) Beckman and Kocel's (1982) Model of Treatment Utilization; 2) Rosenstock's (1966) Health Belief Model and 3) a re-conceptualization of "delay" in seeking care among drug dependent pregnant women. The clinical and policy implications of each model will be examined as well.

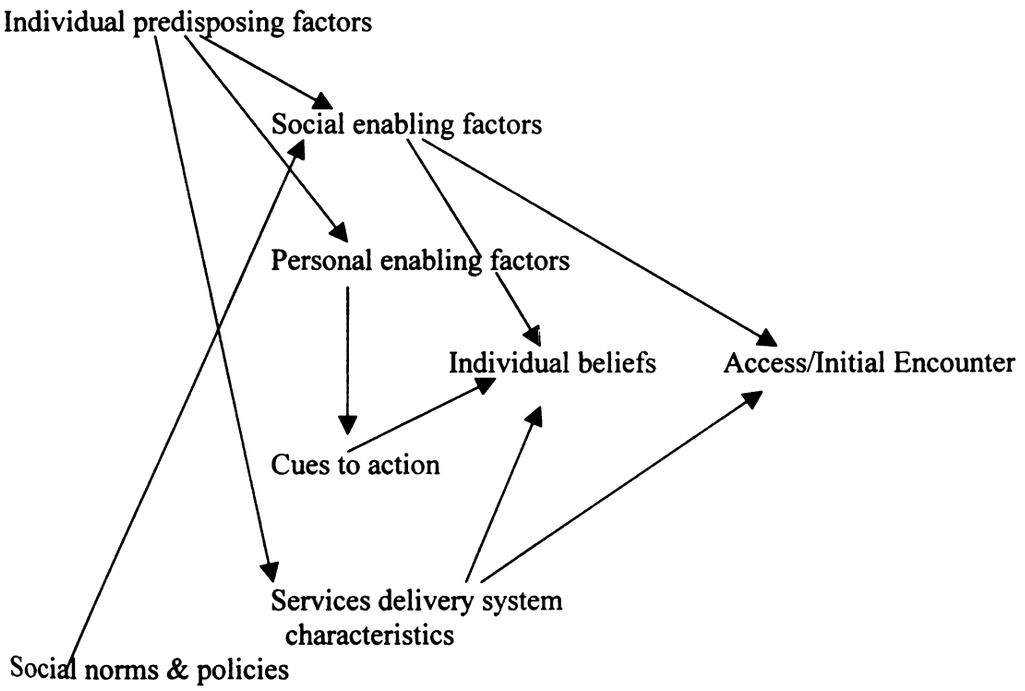
Beckman and Kocel's Model of Treatment Utilization.

Beckman and Kocel (1982) developed a model of the alcohol treatment utilization process among women and defined intrinsic and extrinsic characteristics as determinants of treatment enrollment. Their model is based upon similar elements of individual and environmental treatment determinants in Anderson's model of the use of health care services (Anderson & Newman, 1973) and the Becker's (1974) Health Belief Model. Beckman and Kocel define these characteristics as barriers, noting that they affect the alcoholic woman's "ability to secure and propensity to use services" (p.139). Characteristics include social enabling, structural features of treatment services, individual predisposing factors, perceptions and beliefs, and personal enabling traits (see Figure 2. 1).

Intrinsic barriers. In Beckman and Kocel's (1982) model, intrinsic barriers include individual predisposing factors such as age, socioeconomic status, ethnicity, gender or religion. Perceptions and beliefs are those held by the individual women about alcohol, health and treatment. Personal enabling traits are personality characteristics, drinking and treatment history.

Figure 2

Theoretical Model of Treatment Utilization
(Beckman & Kocel, 1982)



Extrinsic barriers. Service delivery system characteristics include staff composition, outreach methods and actual services offered. Social enabling characteristics include childcare, transportation, support networks and geographic location of treatment sites (i.e. living far from the treatment center which could obstruct enrollment).The authors note that social enabling characteristics are influenced more by policy changes than by the above-mentioned intrinsic barriers.

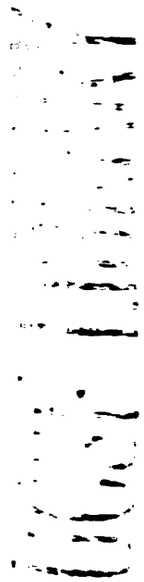
Operationalizing the model. Beckman and Kocel's (1982) model led to a descriptive study of structural characteristics of 53 public and private alcoholism treatment programs and the types of programs that women selected. Males-only programs were excluded. The authors examined the relationship between structural variables, such as staff composition and agency services, and the percentage of women clients using the agency; the unit of analysis was the program rather than the individual woman client. In the analysis, the authors noted that women clients preferred agencies that had a higher percentage of professionally trained female staff and fewer minority staff. These results may in part reflect the prevalence of White staff in the workforce in alcohol recovery programs in the 1980's. Agencies that had childcare and children's treatment services also served more women than

men. Additionally, word-of-mouth, advertisements, walk-ins, family and friends were the major sources of referral for the women clients in this study. Staff attitudes toward women alcoholics were not associated with the program use rates for women.

Significance of the Beckman and Kocel Model. The inclusion of intrinsic and extrinsic barriers in Beckman and Kocel's model acknowledges the significance of policy in the ability and propensity of women to enroll in treatment as well as the dynamic interaction of intrinsic factors with extrinsic barriers. The authors' highly conscious call for an analysis of women's motivation for treatment in combination with their awareness of the influence (often deterrent in nature) of extrinsic barriers, may represent one of the earliest points of historic awareness of this dynamic for women. In 1982, policy issues referred to in this model were largely concerned with the expansion of treatment models to include gender-specific programming. Today, this model has potential for policy that includes the prosecution of drug dependent women during pregnancy. In a far-sighted statement regarding their model and the interaction of policy and women's service utilization, the authors note: "...the residual impact of attitudes [of the women]...toward treatment, derived from prolonged lack of access, may

attenuate future treatment-seeking actions" (p.143). In this regard, Beckman and Kocel's model has great relevance for examining extrinsic barriers to treatment for pregnant drug dependent women.

Of additional significance is the finding that when alcohol dependent women seek treatment, they are conscious selectors of particular services, which may be specific to their needs as females. The power of agencies to attract women based on the constellation of available services indicates that agencies themselves may play a very important role in early treatment enrollment. However, the increasing trend toward mandated treatment for female clients, whose activities cause them to intersect with child welfare and legal diversion programs, may decrease some women's ability to self-initiate the selection of a treatment program. Nonetheless, Beckman and Kocel's theoretical model has implications for the potential entry and retention of women in programs wherein a more optimal match between client needs and services offered may be rendered.



The term "cue to action" is briefly mentioned in the model and reflects the actual motivation for seeking treatment. Beckman and Kocel (1982) define it as "an inter-personal crisis" or "diagnostic decision made by a community gatekeeper" (p. 142). Interestingly, this element, "cue to

action," is the focus of much current motivational research, yet Beckman and Kocel's usage of the term "cue to action" could be criticized as highly reductionist. Rather, it is reflective of an evolutionary stage of theory development within the field of addiction research. Several years after Beckman and Kocel published this model, addiction researchers and treatment programs begin to more fully examine and integrate psychological constructs of motivation and readiness into the notion of treatment-seeking (Miller, 1985; DiClemente & Hughes, 1990).

Finally, Beckman and Kocel's (1982) Model of Treatment Utilization contributes an important philosophical perspective in their treatment of the women (recovery services consumer) as the main focus of the model. In describing their model, the authors cite institutions' deficiencies (i.e. treatment programs and health care services) in attracting women, as well as a pervasive insensitivity and pessimism about women's recovery. Their model confers institutional responsibility and calls on these institutions to "identify structural factors...change those factors, and thereby facilitate women alcohol abusers' entry into and continuation into treatment" (p.149). In this aspect, Beckman and Kocel do not regard the woman at fault for not enrolling in treatment. Rather, they fix responsibility on institutions to be

self-critical and to remedy their historic inabilities to attract and retain women in treatment.

Rosenstock's Health Belief Model

Rosenstock's (1966) health belief model was originally conceived to explain an individual's use or non-use of preventive health services (1966). The original model hypothesized that actions related to health would depend on the existence of motivation that would make the issue one of concern to the person, the presence of a perceived threat regarding an illness and the belief that the remedy would be beneficial relative to the required expenditure of attention and energy in overcoming barriers. Rosenstock, Strecher and Becker (1988) then posited a revision of the original health belief model to include Bandura's (1977) notion of self-efficacy. This expansion led to a consideration of behavioral change in the context of chronic illness, such as alcoholism and other drug dependencies, thereby deepening the relationship between social cognitive theory, which traditionally did not include considerations of extrinsic factors for health action, and the Health Belief Model which valued perceived environmental barriers. Rosenstock, Strecher and Becker rejected an earlier proposal by Janz and Becker (1984) that self-efficacy deserved placement into the barrier

category. They maintained that perceived barriers should be limited to "financial costs, phobic reactions, physical barriers, side-effects, accessibility factors and even personality characteristics" (p.179).

Operationalizing the Health Belief Model. Rees (1985) claimed to be utilizing the "reformulated health belief model" of Becker and Maiman (1975) when he examined treatment compliance (i.e. retention) in a study of 119 patients (26% female) attending an outpatient alcoholism treatment program. Because Rees was examining an in-treatment population, the barrier aspects of the Health Belief Model were less relevant. In his application of the motivation aspects of the Health Belief Model, Rees devised a patient self-report questionnaire and focused on locus of control, severity of alcohol dependence and alcohol-related symptoms related to motivation. Motivation was positively correlated with retention and longer-term attendees rated their drinking as more seriously affecting their lives than shorter-term attendees and drop-outs.

Participant control of drinking was measured by the Locus of Drinking Problem Scale (Stafford, 1980); severity of alcohol problems was measured by the Hilton Questionnaire (Hilton, 1981). The author also created a scale to measure alcohol-related symptoms through patient self-

report. Staff psychiatrists also assessed each patient during their initial interview and rated their motivation on a five-point scale. Length of stay differences for four groups (immediate drop-outs; stayed less than 30 days; dropped out at 2-5 months in treatment; and those who attended for six months) was examined. Twenty-seven patients (23%) "received what the ...psychiatrists felt was an adequate amount of treatment" (p. 522); 41 (35%) attended treatment once and 21 (18%) dropped out within one month.

One problem with this study was the conflating of the Health Belief Model into one concept of motivation and deletion of any examination of perceived environmental barriers. While the longer-term attendees rated themselves as more seriously ill due to their drinking than the shorter-term attendees, there was no measure or discussion of why the shorter-term participants left treatment or what in-treatment barriers arose for them. Additionally, the study participation refusal rate was not noted; nor were reasons for non-participation. It would have been informative to inquire about motivation and barriers among the patients who made initial calls to the treatment center and did not show up for entry.

Significance of the Health Belief Model. The Health Belief Model has relevance for examining barriers to treatment for drug dependent pregnant

women due to the interaction of extrinsic and intrinsic barriers that occurs during the process of treatment readiness and the process of treatment-seeking. The inclusion of perception of barriers in the Health Belief Model lends itself well to the situation of pregnant drug dependent women because the concept of perception implies judgment by the individual woman who is occupied with negotiating barriers in her move toward seeking treatment. Because fear of punitive consequences and negative past interactions with the health care system and child welfare services have been noted as elements in delay and non-treatment-seeking for pregnant drug-using women (Poland, Dombrowski, Ager & Sokol, 1993 ; Leppert, Partner & Thompson, 1996; Brown, 1995; Sheehan, Oppenheimer & Taylor, 1988), the Health Belief Model (Rosenstock, 1966) is additionally relevant to pregnant drug dependent women. The Health Belief Model underscores the significance of a therapeutic advocacy-based model of service provision, as opposed to a punitive model, in determining health actions by pregnant drug dependent women.

A Re-conceptualization of "Delay" in Seeking Care

Traditional constructions of delay in seeking health care have largely characterized delay as rooted in patient denial or beliefs that keep them away

from the help they need (Facione, 1993; Sterne & Pittman, 1965; Jordan & Oei, 1989). Delay has been conceived as a state of being, where inactivity, passivity and even provocation are its main components. This delay evokes concern, frustration and even anger from health care providers. Rather than viewing this behavior negatively as delay, there is reason to reframe it as a response to legitimate barriers requiring alterations in gender-specific health policy and specialized clinical interventions.

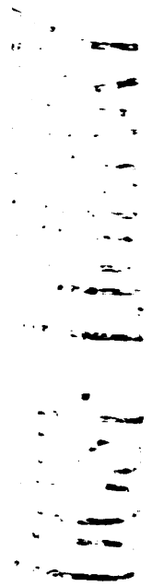
Descriptions of delay-related concepts of entry to treatment and denial among alcohol and drug dependent persons have constructed delay similarly (Dahlgren & Myred, 1977; Jordan & Oei, 1989; Sterne & Pittman, 1965). For example, alcohol dependent women apparently "wait" to enter treatment until they are suffering from acute physical and psychological complications of their alcoholism (Dahlgren & Myred, 1977), yet the content of the experience of "waiting" is not experientially examined or explained. Delay and reluctance to enter alcohol treatment is reduced to simple "denial" by treatment staff, who characterize this delay as an intrinsic character defect (Sterne & Pittman, 1965).

In the case of pregnant drug dependent women, what has been construed as 'delay' could be deconstructed and viewed as gender-specific

activities of 'making-ready' (Jessup, 1999). The encountering of extrinsic barriers by drug dependent women could be then viewed as a process, characterized by gender-specific forms of barrier negotiation and making-ready. This more active interaction with barriers is suggested as an re-conceptualization of traditional perceptions of treatment readiness in pregnant drug dependent women, wherein forms of adaptive activity remain invisible and undetected (Jessup, 1999). Yet, little is known about these barriers, how drug dependent pregnant women actually interact with them, or to what extent these barriers influence late enrollment in substance abuse treatment and prenatal care. This re-conceptualization of delay acknowledges the current social context of antipathy toward pregnant drug using women and relocates the pregnant drug dependent woman, with her own individually held intrinsic barriers, into a context wherein her behavior is understood as adaptive and therefore perceived less negatively. Perception of the extrinsic barriers, similar to Beckman and Kocel's (1982) "individual beliefs," is a significant element in consideration, negotiation and interaction with these extrinsic barriers. The inclusion of perception allows for the possibility of change in a woman's response to barriers (Gulzar, 1999) and that change can be positively and negatively affected by the actions of

family, friends, health care services providers, policy-makers and the criminal justice system. These actions by others promote conditions that either advance pregnant women toward, or deter them from, treatment entry.

Inclusion of perception in the alternative explanation also supplies the conceptual link between intrinsic and extrinsic barriers and adds a dynamic, conscious and interactive process of relational activity by the woman with her social environment. This re-conceptualization also affirms the woman as the dynamic center of the activity, and does so in order to describe the phenomenon of treatment-seeking as a human process, characterized by dynamic interaction between extrinsic (environment) and intrinsic (person) barriers.



In their discussion of gender differences as they relate to delay in accessing alcohol treatment, Weisner and Schmidt (1992) suggest that the way women define their problem, as one of health or mental health, may lead them to seek help later in the course of their disease. Weisner and Schmidt note: "there may be systematic differences in the pathways by which women and men reach treatment..." (p. 1875). This presents an interesting line of inquiry regarding delay in treatment-seeking among drug dependent pregnant women. Pregnancy itself, which involves maternal

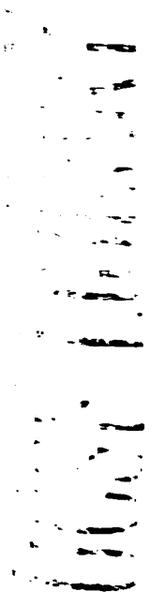
role adaptation (Mercer, 1981) and numerous physical stages and transitions, may contribute other routes on such a pathway.

This alternative perspective on "delay" seeks to identify the interaction of women with their environment. As noted by Melnyk (1988), "the concept of barriers is of particular interest because it helps define the interface between the consumer and the system" (p.196). This re-conceptualization of "delay" also considers the potential for recovery among drug dependent women within the context of social change, an inherent requirement for efforts to reduce barriers to treatment for pregnant drug dependent women.

Future Research

In the field of addiction at large, more research on outcomes of programs based on theoretical models of addiction treatment is now indicated. These theoretical models include stages of change theory (DeClemente & Hughes, 1990), cognitive-behavioral models such as motivational theory (Miller, 1986; Miller & Rollnick, 1991), skills training (Roberts, Shaner & Eckman) and traditional 12 Step models of recovery (Alcoholics Anonymous, 1939). Empiric research on the effectiveness of GST among more complex populations of women is now indicated. Feminist theoretical models of

treatment, such as that proposed by Finkelstein (1993b) and Covington and Surrey (2000), should be tested in women with trauma histories where chronic drug-using populations of women are involved, rather than the relatively new-user population. Co-existing mental illness and substance abuse, documented among pregnant and parenting women (Mallouh, 1996), is virtually untouched in terms of testing intervention programs. The impact of psychiatric symptoms, homelessness, psychotropic medications and addiction among women needs further study, particularly in light of increasingly effective psychotherapeutic and pharmacologic interventions that now exist. Research on outcomes for gender and culturally specific treatment for women is also non-existent and needs to be examined as the effectiveness of culturally-specific programming in the context of a women's program has not been strongly demonstrated. Research examining the effects of parenting interventions in GST should have longitudinal designs to observe eventual custody status, child development, quality of attachment and parenting, and occurrences of child abuse and neglect among this population of women.



Finally, research on extrinsic barriers utilizing the source of women's narratives must be explored. Research on extrinsic barriers to treatment should include an exploration of the process of treatment entry with a focus on

women's perceptions and responses as well as negotiation of barriers in their social environment. In particular, women's narratives after having entered GST would illuminate those treatment-seeking and entering experiences and whether or not entering a GST program affects perception of barriers.

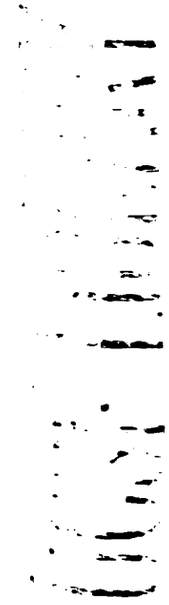
Conclusion

While previous research on barriers is informative, new findings from a qualitative perspective can be a source of greater experiential evidence for knowledge about women and barriers to treatment. For example, the findings of Festinger and colleagues (1995) are important in understanding of delay in first counseling contact as well as correlates of treatment attrition. However, the findings would be enhanced by ascertaining gender in relation to attrition. Additionally, Beckman (1984) made a significant contribution to descriptions of women's difficulties in entering treatment due to opposition from family and friends. However, it is critical to determine why families and friends oppose treatment by examining the role that the addicted woman has in the lives of those who oppose her treatment as well as her perception of family opposition. The potential impact of punitive laws aimed at pregnant drug users and their behavior during pregnancy also requires querying women about their experiences and analysis of the

potential risk of driving women away from their sources of care.

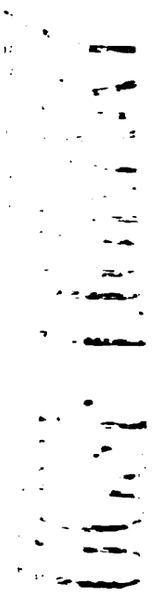
Finney and Moos (1995) posited that barriers for women may arise early in the treatment entry process and that is an area in need of examination. Other questions about extrinsic barriers include: is there a relationship of perception of barriers to the stages of change? Are there different extrinsic barriers at different points or stages in the treatment-seeking process?

All of these lines of inquiry have implications for social policy to minimize extrinsic barriers. With the exception of some regions of the U.S. during a brief historic period (1989-1993), pregnant women have rarely been encouraged to participate in any modality of treatment where unfettered entry and unhindered full participation is advocated, supported and possible. Until extrinsic barriers are removed and appropriate models of treatment are fully financed and accepted as the standard of care, genuine exemplars of best outcomes and effectiveness cannot be produced to the extent that they could in a fully humane and unobstructed system of care.



Rather than a rationale for failure due to what are perceived as intrinsic flaws in drug dependent women, acknowledging environmentally based barriers to care is a basic source of hope for improvement in outcomes

among drug dependent women and their children. Removal of system-located barriers and provision of supports for long-term treatment can allow for a full and authentic evaluation of effective models. According to Beckman and Kocel's (1982) model, evidence-based practice in public policy initiatives can reduce extrinsic social barriers to treatment leading to increased enrollment and improved outcomes for women and their families. However, without knowledge of women's experiences from their own perspective, a key component of the model, intervention, cannot claim to significantly change barriers to treatment and delayed or late entry to care for drug dependent pregnant women.

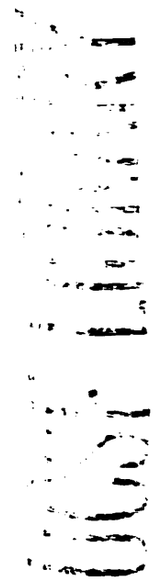


Chapter Three

Methodology

Introduction

Research on extrinsic barriers to treatment entry for pregnant drug dependent women requires an awareness of multiple issues and dynamics inherent in the process of scientific inquiry. Gender, ethnicity and the experiences of pregnancy and drug dependency influence the perspective and approach of the researcher as well as the response of participants (Marshall & Rossman, 1999; Blauner & Wellman, 1973).



Quantitative and qualitative methods of research allow for unique, yet differentially intriguing opportunities for entrance into unknown regions of human experience, emotion, behavior, cognition and spirit. In the case of inquiry about extrinsic barriers to treatment for alcohol and drug dependent pregnant women, due to the dearth of information, the phenomenon begs consideration of both types of methodologies. Using quantitative instruments as measures of extrinsic barriers to treatment for persons with drug dependencies can estimate general characteristics and momentary events experienced by the population. Qualitative methods provide in-depth narrative and allow for insight and revelation, interpretive stance, and

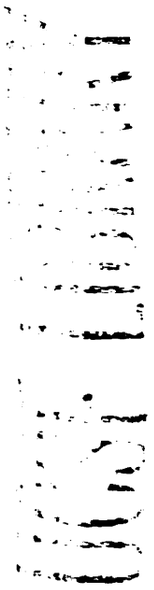
documentation of previously unknown and invisible lives. In qualitative methods, the investigator's use of self is the most significant instrument in data collection and self-conscious examination of the "contradictions that percolate at the Self-Other hyphen" (Fine, 1994, p. 70) is required. This chapter reviews methodological and ethical issues encountered in research with drug dependent pregnant women and briefly describes quantitative methods and two studies using qualitative methods to further understand barriers to drug treatment. This chapter also discusses the qualitative method of socially contextualized life history as the method used in this study.

Quantitative Measures of Barriers to Treatment

The Allen Barriers to Treatment Instrument

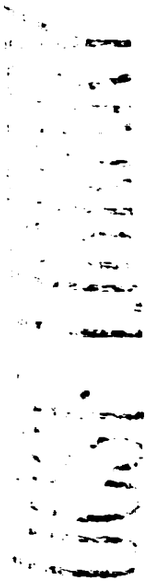
The Allen Barriers to Treatment Instrument (ABTI) is the only existing quantitative instrument that has been designed to measure barriers to treatment for drug dependent women (Allen, 1994a) and it is not specifically for use among pregnant women. The ABTI is a 30-item self-administered interval rating scale that utilizes a four-point Likert-type response format. Instrument development included generation of each barrier item through an extensive review of the literature from the early 1980's to 1994 and categorization of those barriers into one of three

domains: 1) treatment program characteristics; 2) individual characteristics; and 3) socio-environmental issues. In addition to these 30 select closed-response barrier items, there are three open-ended questions (one per domain), "designed to elicit from respondents any barriers which exist for them which are not on the instrument" (Allen, 1994a, p. 439) and 11 subject demographic items at the end of the instrument. The ABTI utilizes a criterion-referenced framework and total instrument scores can range from 30 to 120. The higher the score, the lower the likelihood the respondent is in treatment. The author indicates that the ABTI is appropriate for identifying barriers for women, but suggests that "a reliability factor be obtained of the instrument" (Allen, 1994a, p.440) when used in another "country or culture" (p.441) before using the instrument. Additionally, the ABTI was pre-tested on 10 substance-using women (five White and five African American) who were not in treatment. Pre-testing revealed that use of the ABTI was feasible as it was found easy to complete and required no revision (Allen, 1994a). Although in the introductory article on the ABTI (Allen, 1994a) the author cites one gender-specific theoretical model of treatment utilization (Beckman & Kocel, 1982) and literature on women's patterns of help-seeking (Thom, 1986;Beckman & Amaro, 1986), this instrument lacks a



strong theoretical basis. Rather, the author generated her own "theoretical definition of barriers" which concludes that the "conceptualization of barriers comes from three domains: treatment program characteristics, individual characteristics and socioenvironmental issues" (1994a, p. 438). These are three of the elements in Beckman and Kocel's (1982) model of treatment utilization, though no acknowledgement of that is made in Allen's work.

Psychometric assessment of the ABTI included internal consistency reliability and five types of validity (face, content, convergent, construct and criterion-related) (Allen, 1994b). Adequate internal consistency reliability was ascertained by Cronbach's alpha (coefficient) for the overall 30-item instrument (.87) and for each barrier subscale: 1) ten treatment program characteristics (.84); 2) ten personal beliefs, feelings and thoughts (.67) and 3) ten socio-environmental issues (.75). Regarding face and content validity, a panel of three judges rated the scale items as being "77-97% domain appropriate" (Allen, 1994b, p.553). Criterion-related validity was determined using criterion group analysis between two groups: "being in treatment" (n = 97; 64% African American, 30% White, 6% other) and "not being in treatment" (n = 35; 71% African American, 23% White, 6% other).



Analysis of variance between mean ABTI scores of the two groups was statistically significant in support of the hypothesis that in-treatment group would have lower scores and there was a strong relationship between ABTI scores and being in treatment ($\underline{r} = .48$).

Construct validity was examined by determining convergent validity of the open-ended questions and a qualitative comparison for repetition between those and the 30 barrier items. Factor analysis using principal components method and varimax rotation yielded four factors with Eigenvalue two as the cutoff point: 1) Interactions with Others; 2) Aspects of Treatment Program; 3) Social Support; and 4) Financial Concerns. Finally, item-total correlation scores demonstrated adequate construct validity also (24 of 30 items correlated > .30). Though four domains emerged from the factor analysis, Allen inexplicably devised three domains in the ABTI (Allen, 1994b).

Though the study sample was 64% African American, 30% White and 6% Other, Allen consistently reports the findings as data about African American women. From these results Allen concludes that "most of the eight barriers identified are intrinsic to the women." However, fear of loss of custody (#5), lack of space in the program (#8), and lack of treatment access

due to financial limitation (#2 and #3) should be considered extrinsic barriers. The eight most frequently cited barriers in Allen's study using the ABTI (Allen, 1995) are listed in Table 3. 1.

Table 3. 1

Most Frequently Cited Barriers to Treatment

(Allen,1995)

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1) "Having responsibilities at home as a mother" (55% of subjects);
2) "I cannot pay for treatment of this problem" (46%);
3) "I do not have health insurance for this problem" (45%);
4) "Needing alcohol and/or drugs to deal with stress of daily life in my community" (42%);
5) "Fear that my admission of this problem could be used by someone to take my children away" (40%);
6) "I feel ashamed when I admit to having this problem" (40%);
7) "In the past I have been unable to stay alcohol or drug-free after treatment" (39%);
8) "Having to wait for an opening because the program is full" (38%).

Attribution of these barriers as intrinsic to the women ignores the larger social context in which perinatal addiction exists and precludes examination of policies, attitudes and institutional and community dynamics that may be influential. In this regard, Allen's absence of a socially contextualized conceptual framework leads to location of the problem

primarily within the woman. During a historical period wherein only half of all African American mothers received adequate prenatal care and were twice as likely as White women to have inadequate or no prenatal care (Wegman, 1994), examination of these issues as partially socially induced is critical. The lack of such a view is a major conceptual flaw in Allen's study (1995) and in the ABTI (Allen 1994a, 1994b).

Another concern about the reliability and validity testing of the ABTI is the sampling procedure utilized by Allen. The respondent categories of "in-treatment" ($\underline{n}$ = 35) and "not-in-treatment" ($\underline{n}$ = 97) were blurred, poorly defined and overlapped. None of the women in either respondent group were noted to be pregnant at the time they filled out the ABTI, though 88% of the "not-in-treatment" group had children compared to 83% of the "in-treatment" group (Allen, 1994b). The "not-in-treatment" group consisted of women who had contacted drug treatment programs and then not followed through on enrolling, and drug-using women who were contacted by "women in recovery" who knew of their addiction. This "not-in-treatment" group also included women enrolled in detoxification programs. However, the author did not believe that a program of detoxification alone constituted treatment, per se, so detox participants were also placed in the "not-in-

treatment" group. The "in-treatment" group was enrolled in unidentified types of treatment. This is an example of investigator bias with a philosophical stance that blinds the researcher to the poor sampling design. Likewise adding women to the "not-in-treatment" group who had called a program but did not follow through also potentially contaminated the sample.

Despite the limitations of the ABTI, Allen has made a contribution to the literature by defining and categorizing barriers for women and designing a gender-specific research instrument that could be utilized with a larger sample of women. While many of the ABTI barriers may be relevant for pregnant drug dependent women, the ABTI is not representative of an exhaustive list specific to pregnant drug dependent women. Additionally, the value of re-listing known barriers to treatment is questionable unless the experiential meaning of those barriers is described as well as the things that eventually eliminate them or the individual circumstances that prevent them from being overcome. The ABTI fails to consider the context of the barrier(s) in the woman's experience. Deconstructing these elements is critical in order to facilitate early treatment entry for pregnant drug dependent women, especially because of the relatively narrow window of

opportunity imposed by pregnancy.

Other Related Instruments

Other related quantitative instruments require brief mention because of their close conceptual relationship to barriers to treatment. There is a genre of instruments designed to assess motivational status and treatment readiness in persons with substance dependence disorders (DeLeon & Jainchill, 1986; Goldsmith & Green, 1988; Salloum et al, 1998; Curry, Wagner & Grothaus, 1991; Mee-Lee, 1988; Miller& Tonigan, 1996; McConnaughy, DiClemente, Prochaska & Velicer, 1989). A summary of these instruments can be found in Appendix E. This class of instruments is mentioned in order to note that, while it might seem logical that extrinsic barriers would have been included in these instruments, none of these motivation/treatment-readiness measurements include estimates of extrinsic barriers to treatment. Because readers versed in the clinical concept of motivation assessment may question the exclusion of these clinically popular tools from this review, it is relevant to clarify their absence.

Qualitative Studies on Barriers to Treatment for Women

The "Flight From Care" Structured Interviews

In a rare triangulated study of extrinsic barriers to treatment, postpartum

women were interviewed about their attitudes toward punitive laws against pregnant drug-using women (Poland, Dombrowski, Ager & Sokol, 1993). A convenience sample of 142 urban, at-risk, low-income women was utilized and the women, all of whom delivered singleton infants in good health, were surveyed 2-5 days after the birth of their infants. The sample consisted of two groups: women "walk-ins" with no history of prenatal care and women who were registered for care in the affiliated clinic. Analysis of the sample showed that 30% of the women had received inadequate care and 15% revealed use of illicit drugs during pregnancy.

Open-ended questions about prosecution of pregnant drug-using women were then posed to each participant, prefaced with "a statement that described a law in another state where women who had a baby addicted to drugs went to jail" (Poland et al., 1993, p. 200). The researchers then stated, "while this was not a law in Michigan at this time, we were wondering if a law like this one was enacted, how it might affect drug-using women seeking prenatal care, having a test for drug use and seeking drug treatment." The final question was "Do you think pregnant women who use drugs should go to jail?" (p. 200).

In response to the questions about the effects of a punitive law on seeking care, most of the women said that pregnant drug-using women would

be less likely to seek prenatal care, drug testing and drug treatment or that it would make no difference ($p < .01$). These authors stated that many of the women's comments indicated that "substance using pregnant women would 'go underground' to avoid detection and treatment for fear of incarceration and loss of their children" (p.202). The authors noted: "Women who used drugs felt that a law threatening incarceration would discourage women seeking medical care" (p.202).

The "Gendered Help-seeking Patterns" Interviews

The only other qualitative study of barriers to treatment was conducted among 25 women (non-pregnant) and 25 men referred (source unknown) to an alcohol clinic in Great Britain (Thom, 1986). The purpose of this comparative study, which consisted of in-depth interviews, was to determine gender differences in help-seeking behavior and "patients' perceptions of the barriers to treatment entry" (p. 777). There were no statistically significant demographic differences between the women and the men in this small sample; men were slightly more likely than the women to be living with a significant other ($p = .078$) and to have children under 16 in the home with them ($p = .074$). The majority of the sample (15 women and 20 men) reported drinking heavily for five or more years before they first sought help; all 25 of

the women mentioned barriers to treatment, as did 22 of the 25 men.

From in-depth interviews of this in-treatment population, it was revealed that women were frequently stopped from seeking help by their spouses who encouraged by them to continue drinking. Fourteen of the women and eight of the men noted that the stigma of alcohol problems deterred them from getting help; interestingly, a good relationship with their primary care provider was as much a barrier to talking about an alcohol problem as was a poor relationship. Two of the women interviewed reported having panic attacks which made it difficult for them to leave their homes; only one woman reported that childcare was an issue (very few participants had school-age children). Fear of hospitals and treatment was also reported to be a barrier for five women and five men in this study.

Qualitative Method of Life History

Definition of Life History

The broad genre of biography includes many forms of life writing such as oral history, autobiography, and life history (Creswell, 1998). Life history is a qualitative method that involves a series of meetings with respondents where interviews and conversations are conducted. There may be one or two interviews with a respondent, or in the extreme, interviews may be conducted

over decades. These interviews are about an individual's life and focus on a pivotal event, a life process, or a story of an experience in the individual's life. The interview seeks the respondent's personal perspective of the way that an event reflects cultural, personal, institutional, and social histories (Cole, 1994). The investigator documents the story and provides an interpretation that allows for perspective on the historical social context, cultural issues and ideologies to come through in the researcher's analysis.

Unlike quantitative methods, which implicitly limit the investigator's questions and asks for no more, qualitative methods allow for a different kind of possibility and opening into human experience as the informant takes over the first part of the method and tells her story. Qualitative methods, and in particular life history, have the ability to access the stories that pregnant drug dependent women can tell. These narratives are powerful, evocative and subjective, in part depending on the dynamic of the researcher and the informant.

In pursuit of knowledge about barriers to treatment, life history is useful in giving voice to a population of women whose feelings, thoughts, and life events are virtually invisible, bringing these highly stigmatized women, too often labeled as "the other," in from the margins. Though a small segment

of the scientific community has conducted what could be termed objective (non-biased) research on perinatal addiction, very little data on the personal experiences of these women exist.

Life history can uncover these unheard stories, illuminate meanings and potentially clarify misunderstood and misinterpreted behavior and, in so doing, create a re-frame of events and actions, where the once strange can be made familiar. Life history can include epiphanies, thick descriptions of the meaning of the stories, and then delineate a relationship of that meaning to the larger literature on the subject of barriers. Life history also allows for description of the relationship of the researcher to the researched and "lessons learned in conducting the study" (Creswell, 1998, p. 30). Forms of biography then, become "gendered class productions" reflective of the writer as much as of the subject (Creswell, p.50).

Theoretical Basis

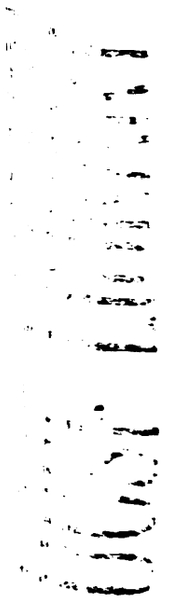
As noted by Fielding and Fielding (1986), "Qualitative measures are procedures for counting to one...fundamentally an interpretive issue where meanings rather than frequencies assume paramount significance, shaped by explicit philosophies and moral positions" (p.6). In examining extrinsic barriers to substance abuse treatment for pregnant drug dependent women, this

writer is guided by a perspective that regards gender and race as among the primary determinants of health outcomes for persons with drug dependency. A gender-based perspective is one in which culturally defined female traits and behaviors, social beliefs, and expectations about behavior are taken into account in describing and explaining a phenomenon (Straussner & Zelvin, 1997). These beliefs and expectations, while held by individuals in the society, are also "introjected by individuals and ...become part of their self-identity" (Straussner & Zelvin, 1997, p. 5). Gender differences in addiction include biological responses, natural history (course) of addiction, motivation for treatment, reproductive health, legal-ethical issues, retention, and relapse. These differences have not been thoroughly examined; nor have gender-specific findings been attended to in the current "research-to-practice" reformation that is taking place within the discipline of addiction research and treatment (NIDA, 1999).

A gender-based perspective on the study of extrinsic barriers for women acknowledges several dynamics inherent in the social world as well as in the research process. One dynamic is that modern objectivist research has distorted findings, because inherent in such objectivist projects is a necessary methodological distancing from the subject (Oakley, 1981). Qualitative

research allows for an up-close interaction with the subject(s) and one outcome of this method is the "reaffirmation of the experience of women, an experience that has been largely ignored, trivialized or misunderstood (until studied by feminists) because of the system of values underlying supposedly value-free traditional [social] science..." (Reinharz, 1995, p. ix).

Another socio-political dynamic acknowledged in a gender-based perspective is that women are oppressed and marginalized and attention to women's experiences in research has the power to alter the traditional conduct of science (Devault, 1990). Devault describes feminist interview research in particular as an "activity fundamentally grounded in talk" (1990, p. 97), intended to rectify the fact that "language itself reflects male experiences and [that] its categories are often incongruent with women's lives" (p. 96). Methods based in a gender-sensitive perspective that intend to study barriers are also needed simply in order to disclose previously unknown data that may positively affect the lives of women and their families. These methods allow for the lived experience of women to be discovered in order to inform gender-sensitive models of intervention and services-provision.



Discussion of theoretical perspectives on race and racism requires some limited definition of terms. Race can be defined as "a complex

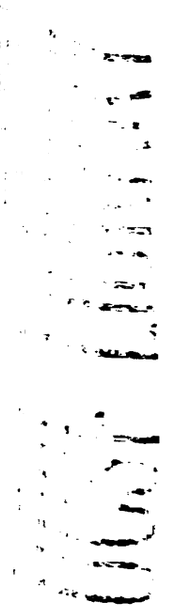
multidimensional construct reflecting the confluence of biological factors, and geographical origins, culture, economic, political and legal factors, as well as racism" (Williams, 1997, p. 327). Race, no longer useful as a biological category, "emerged as a sociopolitical construct useful not only to classify human variation but also to justify the exploitation of groups defined as inferior" (Williams, p. 323). Therefore, theory that seeks to explain the impact of race and racism on pregnant drug dependent women also calls for the use of qualitative methods of inquiry.

Williams' (1997) Model for Studying Racial Differences in Health provides a theory of the impact of race discrimination on health outcomes and informs research on pregnant drug dependent women. Williams proposes that societal forces and biology are the main elements that determine differences in health status and his model specifically includes racism as an important determinant of health. While not all drug dependent pregnant women are women of color subject to individual and institutional racism, the majority of women who have been prosecuted for drug use during pregnancy are women of color (Jos, Marshall & Perlmutter, 1995) and this legacy of individual and institutional racism features prominently in the social construction of perinatal addiction today (Chasnoff, Landress & Barrett, 1990; Siegel, 1994; Roberts,

1997). Williams' theory of differences in health outcomes, while not empirically tested, offers important insights into the role of race and racism in the examination of barriers to treatment. A race-conscious perspective also calls for a study of the experiences of an ethnically diverse group of pregnant drug dependent women, which may further illuminate racialized experiences of care-seeking among this population of women and add to the agenda for research and social transformation.

Williams' theoretical basis for qualitative methods in an examination of extrinsic barriers to treatment emanates from a particular research stance with action and transformation as the central objective (Torbert, 1981). As stated, the experience of pregnant drug dependent women and their encounters with barriers to treatment are nested within the current social construction of gender and race dynamics. These dynamics can be made highly visible by qualitative methods that seek to illuminate individual lives in the context of personal, institutional and social histories (Cole, 1994). A qualitative method was chosen as congruent for gaining knowledge of the phenomenon under examination because of the level of access to subjects and their personal narratives, the opportunity for interpretation and the values and philosophy of the researcher.

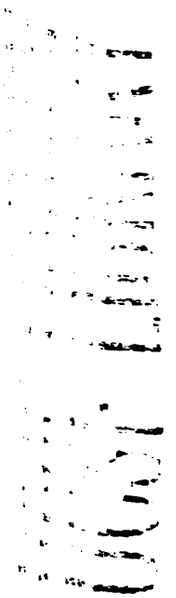
In addition, research methods that seek to elicit individual stories are useful with this phenomenon because with these stories, the researcher is able to construct a "mosaic" of a community (Becker, 1974), allowing for movement toward and interpretation from the subject's point of view, rather than the observer's (Smith, 1994). In the case of pregnant drug dependent women, generally viewed as a group of undistinguished women, their individual stories need to be documented. Life writing, specifically life history as a qualitative method, has the potential to uncover pregnant women's subjective experiences about the process of encountering extrinsic barriers in the process of seeking drug treatment.



The Strengths of Life-History Method

With life history, the phenomenon of barriers to treatment among pregnant drug dependent women can be addressed through the open-ended questions of "How did you get into treatment this time," and "What was that like for you?" Additional probes that follow the contours of the narrative are an essential part of communication skills about daily life and qualitative methods have the power to yield such details, producing tone and emotion not possible in quantitative methods. Stories can include descriptions of the weather on the day she (the participant) went into treatment, who was standing

on the corner when she packed her car, the look on her grandmother's face when she left, the feeling she had as she handed her only child into the arms of her mother as she entered a program that did not allow children. Contours of meanings, memory, body posture, expression, laughter, hesitation, crying, anger, impatience, jargon, avoidance of gaze, eagerness and contentment can all be encountered in the interview and conveyed in the interpretation. This qualitative method allows for witnessing the informant's affect that attends the story; the therapeutic skills of the interviewer can nurture and continue the interview as an alliance is built while telling the story. Stories allow the interviewer to reveal the concrete extrinsic barriers the informant had to navigate in order to walk into the setting (i.e. childcare, partner objections or warrants for her arrest).



Qualitative methods also allow for the interpretation to appear and assert its stance. Life history from a feminist perspective is a strategy that intends empowerment of its subjects. Through qualitative methods, investigators are privileged to see people coping with their lives and in the telling, stretch the boundaries of what is generally believed to be real, thereby allowing for the existence of multiple truths and multiple realities. In Lather's account of women with HIV/AIDS, for example, the author speaks of herself

as a "translator bearing witness" as her informants speak of suffering, death and the uncertainty of their condition (Lather, 1995). Qualitative methods provide the opportunity for the investigator to witness activity, which when turned to action can inform policy, change attitudes and amplify the no longer silent voices.

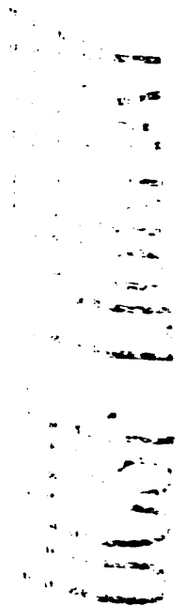
Methodological Challenges of Qualitative Approaches

Numerous methodological and ethical issues arise in the process of conducting qualitative research. These include sampling strategies, setting, reflexivity of the interviewer and participant interaction, checks on the trustworthiness of the data, and ethical issues in research with women who are pregnant and drug dependent. Consideration of each of these must be given in advance of, and during, data collection.

Sampling. Sampling techniques, which have a profound impact on data outcomes, should reflect the population in question who "manifest[ed] the phenomenon intensely" (Marshall & Rossman, 1999, p. 73). Examination of barriers to treatment for pregnant drug dependent women could be accomplished with interviews with in-treatment and/or out-of-treatment populations. A main goal of this research is to obtain self-reflective narratives of encountering and negotiating barriers to treatment. Therefore, optimal

conditions that would yield the richest data in terms of settings, events and actors must be sought (Marshall & Rossman, 1999).

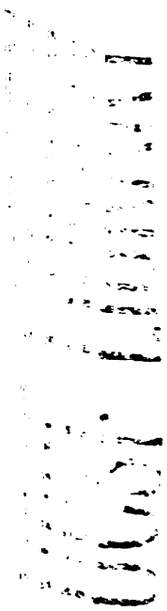
A number of different groups of drug dependent women could potentially be interviewed about their experiences with barriers to treatment. These groups could include women with many years in recovery, women who are pregnant and not in treatment and women who are pregnant and in treatment. In-treatment pregnant women have a specific story to tell of their recent experience of entering treatment and it would be reasonable, as a beginning phase of research on this issue, to obtain the data in their stories. Likewise, women with a young child can reflect on barriers they encountered during their pregnancy, whether they were in treatment or not.



The setting of gender-specific perinatal residential treatment is also a cloistered, long-term modality that allows for a woman to "settle in" and to have some time for reflection and self-conscious awareness. Public sector gender-specific perinatal treatment traditionally focuses on issues that are salient in drug dependent women's lives. These include trauma experiences, parenting, relationship management, and survival resources such as housing, financial support, budgeting and health care maintenance (Finkelstein, 1993). Because of the intensive self-focus and the traditional length of treatment

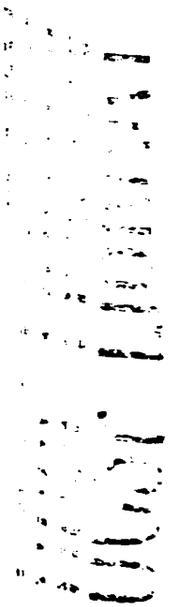
(three to twelve months), enrollment in residential treatment suggests a higher level of severity of addiction-related consequences as well as a willingness to make sacrifices in order to commit to the difficult task of sobriety and recovery. Because many women in residential treatment are there due to contracts they have with child welfare services, the research interview on barriers would be no more intrusive than anything they may have been asked about since their entry to treatment.

Purposive sampling is used to enhance the diversity of viewpoints. As noted by Morse (1991),"Bias is used positively as a tool to facilitate the research"(p. 138). Maximum variation sampling is a recruitment strategy that can sample a wide range of study participants. Narratives of diversity are needed and therefore ethnically divers women from programs that are in urban/rural, multi-ethnic, gatekeeper/no gatekeeper settings (i.e. public sector managed care alcohol and drug treatment) and women who are primiparas/multiparas, single/partnered, have planned/unplanned pregnancy, in initial lifetime treatment/multiple times in treatment should be sampled to enhance generalizability.



Reflexivity of the interviewer and participant interaction. Reflexivity of the interviewer is defined as the interviewer's self-awareness that her interview

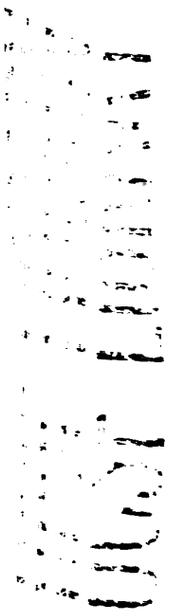
style and reactions to the respondent are a part of the data and that her own insights into herself are actually a source of data (Lipson, 1991). This instrumental use of self in qualitative research allows for skills common to clinical nursing and life history interviewing to be utilized including "astute observation and interpretation on several levels simultaneously...and intentional use of self" (Lipson, p. 77). Spradley (1979, p.79) describes a step-wise rapport process that is a normal part of entry and initiation of qualitative interviews from apprehension to exploration, from exploration to cooperation, and from cooperation to participation.



In this vein, Lipson's (1991) "therapeutic use of self" is a valuable model for an interviewing stance that seeks to build a relationship in the process of eliciting information. Such an interview style requires self-knowledge of one's values, interactive style, and attitudes and is based on trust, respect for the respondent and an awareness of the struggles in the lives of the respondents. There are numerous influences on the interview style and the use of self, including the setting, the respondent's reaction to the researcher and the characteristics of the researcher (Lipson, 1991).

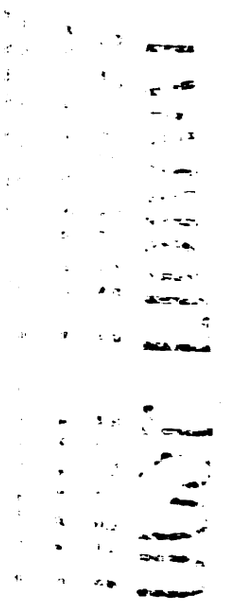
In a study of barriers to treatment utilizing life history interviewing, the setting for the interview would be the residential treatment center itself. While

this setting may enhance feelings of comfort in both the respondent and the interviewer, as the space is familiar, it may restrict the respondent's responses if confidentiality or fear of giving voice to conflicted feelings or experiences are concerns for the respondent. These programs tend to be somewhat chaotic, busy and lacking in space, which may negatively influence the ease of the interview process. However, these difficulties are elements of the process that present opportunities for observation of the self and the respondent and should, even if aggravating, be thought of as benefits to the research process. Emotional reactions of the respondent and the researcher to chaos in the environment can add tone and content to the data.



The respondent's reaction to the researcher lends interesting dynamics to the interview process and is dependent on the interaction styles of both individuals and the type of identifying introduction provided to the study participants. In working with drug dependent women, the interviewer must consider how to identify (and reveal in the course of the interview) herself professionally in terms of clinical experience and personally in terms of age, parenting and recovery status and even marital status. The extent of self-disclosure may positively or negatively affect the research process by identification of the respondent with the researcher and should be carefully

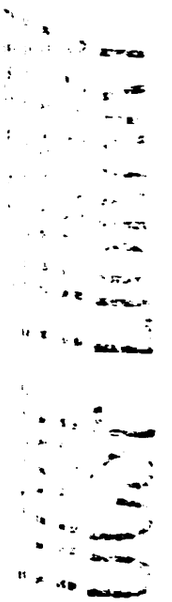
considered in advance of the interview process as well as in the midst of an interviewing interaction. Revealing a history of advocacy and clinical experience in the researcher could create a sort of "shorthand" communication that respondents may find either comforting or unsettling, depending on the status of their own recovery and their feelings about emotional self-disclosure. Class-consciousness, ethnicity, gender role assumption, and attitudes of both the respondent and the researcher will also affect the interaction and the production of data. Denzin (1989) stated that gender acts as a filter for knowledge, and that differences in the sex of the respondent and the interviewer are "filtered" through the boundaries of culture and gender roles (Fontana & Frey, 1994).



Cultural humility has been described as a clinical interaction style that requires "humility as individuals constantly engage in self-reflection and self-critique as lifelong learners and reflective practitioners. It is a process that requires humility...[to] check the power imbalances that exist in the dynamics of physician-patient communication..." (Tervalon & Murray-Garcia, 1998, p. 118). Cultural humility, a useful stance to adopt in the interviewing process, also suggests an attitude of acceptance that the interviewer is not necessarily completely competent about existing cultural differences between the

respondent and the interviewer, but is respectful, open and willing to examine her own attitudes.

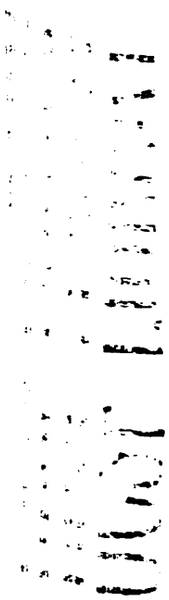
Researcher characteristics can also define the relationship with the respondent and thus will influence the data. Interviewer responses to emotional moments in the respondent's story can either facilitate the telling or end it. If the researcher is viewed as remote, cool, distant and "professional" with no insight into the lives of drug dependent women, an interview may be derailed by the lack of an alliance. Preoccupation with managing one's own responses to emotional content in the narrative can block access to the data and wrongly locate the primary focus of the process on interviewer reactions rather than the respondent's story. Expressions of empathy from the interviewer may facilitate the telling of the story as long as the objective is the genuine expression of humane concern and not a manipulation of the respondent.



Trustworthiness in Qualitative Research

Quantitative and qualitative methods do not share similar goals for data verification. Quantitative studies seek to ensure the reliability and validity of data through the assessment of instruments, research design, sampling techniques and complex statistical operations (Rosenthal & Rosnow, 1991). In qualitative research, a different set of measures supported by a distinctive set

of values, is brought to bear on the question of verification, rather than validity, per se. Qualitative research, essentially an interpretive enterprise conducted in naturalistic settings, seeks to describe phenomena in terms of the personal meanings inherent in the experiences of the subjects. Qualitative research also seeks to "subvert the dominant paradigm," and acknowledges multiple realities, with multiple "truths." Lincoln and Guba's (1985) use of the terms credibility, transferability, dependability and confirmability supplant the positivist quantitative nomenclature and offer these alternative terms to more adequately grasp the intent and meaning of qualitative research.



Credibility (a parallel concept related to internal validity in quantitative methods) of findings in the qualitative tradition is established through the use of procedures that enhance the trustworthiness and authenticity of the study (Lincoln & Guba, 1985). As cited by Creswell (1998), these procedures which enhance overall verification of qualitative data include prolonged engagement and constant observation in the field; peer review and debriefing; negative case analysis; member checks; rich, thick descriptions; external audits; triangulation (Lincoln & Guba, 1985) and clarifying researcher bias from the beginning of the study (Merriam, 1988). Creswell (1998) suggests that researchers conduct at least two of these strategies in any qualitative study. Member checks can be

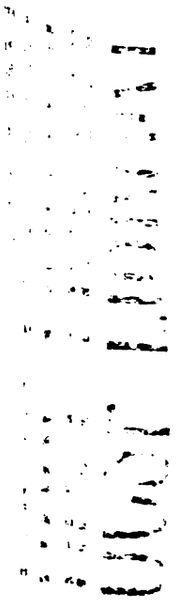
carried out over multiple interviews and involve asking respondents to verify the interviewer's understanding of what they said and meant in the conversation. Peer review and debriefing are conducted by the researcher and an individual, such as a colleague, whose role it is to provide rigorous external examination of the data, the methods, and the interpretation. The researchers and this individual, usually a peer, keep written accounts of these "peer debriefing sessions" (Lincoln & Guba, 1985).

Transferability is a parallel concept related to external validity in quantitative methods (Lincoln & Guba, 1991). Transferability in qualitative methods can be enhanced by the researcher demonstrating the way in which data collection and analysis was guided by theoretical frameworks and models (Marshall & Rossman, 1999). Transferability can then be assessed by others who wish to apply those same study results to policy or clinical decision-making.

Dependability, a concept similar to reliability in quantitative methods (Lincoln & Guba, 1991), is how the "researcher attempts to account for changing conditions in the phenomenon chosen for study and changes in the design created by an increasingly refined understanding of the setting" (Marshall & Rossman, 1999, p.194). Adoption of theoretical sampling

(seeking data supportive of a specific theory) well into the course of a qualitative study would be one strategy for dependability.

Finally, confirmability is the parallel construct to objectivity in quantitative methodology. Some researchers state that no qualitative study could ever be confirmed by another researcher simply because the circumstances and interactions of the respondents and interviewer could never be exactly replicated (Lincoln & Guba, 1985). Rather, the more fitting measure of confirmability is whether the data "help confirm the general findings and lead to the implications" (Marshall & Rossman, 1999, p. 194).

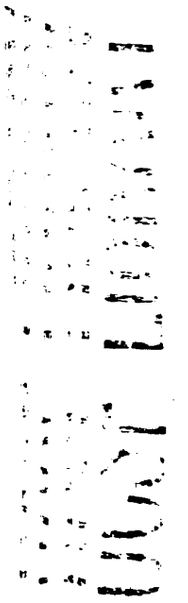


Data Analysis: Mandelbaum (1975)

Analysis of interview data is the most creative and challenging phase of the qualitative method. Life history interviews usually produce large amounts of data and analysis requires a planned strategy. Mandelbaum (1975) suggests using dimensions, turnings and adaptations as guidelines in shaping the frame of reference for the analysis. In this regard, these ideas help the researcher develop concepts from the data.

Dimensions of the life history are made up of "experiences that stem from a similar base and are linked in their effects on the person's subsequent actions" (Mandelbaum, 1975, p.180). Dimensions to be explored in the lives

of pregnant drug dependent women, for example, would include the biological, cultural, social and the psychosocial. Mandelbaum (1975) describes the potential for deep insight during consideration of these dimensions: "...the student tends to become especially aware of the person as an active doer and seeker and not only as a passive recipient or a subject for scientific generalizations" (p. 181). This notion of discovery of the "active doer" in all participants may have particular relevance to the stories told by pregnant drug dependent women in the process that has been labeled "delay" in treatment-seeking.

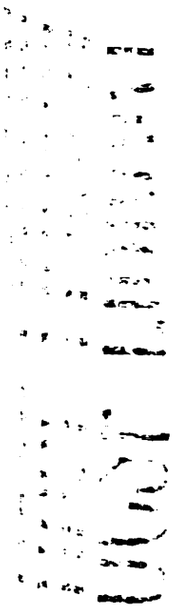


Turnings are life events, transitions, and epiphanies that occurs when a person takes on a new role, enters a new phase of life or "acquires a new self-concept"(p. 181). Turnings have special relevance for stories of negotiation of extrinsic barriers to treatment among drug dependent women, particularly for women who have successfully entered treatment. Mandelbaum notes: "Once we understand the major transitions we also know something about the main parts of [his] life, that is, about his salient roles, social relations, and self-conception from one transition to the next; " (p. 181).

Adaptations are adjustments and alterations in the way a person lives her life, "in order to maintain continuity, whether of group participation, or

social expectation of self-image or simply survival" (p. 181). Researcher sensitivity to adaptations reveals why and how people change, as well as the possibilities and limitations imposed or internalized by the participant.

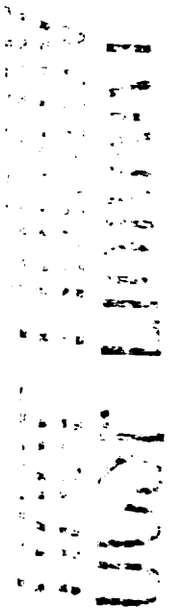
Marshall and Rossman (1999) offer a framework for phases of data analysis of qualitative method. Their proposed plan of data analysis involves the following procedures: 1) organization of the data; 2) coding of the data; 3) generation of categories, themes and patterns; 4) testing emerging concepts; and 5) seeking alternative explanations. Organization of the data consists of reading and re-reading to fully inventory the content. Computer software may be used to organize participant characteristics or other categories of choice by themes. Coding, the "formal presentation of analytic thinking" (Marshall & Rossman, 1999, p.155), is the process of detailed review of the data, wherein the researcher creates a coding scheme and assigns codes to salient themes, patterns, recurrent ideas or beliefs which have emerged in the participants' interviews.



Coding is not primarily a technical task, but a creative one, wherein thematic ideas and concepts emerge as the researcher sifts through the data. Generation of categories, themes, and patterns can lead to uncovering "indigenous typologies" (Patton, 1990, p. 309) and "analyst-constructed

typologies" (p. 393). "Indigenous typologies" are the perspectives, ideas and themes that emerge from participant data. "Analyst-constructed typologies" are those created by the researcher. Testing emerging concepts involves an evaluation by the researcher of the plausibility of the ideas and concepts that are emerging, including an evaluation of the usefulness of the data in explaining the phenomenon in question. Seeking alternative explanations for the data is critical in order to demonstrate how the explanation offered (by the researcher) is truly the most plausible (Marshall & Rossman, 1999).

These methods of qualitative data verification and analysis are critical for researchers in the defense of logic of qualitative findings. Just as critical, however, is the ethical conduct of science in research with women who are pregnant and drug dependent.



Ethics in Research with Drug Dependent Pregnant Women

In the process of research with drug dependent women, ethical issues emerge which require an awareness of, and sensitivity to, the unique power and privilege conferred on the researcher in such a context as scientific research. Life history, as a method of qualitative research, is a particularly personally "invasive" form of research, and the researcher needs to be aware of the power dynamics that can enter into the context of interview research. A

respondent, particularly a woman, may feel vulnerable, yet believe that she has to reveal feelings, thoughts and experiences simply because she is being asked by the "professional" researcher.

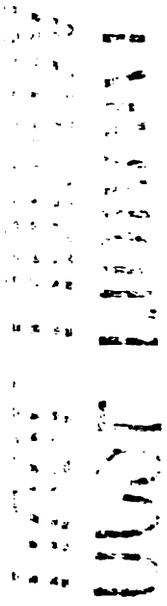
The dynamics of power that can dominate an interview relationship still exist when the researcher and respondent are both females, but may revolve around issues and projections of class and race superiority and discrimination. These introjections and projections travel between subject and researcher in both directions. In a model of research that is ethical and moral, the researcher is obligated to conscientiously face and address these concerns prior to conceiving the project and during its conduct. Punch (1998) notes these dynamics:

> ...the women's movement has brought forth a scholarship that emphasizes identification, trust, empathy, and non-exploitive relationships. Feminist research by women on women implies a "standpoint epistemology" that not only colors the ethical and moral component of research related to the power imbalances in a sexist and racist environment, but also inhibits deception of the research "subject." Indeed, the gender and ethnic solidarity between researcher and researched welds that relationship into one of cooperation and

collaboration...the personal is related to the ethical, the moral and the political standpoint. And you do not rip off your sisters (p.196).

When the ethnicity of the interviewer differs from the ethnicity of the respondent, sensitivity to the significance of racial-ethic dynamics in the interview process is required. Blauner and Welman (1973) note the difficulty of White scholars conducting research within communities and with persons of color, for example:

> There are certain aspects of racial phenomena, however, that are particularly difficult, if not impossible for a member of the oppressing group to grasp empirically and formulate conceptually. These barriers are existential and methodological as well as political and ethical. We refer here to the nuances of culture and group ethos; to the meaning of oppression and especially psychic relations: to what is called the Black, the Mexican-American, the Asian and the Indian experience (p.329).



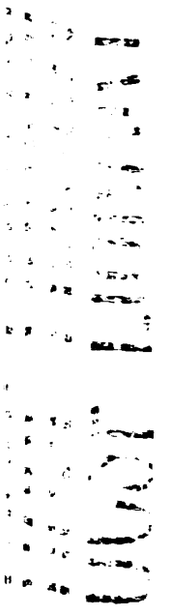
Devault (1995) notes that "close analysis [of interview data] suggests that talk will sometimes reveal racial-ethnic dynamics even when these are not explicit topics and that active attention to such structured inequalities produces a more robust analysis" (p. 612). One strategy for enhancing the sensitivity and humility of the majority group interviewer is active acknowledgement that

material life sets limits on the researcher's abilities to understand these social relations and that the subject as well as the researcher is a different, rich and unique source of life knowledge (Punch, 1998). Collins (1986) suggests the strategy of "outsiders in" for African American feminist scholars as a way to access knowledge and other scholars can also benefit from using their own ethnic, gender, and class identities for purposes of insight. The ability of these researchers to exceed socially imposed limits on perspective depends on the quality of interpersonal interaction, the class and race consciousness of the researcher, and her skill in creating an environment conducive to trust and respect.

For drug dependent women enrolled in perinatal treatment settings, the therapeutic process involves a process of surrender to a more knowledgeable authority (the staff) and admissions of powerlessness (Step One, Alcoholics Anonymous) as well as commission of past wrongs (Step Four, Alcoholics Anonymous). Because of the inherent and even therapeutically-reinforced shame and poor self-esteem among drug dependent pregnant women, research conducted in the context of a treatment program must acknowledge that built-in power dynamic, as it exerts influence in the relationship as well as in the data. Adoption of a non-judgmental, friendly and direct interviewing style, in

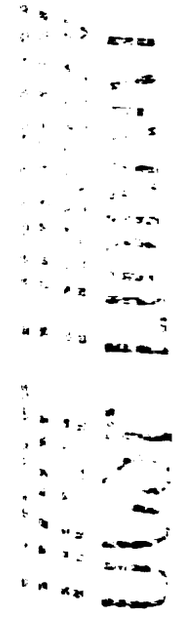
addition to appropriate expressions of identification, empathy and understanding can minimize these power differentials.

Other ethical concerns in the process of research with addicted women, is the respondents' past or present participation in illegal activity. Respondents may fear revealing such illegal activities and therefore not volunteer for research studies, or once enrolled may hold back this type of information. In human research, subjects have the right to withhold any information they wish and researchers have to be clear that this information if revealed, is protected, anonymous and confidential. The one exception to the protection of confidentiality extended to subjects in human research is a subject's report of child abuse and child abuse reporting (California Penal Code Section 11165-11174.5; California State Department of Social Services, Office of Child Abuse Prevention, 1997). As mandated reporters of child abuse and neglect, nurse researchers must report to local child welfare services persons whom they believe have committed or are in the process of committing child abuse and neglect (California Penal Code section 11166[a]). Because of the profound ethical and legal implications of such a report for the subject and her family, nurse researchers need to be well-versed in regional child protection statutes in advance of initiating research wherein such information may emerge, and also



be aware of local and regional child welfare procedures in these matters. The researcher and the research process are also benefited if consultation on child abuse reporting procedure is available at the time such an issue arises. Subjects must be informed of this limit to the protection of confidentiality laws in advance of providing consent.

Because the well being of the study participant is of primary importance, confidentiality, anonymity and informed consent must be explained thoroughly to each subject and adhered to throughout the entire process of research. The rights of scientific study subjects must be reviewed in advance of consent and informed consent include a discussion of the benefits and risks to the subject. "Risks of interaction" (May, 1991, p. 199), emotional reactions to telling life histories, are always present in the interview process and researchers need to consider how subjects' needs for additional support will be met, either by the researcher or by referral.



Research Design

Setting

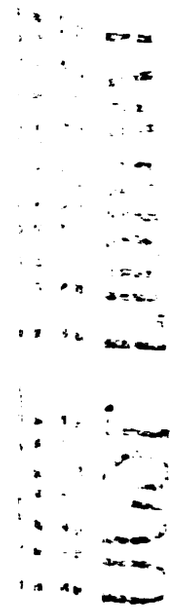
This research was designed as a qualitative life history study. The setting for the research was residential substance abuse treatment programs for pregnant and parenting women. The fifteen programs were located in

residential communities of six counties of northern California. Six programs were located in an urban setting; four were suburban, one coastal and one in the central valley of California. The residential facilities were classified as drug free long term (> 30 days) and perinatal-specific. All programs allowed at least one child (aged newborn to 6 years) to accompany the mother into treatment. Some programs allowed more than one child to enter the program depending upon space. One of the urban programs had coed day treatment services. The remainder were women and children only. Most programs housed 10-15 women; the range was from 6-26 women and their children.

All of the programs were highly structured in terms of time, therapeutic activities and behavior codes. All programs were collective cohabitation environments with residents assigned house jobs, such as food preparation, cleaning, washing clothes, and shared childcare. The staff were present on site 24 hours a day, seven days a week with staff reductions to one or two persons on weekends and at night. The majority of program staff were recovering addicts themselves; all staff were female. The environments consisted of bedrooms or dorm rooms for mothers and children (often shared with 1-3 other women and their children), kitchen, group room(s), staff office(s) and small indoor and outdoor play spaces for the children.

Treatment Program Environment

Anonymity of the women and the programs resulted in the absence of program names and public notifications at the entrances, in part because some programs doubled as shelters from violent partners. Some entrances were very inviting with brass doorknockers and wreaths; others appeared to be minimum-security facilities with multiple locks and security screen doors. The settings varied in amenities; some had plants, gardens, colorful wall art and many visible books on childrearing and the spiritual aspects of recovery. Others were sparse with little or no interior decoration, filled with worn out furniture in need of paint. All were exceedingly scrubbed and neat; all had rules and recovery slogans posted on the walls. Televisions and toys were also in all settings. To the public, these facilities would be taken for large private homes or multiple-unit family apartment dwellings.



The interviews were conducted in vacant offices, at the kitchen table, on group room couches or sitting on the resident's bed. On one occasion an interview was conducted at the bedside of a pregnant study participant who was on complete bedrest. Several of the interviews were conducted with babies playing or sleeping on the laps of the study participants or playing on the floor nearby. Multiple interruptions were inherent in the interview process including

rattles and toy bells and beads, buzzing intercoms, ringing phones, fussing or crying babies, staff and clients seeking other staff and clients, emotional outbursts from group or hallway confrontations and from needing to re-locate to another space so that unexpected staff could use the space.

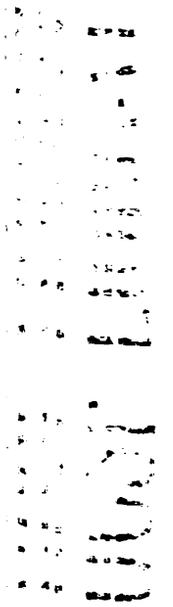
Criteria for Sample Selection

Inclusion criteria for the study was: 1) alcohol or other drug dependency; 2) at least 24 weeks pregnant or have a child under 12 months of age; 3) enrolled in residential treatment program and 4) at least 18 years of age. Pregnancy status of at least 24 weeks was selected as the women would be past the time period where therapeutic abortion would be an option. Residential treatment was selected as the setting because this modality requires the highest level of commitment in terms of sobriety and loss of personal autonomy. It is also thought to be the most difficult for gaining entry due to waiting lists and program-based requirements for entrance (e.g. sobriety for 48 hours required prior to admission, limited child placements with loss of other non-placed children to foster care, no communication with family or friends for 30-90 days). Thus these women would have faced the greatest number of barriers to receiving treatment.

Data Collection

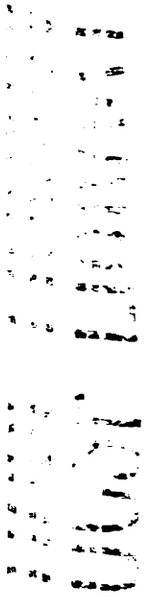
Human subjects assurance. Approval for the study was granted by the UCSF Committee on Human Research (approval No. H5464-15476) for the study entitled "Barriers to Treatment Among Pregnant Drug Dependent Women." Approval was granted for the period of August, 2000 through August, 2001. All procedures were carried out according to these guidelines.

Recruitment of study participants. Of the 21 programs initially contacted, 15 programs were recruited for the study and agreed to participate. Of the six that did not participate, one program declined to participate, as there were no pregnant women enrolling, one was too chaotic and was therefore not pursued and one rural program closed due to de-funding. Another program was a drop-in case management program and therefore not appropriate. Two were excessively geographically distant from the investigator. One health care clinic was recruited in order to reach study participants whom the providers knew to be in residential treatment. Flyers (see Appendix F) were posted in the programs and potential study participants were asked to call a toll-free number. At that time a screening interview was conducted by phone to determine that the potential participant met the inclusion criteria. If so, then a mutually convenient meeting time was then set up and the



investigator went to the program to interview the participant.

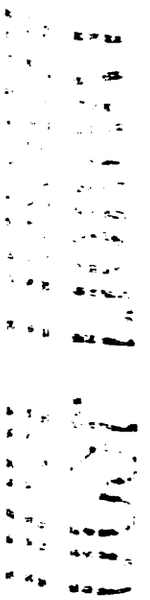
After four weeks using the initial sample inclusion criteria, only three subjects had been recruited. At that time, the inclusion criteria were expanded to include women with infants. A revised protocol was then submitted and approved by the Committee on Human Research (CHR). Fortuitously, this expanded the sample to include not only women who had entered treatment during pregnancy, but also those with children who did not enter treatment until after the birth of their child. Recruitment was still initially slow, but improved with personal visits to program staff to explain the study and, as subjects were interviewed, snowball technique was also successful. A total of 36 women from 12 of the 15 programs were ultimately interviewed over a period of five months (no participants responded to the flyer in three of the programs). Purposive sampling was used to enhance the diversity of participant viewpoints. Specific programs were recruited in order to try to reach a variety of ethnicities and users of specific drugs (see Appendix G for program distribution of study participants).



Consent. Informed consent was obtained according to federal guidelines for consent and as required by the UCSF institutional Committee on Human Research (CHR). In order to ensure the highest level of protection

of human subjects, CHR recommended that consent in the form of an information sheet only be obtained for this study, thus allowing for complete anonymity of the study participants (see Appendix H 1).

The interview. The interview consisted of a demographic questionnaire (see Appendix H 2) and semi-structured life history interview. The one to two hour interview consisted of one central open-ended question: please tell me about the period of time before you entered treatment. Probes included: how did you learn you were pregnant? How did you get to treatment? What was that period of time like for you and what were you doing during that time? Though the interviews could have been longer because the women had a great deal to say, interview space was hard to come by and most participants had to adhere to rigorous program schedules that also limited the length of the interviews. Interviews were taped and at the conclusion of the interview, participants were presented with a $25 gift certificate from a local retail variety store of their choice. The audiotaped interviews were then transcribed verbatim by a medical transcriptionist and sent to me via e-mail for coding. Sample characteristics will be further described in Chapter 4.



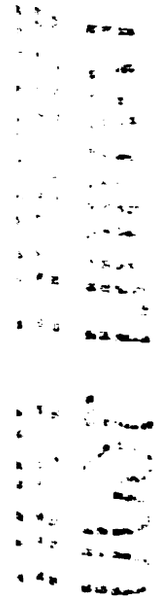
Data Analysis

The method of qualitative analysis for life histories described by Mandelbaum (1973) was used in this study. As noted earlier, Mandelbaum suggests the framework of dimensions, turnings and adaptations as guidelines for analysis. In this study of extrinsic barriers among pregnant drug dependent women, the dimensions of perinatal addiction, adaptations that occurred during the particular period of time in the participants' lives (before, during and after pregnancy) and the turning of pregnancy were the focus of this study.

The biological, socio-cultural and psycho-social dimensions of the phenomenon of socially constructed perinatal addiction were examined. These dimensions were analyzed in order to understand common experiences between the women and the primary forces affecting their lives. Adaptations were analyzed in order to examine the feelings, perceptions and actions before and during the process of treatment-seeking. According to Mandelbaum (1973), adaptations are the ways that people change and cope with new situations that arise from changing external social conditions. He describes these adaptations as allowing for group participation, fulfillment of social expectations, development of a self-image and survival. Implicit in

this is Mandelbaum's concept of the "active doer," which has particular relevance to the prenatal activities and behavior of pregnant drug dependent women who have often been labeled "delayers" in seeking help. Rather, utilizing Mandelbaum's analytic methodology to examine adaptations, the multiple forms of "creative coping" (Becker, 1966) are made visible. Herein, as Mandelbaum (1973) states, life history provides a "vivid feeling for what it means to be a certain kind of person" (p. 179); in this case, a pregnant drug addicted woman.

The turning of pregnancy was a major life transition among the study participants. This turning was analyzed in terms of new roles assumed and ascribed and its impact on motivation for recovery and abstinence. Mandelbaum states that a turning "serves as an index to the person's conduct after" a gradual shift or a specific turning point (1973, p.181).

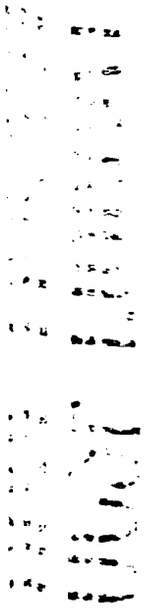


Trustworthiness

Interviews were coded using NUD*IST 4™ ethnographic software. This software is a tool for thematic sorting of topics (nodes) and for noting and comparing these themes and trends in the data. As coding of interviews proceeded, nodes and themes increased in number and in contour. Thus, the first 8-9 interviews were re-coded after the accumulation of more codes

because of an expanding insight and awareness about the data that developed. As the data were coded, subtleties of meaning and other nodes emerged that then applied to later material that were not visible in the process of earlier naive coding. As a result there was on-going coding of new interviews with a simultaneous return to earlier data. At the beginning of the coding process, interviews were also continuing, which allowed for theoretical sampling.

Trustworthiness of the data was further ensured by using strategies to establish credibility, dependability and confirmability. Strategies to ensure credibility included writing a reflexive journal and being comfortable and familiar with the research setting and context. As the investigator, I have over 20 years of experience with alcohol and drug dependent pregnant women and have spent 14 months teaching parenting classes in a residential perinatal program and many years conducted multiple trainings and consultations to staff of these programs.



Member checks and peer reviews were also conducted to ensure credibility. Regarding member checks, during the course of the interviews I frequently asked study participants about the meaning of their statements, e.g. "I understand you to be saying this; is that correct?" Additionally, I met

with one study participant, presented salient findings and received feedback on the plausibility of the data. Member checks were also conducted with treatment program staff from one of the residential treatment programs that served as a site. In this meeting, the seven staff members provided feedback on plausibility of the salient themes from the perspective of treatment personnel knowledgeable about pregnant drug dependent women. Three of these staff members also provided perspective from their past, as formerly pregnant and drug dependent women, prior to becoming substance abuse treatment professionals.

Peer reviews were also conducted. The process with two interviews and one significant theme in the data was reviewed for reasonableness and plausibility with two peer reviewers. One of these peers had substance abuse treatment expertise and the other had minimal qualitative interview experience.

With regard to dependability and confirmability, alertness to developing themes allowed for theoretical sampling and examination of emerging themes. For example, I asked more specifically about learning of the pregnancy (a node), which led to stories about the role of partners. Questions about positive and negative experiences with health care providers

(two nodes) led to specific descriptions of fears of going in for care and expectations of treatment. At the end of each interview, theoretical sampling was also used to ask women about specific barriers that other women had mentioned such as "the list" and a frequently referenced child welfare policy. Constant comparison of data was conducted to confirm the findings. This comparison included reviewing participant interviews, field notes, memos and the extensive demographic data about the women.

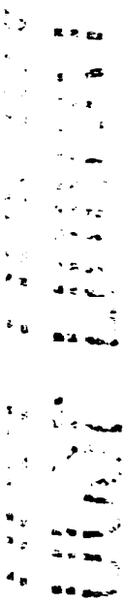
Finally, in the interpretation phase of the analysis, reflexivity regarding the participants and their stories became a source of data as well. My own awareness and experience of class privilege during the interview phase of the study allowed me to explore these dynamics of human connection between myself and the study participants and then between health care providers and drug dependent women. My experience of the differences in life options and resources between me, and those of the study participants, informed a part of the analysis process. Quoting from my personal log:

> ...One of the things that resonates in me is that when I leave there [the treatment program] and drive home, it is really actually very close to my home, yet so extremely far away. It is like the homeless person

> sitting on the stoop of the luxury hotel. There is no way they are getting in there. It is implacable. These worlds and people can get closer to each other, but never be completely known to each other... When I come home, it is jarring...as if I have been simply out in the garden or out at a desk job somewhere. The extreme disconnect between the deprivation and struggle and complete destitution of these women...is painful. It is literally staggering for me to come home and look out at my garden and its neatness. It is painful to see these conditions and hear these stories and yet, their resilience is at times unbelievable....The distance cannot be closed.

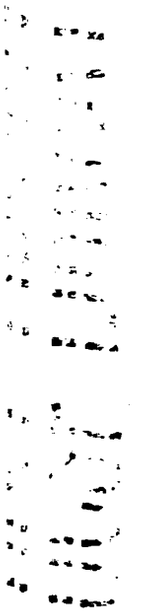
As noted by Punch (1998), material life sets limits on the researcher's abilities to understand the social relations between subject and self. Personally re-experiencing this rigid class segregation in the research context led me to explore this particular dynamic and how it permeates the research relationship as well as the social relations of "helping" professionals and drug dependent women. These dynamics of class privilege, definitive in its power in people's lives in this society, promote a form of separation that is characterized by emotional distancing and a misunderstanding of the different-ness of drug dependent women. These

dynamics may also promote a form of bigotry, which can take multiple forms such as threats, abuse and vilification. Without a consciousness of these dynamics, helpers can stay separated and successfully deny any commonalities they actually share with drug dependent women. As a researcher, personally feeling and acknowledging these "structured inequalities" (DeVault, 1990) allowed me to be more sensitive to the effects of poverty and limited life options in understanding the study participant's adaptive behaviors I was hearing about. With an understanding of these embedded inequalities as the lens, I was able to have a particular clarity of insight into their stories of interactions with helping professionals.



The majority of the women in my study (n=28) were women of color and I was very aware that there were probably "aspects of racial phenomena" (Blauner & Welman, 1973) that I could not be attuned to. During the interviews, I related well to the study participants in rapport-building, humor and in expressions of empathy. In turn, they were very responsive and open with me about their experiences and views. Yet, because I am not a person of color, I acknowledge that I could not, in a complete sense, be privy to or personally understand the "group ethos" of the women of color. Though I did not feel uncomfortable with, or worried

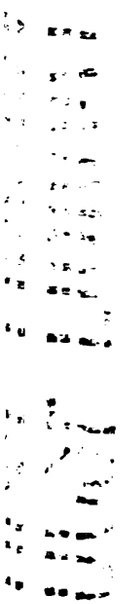
about, the way I related (as a person and as a researcher) to the women of color, an African American or Latina woman researcher may well have obtained different data and possibly created different relations during the research process. Though I was allowed intimate knowledge of the women's lives, a person of color as researcher may have been able to elicit more, certainly different, content than I did. My stance was one of cultural humility (Tervalon & Murray-Garcia, 1998), which was one of respect, openness and a willingness to examine my own feelings and reactions. I feel that my own level of race consciousness as a White woman allowed the women to share as much as they did.



Another form of reflexivity included listening and relating as a mother. I did experience numerous deep connections with the women about motherhood and "what we do." These included having similar hopes for our children, managing similar anxieties about being a "good" mother and dealing with the role of mother as it is, laden with other's opinions and social expectations. I would often mention my son and the fact that I was a mother, especially in terms of their dealing with their child's behaviors and feelings. I also had empathy for the very difficult decisions and actions on behalf of their children that the women were forced by life circumstances to

carry out.

I started each interview by noting that I was a nurse with 25 years of experience working with drug dependent women. This provided a shorthand way of saying "I understand your situation" and I also indicated my understanding at many points in the interview. After hearing of the women's often bad treatment by nurses and physicians, that introduction of myself may have injected some unanticipated distrust of which I was unaware at the time.

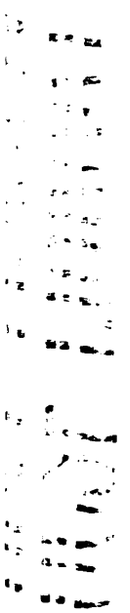


Chapter Four

Extrinsic Barriers to Treatment Among Pregnant Drug Dependent Women

Introduction

According to Mandelbaum (1973), life history analyses examine how persons cope with society. In these descriptions of personal experiences, the relevance to social institutions is uncovered. The narratives of the 36 study participants reveal how they coped in the ubiquitous shadow of health care and child protection institutions, which they perceived to be threatening to their welfare, to the cohesion of their families and to their individual autonomy. The following discussion of the study results describes the characteristics of the sample and the dimensions, turnings and adaptations in the lives of the 36 study participants.



Sample Characteristics

The sample of 36 women consisted of 12 women who were pregnant at the time of the interview and 24 who had had a child within the previous year. The mean age of the sample was 30.2 (±5.81 S.D.) years, with a range of 19-43 years of age; 34 of the 36 women were unemployed. For comparison, data on over 13,000 women admitted to residential drug-free long (>30 days) treatment facilities in California was obtained (Department

of Alcohol and Drug Programs, State of California, 2000). This modality of residential drug-free long treatment was the setting for this study. Demographic comparisons between this study and the State of California (2000) are detailed in Table 4.1.

Compared to women in long-term residential treatment in California during FY 1999-2000, this sample is similar in education, age and employment status. However, in comparison to the California state data, women in this sample over-represents African American women (55.6% vs. 27.2%) and under-represents White women (22.2% vs. 50.2%). The participants were also over-represented by women whose primary drug of abuse was cocaine/crack (23.4% vs. 13.4%) (see Table 4.1).

Of the 36 women in this study sample, 15 (42%) had their infant and/or older child(ren) with them in the residential treatment facility. Of the remaining women, 19 (53%) did not have custody of their children; placement of these children included temporary and permanent foster caregivers and relative caregivers and permanent adoption. The remaining two women were pregnant for the first time. Primary drugs of abuse included crack cocaine (n = 14), alcohol (n = 6), heroin (n = 6), methamphetamine (n = 5), cocaine (n = 2), cocaine/marijuana cigarettes

(n=2) and psychedelics (n=1). The mean time of abstinence was 18.4 weeks (±20.1 S.D.) with a range from one to 96 weeks. The mean gestational age (GA) at entry to substance abuse treatment was 17 weeks (±14.4 S.D.)

Table 4.1

Demographic Characteristics:
Population of California Women in Treatment
Compared to Dissertation Sample

	Dissertation n=36	CA. Pop. n=~13,200
Demographic variables		
Age	30.2 (±5.8)	33.3 (±9.1)
Education		
Completed grade school/some HS	52.8%	41.4%
HS grad/some college	41.7%	54.2%
Employed	5.6%	3.7%
Ethnicity		
Black	55.6%	27.2%
White	22.2%	50.2%
Latina	19.4%	18.9%
Native-American	2.8%	2.0%

and the mean GA at entry to prenatal care was 15.2 weeks (±9.3 S.D.) Among the 24 study participants who had treatment during pregnancy, six were referred by prenatal care providers. These six referrals were initiated due to self-disclosure by four of the women and due to a diagnosis of severe drug withdrawal in the other two. The other 18 women were admitted to treatment secondary to a referral from child welfare as a condition of regaining custody of older children (n = 6), from jail or court (n = 7) and by self-referral (n = 5) (see Appendix I and J for additional demographic data; see Appendix K for a complete table of barriers cited by study participants).

The life circumstances of the study participants were complex and difficult. Homelessness (n = 11), violence against the women by male partners (n = 7) and incarceration (n = 10) were part of the pregnancies and care-seeking experiences of this sample of women. In the case of violence against the women, many of the women spoke about their male partners and the ways in which their relationships with them discouraged and interfered with seeking care. For the 11 women who had periods of homelessness, dislocation and isolation were embedded in daily life and created another layer of obstruction and stigma that had to be overcome in the process of locating help (see Table 4.2).

Table 4. 2

Demographic Information (n=36)

	n	%
Treatment while pregnant	24	66%
Sought/participated in prenatal care	34	94%
Periods of homelessness during pregnancy	13	33%
Violence from partners during pregnancy	7	19%
Incarceration during pregnancy	11	31%
Sudden or violent deaths of loved one	9	25%
Unplanned pregnancy	33	92%
Prior interaction with child welfare agency resulting in relinquishment	24	(66%)
Methadone maintenance	4	(11%)

Eleven of the 36 women were incarcerated for greater than 30 days for drug-related crimes during pregnancy. These women were in jail for an average of 10.4 weeks of their pregnancies and ten of them participated in prenatal care at some point during their incarcerations. Two of the ten were known to have attended drug education groups while incarcerated. Upon release, eight of these eleven went to treatment; two had no treatment and one entered treatment several weeks after her release at 24 weeks GA (see Table 4.3).

Table 4. 3

Incarceration, Gestational Age (GA) and Post-Release Disposition (n=11)

Study Participant	GA of Incarceration	Post-release Disposition
1	10-34	to treatment
6	3-7	to treatment: 24 wks
8	25-36	to treatment
10	16-32	no treatment
11	12-23	to treatment
12	22-28	to treatment
15	5-13	to treatment
19	26-35	to treatment
27	8-23	no treatment
34	26-32	to treatment
36	36-40	to treatment

The sudden death of a loved one due to chronic disease, complications of addiction and violence was cited by study participants as contributing to the escalation of their drug use prior to and during pregnancy. Participants either experienced the death at the time of the pregnancy or confronted the feelings about the death on the anniversary of the loss.

The majority (n =33) of the women's pregnancies were unplanned. One of the pregnancies was planned and two were unknown to the investigator. Though the exact amount of prenatal care obtained by each

woman was unknown, some women had consistent care and many women went in one, two or three times (See Tables J 1- J4 in the Appendix regarding prenatal care participation). Table 4. 4 is a list of study participants; all names are pseudonyms.

Table 4.4

Study Participants
(n=36)

Name	Ethnicity	Age	Pregnancy Status	#Children
1. Treesha	African-Am.	25	yes	3
2. Felicia	Latina	20	yes	3
3. Linda	African-Am.	31	yes	1
4. Leena	Native-Am.	32	yes	7
5. Vicki	White	27	yes	5
6. Annie	African-Am.	33	yes	0
7. Chrystal	African-Am.	36	no	8
8. Naomi	African-Am.	36	no	5
9. Christy	African-Am.	36	yes	8

Table 4.4
Study Participants (cont'd.)

10. Ruby	African-Am.	29	no	2
11. Maria	Latina	23	yes	2
12. Barbara	White	31	no	5
13. Nina	Latina	19	no	1
14. Alice	African-Am.	28	no	3
15. Tony	White	19	yes	0
16. Sally	African-Am.	34	no	2
17. Roberta	African-Am.	36	yes	1
18. Maisha	African-Am.	29	no	1
19. Phyllis	White	36	no	3
20. Anita	African-Am.	33	no	5
21. Kathy	African-Am.	31	no	3
22. Sherrie	Africa-Am.	29	yes	8
23. Shawna	White	24	yes	2
24. Patricia	Africa-Am.	43	no	2
25. Verna	African-Am.	31	no	4
26. Minerva	African-Am.	34	no	6
27. Celia	Latina	32	no	5

Table 4.4
Study Participants (cont'd.)

28. Melanie	White	34	no	1
29. Jacqui	African-Am.	28	no	2
30. Ivy	African-Am.	22	no	2
31. Frances	White	33	no	3
32. Lourdes	Latina	36	no	3
33. Emily	White	23	no	1
34. Margarita	Latina	22	no	5
35. Yolanda	Latina	35	no	5
36. Leticia	African-Am.	36	no	2

Life History Analysis

Dimensions

Dimensions are "experiences that stem from a similar base and are linked in their effects on the person's subsequent actions" (Mandelbaum, 1973, p.180). According to Mandelbaum, these life dimensions are the shared biological, socio-cultural and psychosocial experiences of the group. These dimensions "provide categories for understanding the main forces that

affect a life." Dimensions are the ways in which the commonalities of their socially contextualized status as addicted women affect their actions in response to the relations, forces and conditions encountered by them. These dimensions, turnings and adaptations can illuminate meanings and clarify misunderstood and misinterpreted behavior and, in so doing, transform the inexplicable to the reasonable. The Dimensions of this study are listed in Table 4. 5.

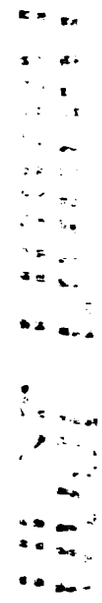
Table 4. 5

Dimensions

Mandelbaum		Jessup
Biological	>	Gender : pregnancy and childbirth Drug dependency
Socio-cultural	>	Maternal role stipulations "Good mother" vs. "Bad mother" Criminal vs. Patient Caring for self and others Sexism and violence/male dominance
Psycho-social	>	Fear Arrest, incarceration, prosecution Loss of infant and other children

The Biological Dimension

In the realm of the biological, the unifying experiences were gender and addiction and the status conferred by both. This status was definitive for the women in biological terms because of the shared experiences of coping with pregnancy and childbirth in the context of chronic addictive disease. The condition of pregnancy invoked conflict and crisis for the women, causing them to reach a deeper level of acknowledgment of their disease. As pregnancy progressed, they felt the desperation of their situations and the enormous contradictions (for them and for their child) inherent in their continued use of drugs while pregnant. Inside this crisis, the conflict emerged in the recognition of the absence of their most basic needs: prenatal care, food, safe shelter, cleanliness, social support and personal serenity. In many cases (n = 19), their pregnancies were also complicated by serious obstetric and/or medical conditions.



The addictive disease set up biological (as well as psycho-social) conditions with which they had to cope. The dynamics of intoxication and withdrawal, drug effects on themselves and their fetus and infant and the acute and chronic medical consequences of addiction conferred a unique, yet shared status. This continued use of drugs also added anxiety and a pre-

occupation with getting money to buy drugs, risking violence, overdose, medical complications and the legal and social consequences of that status.

These co-occurring biological events were also the basis for the marginalization and stigma of these women, as these physical dimensions provided visible "evidence" to society in general and to care-givers in particular of their highly deviant behavior. As a result, these biological dimensions of gender and addiction linked the women together in a similar experience of care-seeking.

Their experiences of care-seeking, necessitated by the biological dimensions of their lives, were similar in three ways. First, most women (n = 34, 94%) sought prenatal care while they were still using drugs and perceived it as important for themselves and their infants. Secondly, unlike their attitudes about the necessity of prenatal care, substance abuse treatment was not identified as a primary or immediate need. Prior to the current treatment episode, all the women viewed the programs of treatment primarily as the way to retain or regain custody of their children. Thirdly, their care-seeking experiences were similarly characterized by a fear of punitive actions by health care providers. The women grappled with disclosure of their drug use and described these traditionally therapeutic

settings as threatening and fearful.

The experience of prenatal care. Most of the study participants (n=28; 78%) described prenatal care as a necessity that they knew they should obtain because it was important in order to have a healthy baby. Of the study sample, 35 (97%) presented for prenatal care and one woman had no prenatal care at all, although even she described it as important for the baby. These 35 women started prenatal care independent of a treatment program mandate or jail (n=22; 58%), as part of a treatment requirement (n=5; 14%) and as inmates transported to prenatal care clinics in county hospitals while incarcerated (n=8; 28%). The amount of prenatal care received varied from a total of one or two visits to the ideal amount of care.

Vicki (all names are pseudonyms), a pregnant 27-year-old mother of five with a sixth grade education, explained the importance of prenatal care:

> I: How did you manage to get yourself into prenatal care?
>
> V: You just have to get prenatal care...Don't you? I think...
>
> I've waited a little bit but then I have to get myself in cause it's better for the baby...even though I'm using...what really gets me in is I start getting worried about, you know, the baby, something could be wrong, and something could happen. I don't know, I just get that

prenatal care.

One woman who obtained prenatal care at 12 weeks GA and regularly after that stated:

> With my second baby, I made every single doctor's appointment, every single one of them. Did not miss one. And with this baby I haven't missed any either....as soon as I found out, then I started going. I was still doing drugs and stuff, but I was still making my doctor's appointments, taking my prenatal pills every day and eating good...(Maria, 23-year-old and pregnant with third child)

Another woman commented:

> [I went to prenatal care] for my daughter, I guess. You know, I mean, as much bad as I was doing to her, I had to feel that I was doing something too...To try and make up for what I was doing so wrong. (Lourdes, 36-year-old alcohol dependent mother of three)

Women who were not able to get to prenatal care fretted and/or felt guilty about it. Phyllis, a single mother of two, was incarcerated from weeks 26 through 35 of her pregnancy and had no treatment during her pregnancy. She described her attempts to get in for care:

> I would think about it and say, oh, I gotta go to the doctor, I gotta

do this. But then something else would come up. I was staying in hotels...you'd wake up, you wouldn't have any money, you'd be on the street again. You know, I had my drug habit I was feeding. I needed money for food...you keep wanting to do the right things... when you're down in that scene, your responsibilities are the last thing you think about. Just worrying about getting the money for your room and your food and to get high.

Kathy, homeless for most of her pregnancy, had two prenatal care visits at around five months. Now the mother of a four-month-old with her in treatment, she describes her experience:

...they found me on the street...the medical van... she listened to my heart, she listened to the baby's heart...they came and picked me up for the appointment...I was thinking about it [prenatal care] but, you know, I just think, I don't react. But with the help of [the clinic] and [the doctor], I did get the help ...It felt good. It felt like somebody cared.

One woman who had two prenatal care visits and then gave up going was Patricia, a 43-year-old who was alcohol dependent. Patricia was also the

mother of a seven month old with fetal alcohol syndrome. In relating an experience of the stigma of addiction, Patricia spoke about obstetricians who were insulting and verbally abusive during her previous pregnancy and with her current pregnancy. As a result she decided to manage her pregnancy herself. She describes her self-care:

> I took care of myself through my diet. [The baby] was seven pounds, eight ounces. [The baby] had a good birth weight... I ate right... I bought the prenatals [vitamins]. So, I pretty much learned to take care of myself. You know, I thought I could...[now] I think I did a good job of taking care of myself, but I put [the baby] at risk. You know, hindsight is twenty-twenty. But, at the time I thought I was doing okay.

The pre-treatment experience. Substance abuse treatment was viewed as a remote and even unknown source of help. Even though 24 women in this sample had been in substance abuse treatment before, treatment of their addiction was not an uppermost priority and the programs were not seen as a primary place to voluntarily seek help. In some cases women viewed treatment as meaning detox, i.e. just stop using. Prior to treatment entry, choosing treatment as a source of help was also seen as the primary way to

ward off loss of custody of the newborn and the loss of other children and as a way to transition from jail to a supportive environment. These women speak about treatment:

> I didn't know what treatment was. But I know that inside I felt I needed, I needed to get well. How, I didn't know, where to find the services, you know, even though I've heard treatment, but I didn't understand the word treatment.
>
> (Yolanda, a 35-year-old mother of five children in treatment for the first time).

Minerva, a 34-year-old woman addicted to crack cocaine and who had no treatment during pregnancy explained:

> I never really knew what a program was. And I couldn't see myself just coming, knocking on somebody's door and saying I want to be in your program.
>
> ...I knew [treatment programs] were there. I just didn't take the initiative to go do them... I think that's why [fear of consequences] I didn't take the initiative...(Phyllis, 36-year-old single mother of three).
>
> Many women also believed they could stop on their own. Emily, a

23-year-old heroin addict and mother of a five-month-old baby stated:

> I didn't feel that I needed [treatment]. I thought I was going to be able to quit on my own...I didn't know what it was like, I didn't. Cause I've never, you know, been to any treatment centers before.

In describing how she searched through the phone book to find Alcoholics Anonymous, a woman commented:

> The hope began in February of 1999. I stayed clean and sober... decided to go to my first program...and it was hard...I was doing it for two reasons. Stay out of jail and get my children back... (Shawna, 24-year-old woman and mother of two children currently in foster care).

In response to a question about whether pregnancy or her child was a motivation for her recovery, another woman stated:

> Absolutely. It [custody of baby] was my main motivation for being here. It wasn't until I had stayed for about a week or two that I became my motivation (Nina, 19-year-old heroin addict and first time mother).

Sally, a 34-year-old health professional and crack cocaine addict, spoke about how she heard about treatment after the birth of her second child:

I think it was the hospital social worker...she said, I'm gonna tell you how to get your baby back. She said, what you gotta do is go to a treatment program.

Among women who knew of treatment or who had a history of past treatment experiences (n = 24), treatment was seen as a possible respite from misery, a second chance, and as a potential path not only to sobriety, but to lifelong recovery as well. Phyllis, addicted to crack cocaine and a single mother of three children said:

...I've heard about treatment programs for a long time...[I was thinking] that I could get better on my own and eventually that didn't work...I found I was pregnant...that's when I decided I should go to a program and see if it works. I didn't want to lose the baby...You know, a second chance, at a positive life...The courts didn't mandate me here...I asked...the judge if they could put me in a program for pregnant women.

Another woman spoke of this:

If you had recovery before, you remember it and the shame, guilt and fear, not being in N(arcotics)A(nonymous)...just rock bottom, and the

only way out or keep your child or save your life is to go to a program, and make that conscious decision...

(Chrystal, a single mother of eight, in treatment for the fourth time).

Care-seeking experiences. The biological dimensions of addiction and pregnancy often invoked threatening and punitive behavior in prenatal care providers. Fear of the providers' reactions prevented these women from disclosing their drug use to their care providers.

Well, I mean, I didn't tell him [physician] the full story. I did, you know, hide a few things from him. But, and he never went more into it. You know, he was like, well, if you ever want to talk about it, you know, I'm here. And it was like, I don't do it, and just sitting there lying, say that I didn't, and I knew better than that, cause I was [using drugs]. He might turn me in...to CPS.

(Maisha, 29-year-old mother of a 10 month old baby).

I was [worried about test results in prenatal care]...but then I needed the prenatal, so I knew I did wrong, but I knew I had to go to the doctor, to see what was going on with my baby...I know they reported me...(because a treatment program began calling her).

(Jacqui, 28-year-old mother of two children).

I didn't tell them [women's health clinic] anything. I was really scared. I thought I could go to jail for it, actually...I thought that I'd end up going to jail if I had the baby, you know. Um, I was told that one of my friends' sister went to jail for child endangerment ...But it's one of those stories that you're not sure of because it was, you know, passed from person to person to person...

(Nina, 19-year-old heroin addict).

Another aspect of the experience of care-seeking was that the study participants were subjected to the sexism of treatment programs in the programs' claim that they were not "set up" to handle pregnant clients and therefore had no perinatal services. Two study participants were asked to leave programs because of their pregnancies. Christy, 17 weeks pregnant and the mother of eight children, noted that the medical problems of her pregnancy (fetal hydrocephaly) had made it difficult for her, as a high-risk pregnant woman, to find a suitable program. She noted that even though there were programs, they required that she be as active and compliant as everyone else. When asked at the end of her interview if she thought there

were barriers to treatment for her, she said:

> Oh yeah. Beds not being available, um, not having enough programs for pregnant women...when you're pregnant, it's a lot of obstacles in the way. You know, because you're a risk. Now they have to give you a snack time...[I've been in programs] where they didn't have enough for you to eat...they have to be equipped to be able to take me back and forth to the doctor. I might have to go twice a week...which might interfere with the class schedule, you know, or a group time, or a meeting time...so there are a lot of barriers.

Other difficulties in accessing treatment programs because of these biological dimensions of addiction were described by the women. Shawna, 24 years old, became an amputee when she was run over by a train at 15 years of age. In a treatment program, she developed an infection and could no longer walk with her prostheses. Returning to her wheelchair resulted in dislocation and transfer to another program and disruption in her substance abuse treatment:

> I got an infection and I was unable to do it [walk in prostheses]. So they gave me an opportunity to be transferred to another program...because it wasn't wheelchair accessible...

The status of opiate dependency during pregnancy also presented challenges in accessing care. Due to a drug-free admission requirement, residential substance abuse treatment programs rarely admit a woman who is on methadone maintenance (MM), even though this is the appropriate and approved standard of care for pregnant opiate dependent women. Being enrolled in outpatient MM is a form of treatment itself. Yet, as the women's stories describe, the status of opiate dependency made treatment entry more difficult. Other problems arose for women on MM including negative judgments from other women in their program, general medical mismanagement in MM prescribing practices, such as dosing irregularities and precipitous termination of MM treatment by a hospital unlicensed to dispense methadone. One woman was also referred to child welfare because of prenatal drug use, i.e. therapeutic MM. Her child was placed in foster care. While not cited specifically by the women, these were also barriers to treatment for opiate dependent women.

In the case of Melanie who was trying to get into treatment while pregnant, the status of opiate dependency prevented her from entering residential treatment because she was on methadone maintenance (MM). In an attempt at self-detox, she used methamphetamine to manage opiate

withdrawal symptoms in order to comply with the residential program's admission requirement. As a result of a positive intrapartum drug test shortly thereafter, she was unable to retain custody of her son:

> "They took my son from me because I didn't have any place to bring him that was safe and clean. Cause I had that dirty test on crank, when I was trying to come off the methadone."

Another woman, Frances, spoke about financial barriers that contributed to the delay in her entry to MM:

> As soon as I was pregnant...I kept telling him [partner]...I got to get down to the methadone maintenance program...And then I thought, maybe they won't let me on...because um, I was financially fee detoxed...I owed them 400 something dollars...and there's no way I could pay that. Cause I used to ask them, could I come back on maintenance. And they said, sure, if you pay this bill...I wasn't sure if ...being pregnant, you know, got me a, you know, a ticket in...So I kept putting off and even going down there to find out...that's how much I hate confrontation and bad news.

The clinic this woman is speaking of would not have let her back on MM had she not been pregnant. However, as a result of federal regulation,

during pregnancy all waiting lists are jumped and fees owed are waived in lieu of admission. But she did not know that due to her inexperience with pregnancy and MM and because of her previous experience with this clinic's for-profit fee practices with non-pregnant women and men.

One study participant who was heroin dependent and pregnant elected not to get onto MM during pregnancy because she feared the effects of MM on the baby. Unknown to her, this practice is known to be more dangerous than MM due to the risk of precipitous preterm labor as a result of withdrawal induced uterine contractions. She self-detoxed after the residential program recommended that she do so:

> ...the [intake worker] asked me not to do any heroin for a week, and then call him back. Because he wanted to make sure I wasn't going through withdrawals or anything, physical withdrawals. And if I was, we'd have to get me on methadone. And then I'd come in, because if I'm withdrawing then the baby could be in danger (Nina, 19 year old heroin addict).

The Socio-Cultural Dimension

According to Mandelbaum (1973), the socio-cultural dimension of a person's life includes the understandings, expectations, stipulated role

prescriptions and behavior patterns for particular sections of society. Mandelbaum notes that these specifications, while narrow, provide some array of choices, which then guide persons toward their actual behavior in society.

The current stipulated role prescription for pregnant drug dependent women is characterized by the belief that drug use and addiction in this population of women is essentially immoral and criminal behavior, rather than a disease. Regarding the mothering capacities of these women, the socially constructed myth is that these women do not care about their children, represent a danger to them, and are unwilling to change. Yet other culturally stipulated roles of motherhood (and therefore womanhood) also demanded placing children's welfare first, practicing selflessness and the adhering to the primacy of male partners' needs. Deviation from, or outright failure, to follow this narrow role prescriptive also invoked misogyny directed at women who do not live up to their socially defined roles as "good mothers." What then emerged from that for the women was a set of social interactions and life experiences deformed by the belief that at root, they are bad mothers who should not have their children. The impact of that socio-cultural belief then, was that the women's statements, intentions, actions,

goals, personhood and spirit were perceived as criminal, suspect and degraded. These beliefs, characterized by mutual forms of mistrust, fear and attempts to gain control, affected relationships and outcomes between the women and their caregivers and child welfare personnel. Yet, because of their power over the lives of these women, the social institutions, and the actors within, ultimately and consistently dominated these drug dependent women through their punitive denial, harmful actions and negative attitudes toward the women.

As their stories reveal, the actual lives of the study participants were characterized by responsibilities for children, care-taking and financial obligations to other family and extended family members, a lack of resources and social support, loss, abuse by intimate partners, trauma, violence, incarceration, illness, loneliness, isolation and stigma. Within these very challenging life circumstances, the women then also had to contend and cope with these socially stipulated role prescriptions embedded in every social interaction with the surrounding social actors. The actors included children, partners, other loved ones, "helping" professionals and nameless representatives of state institutions.

Relations with health care providers. Responses to these

culturally constructed myths about pregnant addicted women included the development of strategies in health care settings to identify and control pregnant addicted women. During one interview, I learned of a region's effort to identify high-risk pregnant women, by developing and distributing a county-wide "list" of names of pregnant women to prenatal clinics, child welfare, and delivery rooms in the area. In checking with colleagues working in this county, such a list does exist. It contains names of pregnant women and was created by the SCAN (Suspected Child Abuse and Neglect) team. Celia, a 32-year-old mother of five, was informed by four different health and child welfare professionals that the list existed and that she was on it:

> Celia: The adoption worker...had told me that my baby was on the list of babies to be taken, because I guess they have a paper, they know who has had babies adopted out and once they find out you're in prenatal care...Like I was at the jail going to the doctor and stuff, and I was on methadone, they found out and they will automatically place your baby's name on a list.
>
> I: So how do you think your name got on the list?

Celia: Prenatal care. Uh huh…a doctor at [prenatal clinic] told me that. That your name goes on a list as soon as you're on methadone, and if you ever had like children adopted out in the past, it goes on a list… this other lady had told me that when you're on methadone, your name goes on the list. A lady told me at the jail that my baby was gonna be taken, and I was like, no. And then the adoption worker told me, well your name is on a list, and we want to place your baby…She [the doctor] told me that CPS would be getting involved because of the methadone, and I told her, well...how's that? She said, because any woman who goes on methadone, your name is automatically on a list. The list I would be on was my children had got adopted out and then here I am on methadone, too. So automatically my name would have been on the list….That's why when I got out of jail and I went back home, I didn't go to the doctor. Cause I didn't want them to know where I was at, and I was going to take off and have my baby somewhere else. But then I figured I might as well stay and face the problem cause I can't leave my other kids behind and run with this baby, and I would be looking behind my back and my other kids not know about me. So I just stayed.

I: And who do you think is keeping this list?

Celia: Um, I guess it's CPS. Cause they're the ones who came, after they told me CPS would come when I had my baby. And they showed up, as soon as I had him...I believe kids should be protected...but all that list, it makes people scared. And I know a lot of people who don't even get prenatal care because they're scared of what's gonna happen when they have their baby.

Two other women in this same community were then interviewed. Though neither of them had heard of a list being kept in their area, both had heard that babies born to drug dependent women who had previously lost an infant to permanent adoption could now have the second one automatically removed. One of them, Margarita, a 23-year-old methamphetamine addict, described the impact of that knowledge on her decision to stay away from prenatal care:

I just heard that story. And that really really scared me. Because, you know, I really wanted to change my life, and I felt if they were to take another child from me, that was gonna be for me to relapse again...

I didn't go in because of the things I was hearing...part of me didn't want to go on with my pregnancy...I was...trying to forget all about it...and I just worked.

The third woman in this same community also avoided most of her prenatal care visits:

Knowing that they were gonna test me for drugs, that's what scared me...they said if you don't go into treatment, your baby will be taken away from you and it might be really hard for you to get the baby back, IF you ever get your baby back. That's why I didn't go to prenatal care....I didn't want to lose my baby.

(Emily, a 23-year-old heroin addict).

In another region, two women were warned by prenatal care providers that, after the third "dirty" drug test, their infants would be removed from their custody at birth. They described these interactions:

They kept telling me that once you get three dirty tests that CPS would automatically be at the hospital when you have your baby. So, after, like after two appointments that I know I gave them dirty urine, then I just, I stopped even going for my prenatal care.

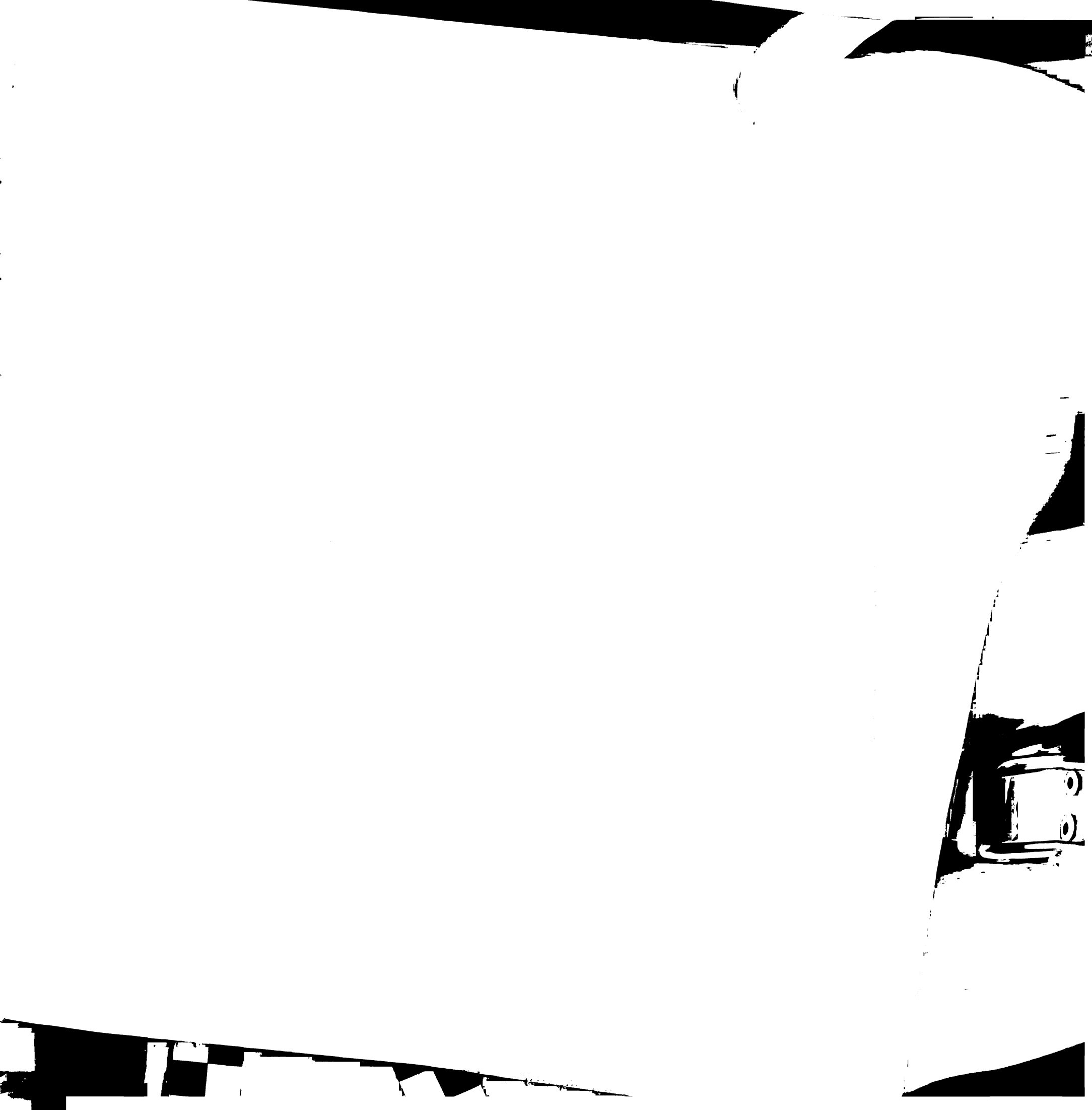
(Linda, 34 weeks pregnant).

> They told me if I come three times dirty, that, you know, when I had my baby they was gonna take my baby. And then the second time I started [to go to prenatal care] I didn't go back no more...[they] told me...the police gonna be right by the bedside to take her.
>
> (Ivy, a 22-year-old mother of two, one of whom was adopted at birth).

Relations with child welfare. Barbara, a woman with six months of sobriety, told the story of being reported to child welfare by a neighbor. Her two-year-old was taken to foster care and she was incarcerated for ten weeks of her pregnancy for child endangerment because she was living in a motel and using drugs. She described her feelings about this experience:

> To me they're very powerful if they took my daughter. I mean, that's mine, and they were able to take her. So that shows me they can do just about anything they want with your kid. And um, you ain't got no say even over your own kid....so to me that's power.

Another woman, six months postpartum, who had been homeless during her pregnancy, spoke about the conflicted role of the child welfare social worker. Her story is about the recommendation of child welfare to remand her newborn from her custody to foster care at birth. Although she had been in treatment for two weeks prior to the birth (in a program that



would accept her infant) and had extensive documentation of treatment compliance and positive intent, a child welfare report was still filed as a result of her honesty about her drug use during pregnancy and because she had a case with child welfare nine years prior. Though now she was clean and sober, this interaction with child welfare was reminiscent of the traumatic loss of another baby son nine years ago:

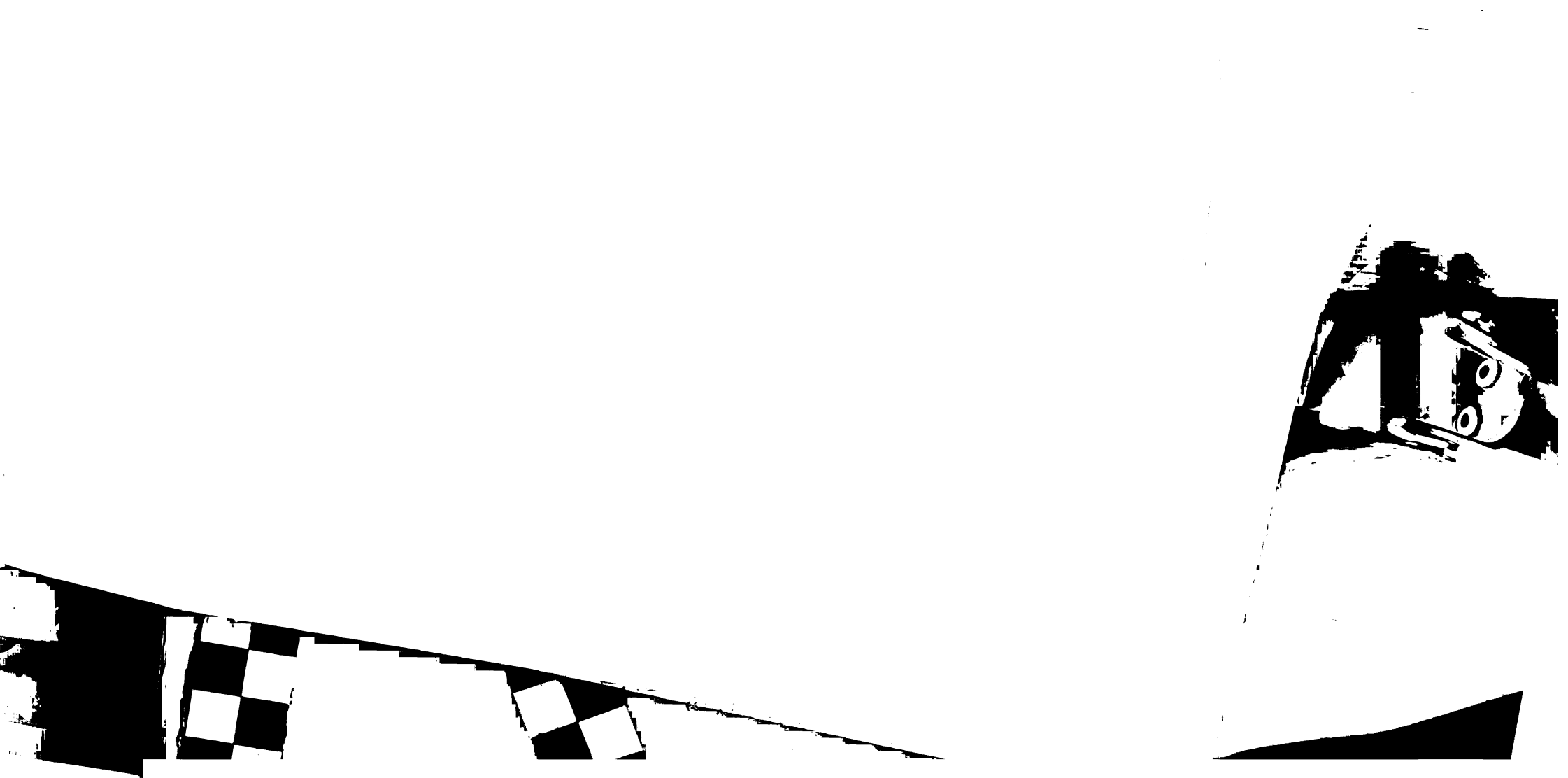
> "...[this time] they came to my hospital...and I had a fit...I was losing it, damn near fainted, they had to revive me and put me on the bed...I...took the phone and I called somebody and told them what was going on. Because I knew I could not win on my own. You can't see it on the tape but I'm crying...I was trying to keep my baby...I just need to say this for everybody...the social workers [child welfare] are not always your friends. They seem to be on your side, but they are not...And you don't know it. You give them all the information in the world and they sit on [the] opposite side of the courtroom. You think they are there with you and are gonna help you, but when you go to court, they're like the D.A., prosecuting attorney... The woman asked me if I had used while I was pregnant...I tell her yes. Then she files a report to take my baby...but now I'm in a treatment program,

I'm doing what I need to do...and you still want to try to take my baby?...this is what happened when she came to the hospital...it seem like it was a carefree conversation, it was OK to express what was going on. No harm was going to come...But then it did."

(Chrystal, 36-year-old with a six-month-old).

In other observations about existing child welfare policy that allows for severance of parental rights if substance abuse treatment is not initiated within a six-month window after the birth of a drug-affected infant, these three women stated:

If you have another child within a three-year period, even if you're staying clean and sober, your child will be taken from you, and can be automatically placed for adoption... [it is a] state policy...I wanted to come in [to treatment]. I was gonna come here [to treatment program] and there wasn't an opening...my original plan was to leave. And I didn't go to my doctor at that time because of my name being on that list to take my baby. And I was really scared of that. And that's what kept me from going to prenatal care...So, I was scared. You know, they're gonna know where I'm at. I was basically hiding from the County. I even went to get Medi-cal from [another] County...it's a



state law, so they're gonna come regardless of where I'm at.

(Celia, single mother of five, awaiting custody of four-month-old son).

And I didn't want to go to the doctor because I was scared, you know, because I had other children tooken from me, and I was hearing a lot about the new law, and so, I was like really thinking about abortion. But then I'm not for that, so, I didn't. I just kept working and you know, trying to forget about me being pregnant.... I heard, um, from a lot of people, if you have children within the two-year period of you having your kids tooken away, they will go and take the next. And so that really scared me. And I didn't want to go through with it, but you know, I didn't want to go have an abortion. I just went through with my pregnancy...I heard it from one of my friends. She was going through the same thing...

(Margarita, 22-year-old mother of five who hid her pregnancy from her family and employer).

Yeah. And they [various sources] kept saying, like they adopt kids at six months now...but I heard it more than one time. And that's scary.

You know, that was like permanent adoption. Matter of fact, I think I heard it on TV too.

(Kathy, 31-year-old homeless woman).

Relations with male partners. Socio-cultural role stipulations about women and men as partners in heterosexual relationships influenced male partners to relate in ways that were hurtful and harmful to the women. These culturally defined patterns of sexism and male dominance and violence placed the women's needs as secondary and led to abusive and dangerous behavior in their male partners. Francis, on MM and in a relationship with an active user of heroin, struggled with the rising conflict of how to go to treatment for herself:

> ...[the] thing that held me back was my significant other, you know, my boyfriend, the baby's father...I didn't want to be separated from him either, you know, and any time I brought up the subject [of going to treatment] he just completely dismissed it. You know, if you go into a program then that's it. And we'll be through. And I couldn't even imagine it at that point...for the last two years he has been my best friend, my confidante, my protector, my lover, you know, just my everything.

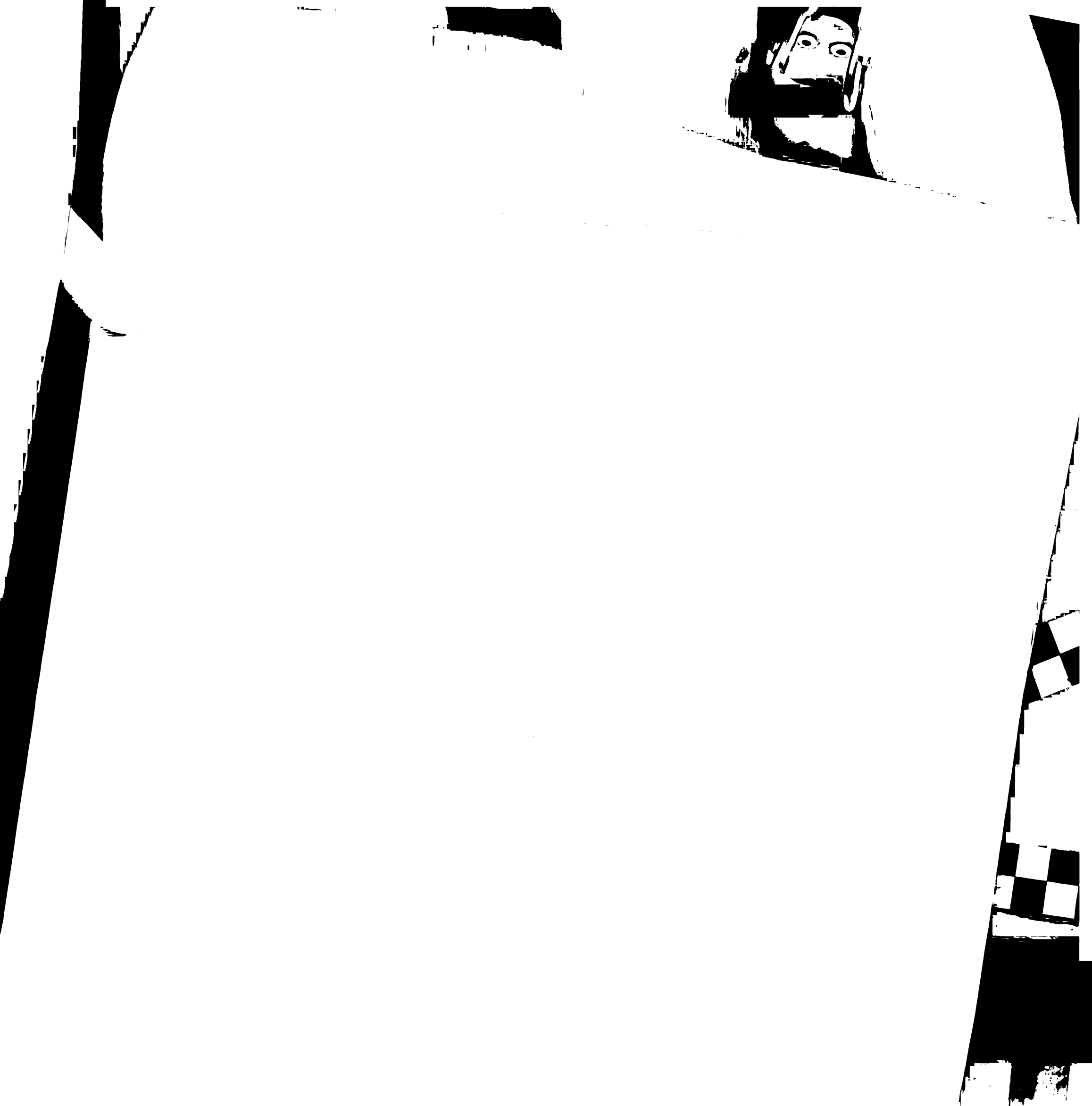
Other women spoke about their partners and the dynamics of abuse and violence and the effect on seeking help:

> It was terrible. It was, you know, he was beating on me. He was feeding me dope. If I wanted, you know what I'm saying, he would go and get it. You know what I'm saying? He wouldn't try to stop me. I was starving, I was hungry, you know what I'm saying. It was terrible. It was real terrible...I stayed up with him until like my seventh or eight month. You know what I'm saying? The fights were getting too bad where he'll kick me in my stomach, he'll hit me in my stomach, he'll push me, and then he act scared, going down. You know what I'm saying, trying to push me to where I fall. And when it got that bad to where I fall, you make me try to lose my baby, I called my mom and I went back home.
>
> (Ivy, a 22-year-old mother of four month old).

> Um, I was in, right then I was living by myself cause the baby's father was in jail. Um, I was struggling with the possibility of leaving him, leaving the house before he got out of jail because he's very

verbally abusive. Um, but I really didn't have anyone or know about the resources to go to get help. I was ashamed to tell my family that I was in this type of a relationship. So I just stayed in it, and I suffered. I was miserable. I was really miserable.
(Leticia, crack cocaine dependent and mother of a 10-month-old and a 16-year-old).

And me and my ex got into a fight, and he had hit me, and I called 911. And when 911 came I was hysterical. And he was just like, somebody I never even met before. He was so calm, and so passive, and just this whole, well, I don't understand what's going on, officer, you know. And I went to jail.
(Melanie, a 34-year-old woman and the mother of a four-month-old in foster care).
And you know you're using and you want to stop but you're living in that environment and you feel like you're trapped down there, there's no way out. And then I was involved with someone else who was using drugs, and he wasn't making it any easier. He was using heroin.
(Phyllis, 36-year-old).

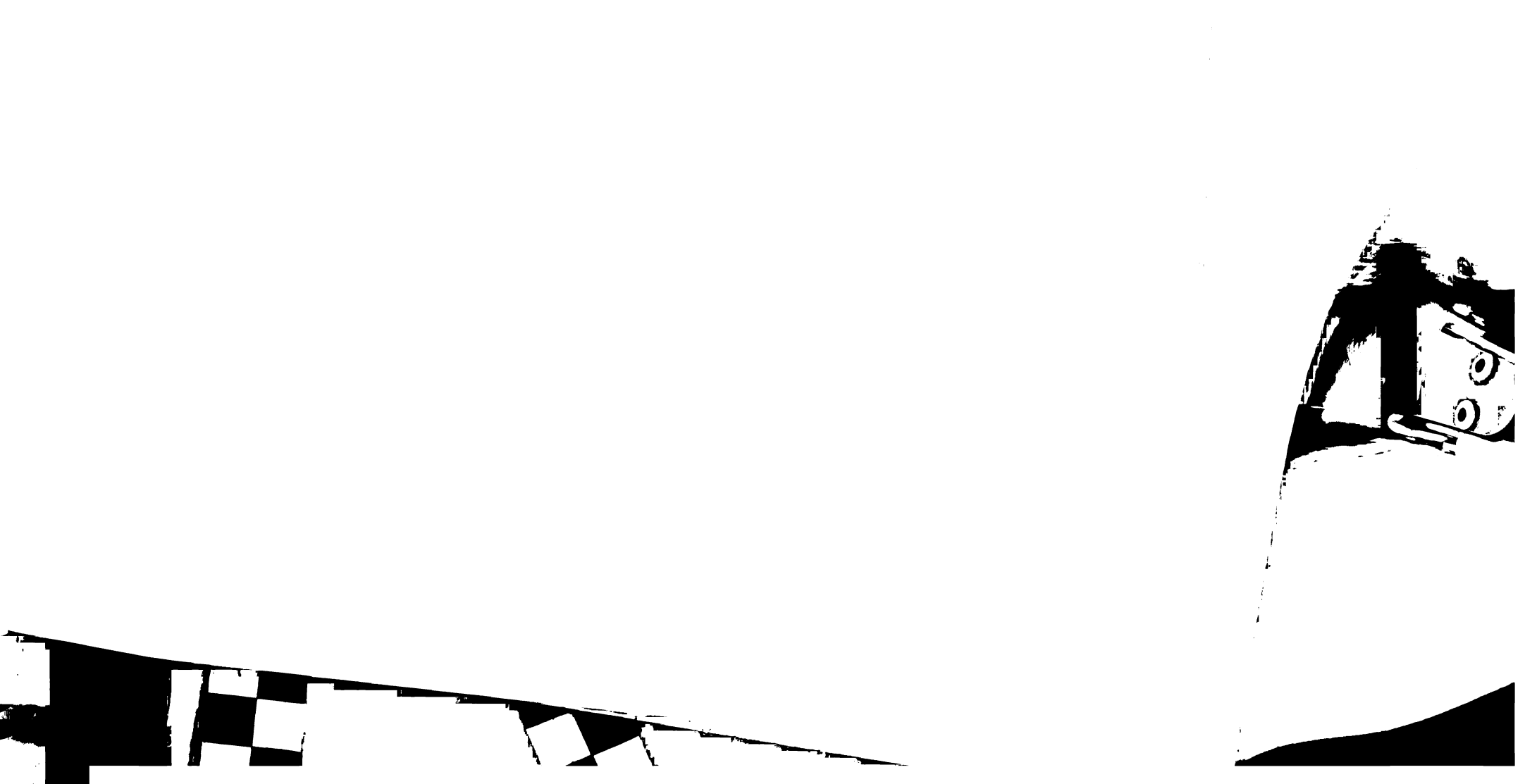


[there were] court hearings for my children that were very stressful and I didn't pick up a drug, but I picked up a man. I had a relationship with a man and allowed him to fix me. And a way of emotionally and physically, so I wouldn't feel so alone. And uh, I got affection the best way I could. The man... he's the father, and I got pregnant. Um, and this is this baby, that I'm carrying. I have, I had acted out because he had relapsed. And went to jail. And I felt like it was doing it all over again. (Shawna, 24 years old).

So I said I was ready [to go to treatment]. So when Thursday came, we came. We brung all our clothes and stuff. But my boyfriend, he had to have his last bit of beer. We get here and [the intake worker] said he said he smelled alcohol. So they sent us back home. (Minerva, 34 years old).

Women also described viewing their partner's needs as coming before their own:

Um, what happened was, I had my own place, three kids, I was involved with somebody...the baby's dad, we both had drug



problems... what happened was I had took my rent money and gave it to the baby's dad to help him, get him out of trouble, some debts that he was in. So I got evicted from the house...I got evicted, [that] day I had CPS come and get my kids, because I had nowhere to go. No money, no diapers, nothing, for my kids. And from there they took my kids...(Felicia, 30 weeks pregnant).

So I always pity him. And I said you can stay in my place, you know. And I was not using that day. So we started talking and everything, so I thought he was okay, you know. He was using, but not as much. Now, by him coming to stay is just like, things got complicated, you know...He's always been my abuser (Yolanda, mother of five).

The Psychosocial Dimension

The psychosocial dimension focuses on "individual's subjective world, his feelings and attitudes" (Mandelbaum, 1973, p.180). While individually experienced, this psychosocial dimension is likely to be similar to that of others in the same situation. This dimension is about the person's attitudes toward others and feelings toward, and image, of herself. Among the participants, the main subjective feelings were fear and worry. Fear

characterized the women's attitudes toward disclosure of their drug use during pregnancy, toward the health and child welfare personnel and toward the process of seeking help as well.

Fear of arrest and incarceration. The study participants feared going in as well as not going in for care. Twenty-one women voluntarily started prenatal care unrelated to a requirement imposed by a treatment program or incarceration. The mean gestational age (GA) at entry to prenatal care for this group was 16 weeks. These women who sought prenatal care (independent of being in jail or in treatment) describe this struggle with going in or not going in for care. Minerva, 26 years old and crack cocaine dependent stated:

> ...I didn't (disclose my drug use)...Um, after the days went on in my pregnancy, I just got scared, I guess. Knowing every day I would wake up, say I got to go to the doctor. But I didn't... I was scared of thinking of, I didn't know what I was gonna go through when I get to the doctor. They gonna ask me questions like why haven't I came to the doctor when I'm on drugs, and I didn't want to go through that...

Jacqui, mother of two children, describes this also:

I was like a month or two [pregnant]. I was taking my vitamins every day. I was missing my doctor's appointments a lot because I was dirty, you know. You know, I was like, I ain't going, because they gonna show up in my urine. [If drugs did show up in my urine]...they would get mad at me and tell me to go get treatment... She [obstetrician] was not happy. The doctor, she said, why do you do that? You doing it to your baby and yourself. It made me feel bad....

Interviewer: But it didn't keep you from coming back [to prenatal care]?

Jacqui: No. I stayed going to the doctor; I didn't care...

Interviewer: And why did you stay going to the doctor?

Jacqui: Cause I loved myself and I loved my baby, but I just have a problem with drugs. I didn't want to hurt my baby...[when asked if she was fearful] I was, but then I needed the prenatal, so I knew I did it wrong, but I knew I had to go to the doctor, to see what was going on with my baby...

Interviewer: And were you worried about them reporting you?

Jacqui: I know that they reported me. I know, because if they didn't, (the treatment program) wouldn't have been calling me that much. I

don't know. I'm just here. You know, and I'm dealing with it for my sake and my kids. I'm gonna make it, I have faith in myself.

The women described their fears of interacting with police in the context of seeking care. They believed that this could happen:

> ...with a dirty tox screen it could have been a lot more severe. I could have had, I could have been taken to court. I could have been arrested if they wanted to. For endangering the life of a child. (Frances, a 33-year-old methadone maintained woman, awaiting hospital discharge of her one-week-old heroin affected infant).

> Because it [worry over positive tox screen] was a big thing when I was in labor, I remember it was like 3:00 or 2:00 in the morning, I had been getting high...And I remember feeling these pains...but I remember thinking, I'm praying to God, please, don't let me be in labor, Lord, please, don't let me be in labor. Cause I know when I go to the hospital they gonna test me and I had drugs in my system... I just remember thinking that over and over and over, that's all I could think, just please don't let me be in labor...you hear on the news or

wherever you may hear it...you go to jail if you're pregnant and use, cause they were sending people to jail... Yeah, they were...it's a law. It's a law...you go to jail if you're pregnant and use, cause they were sending people to jail...it's a law, and I'm quite sure...they can charge you with attempt of murder...they can do that. Yeah. That's weird.

(Ruby, a 29-year-old woman, in treatment for the first time).

Fear of loss of the baby. The women knew from the "indigenous lore" (Atkinson, 1998) of other addicted women, from their knowledge of hospitals and from their own previous experiences that continuation of, and detection of, their prenatal drug use would lead to the loss of their newborn baby. On multiple occasions, study participants were also told by health providers and child welfare personnel that a positive drug test would mean the loss of their infant. This woman described how she knew, even before she got to hospital to deliver, that her baby would be taken from her:

That's how it is now days. That's the law...I just know it and everybody that I know knows it...It's not something that's a secret...

(Patricia, mother of four-month-old).

These women described their worries about losing their children to foster care or adoption through child welfare actions:

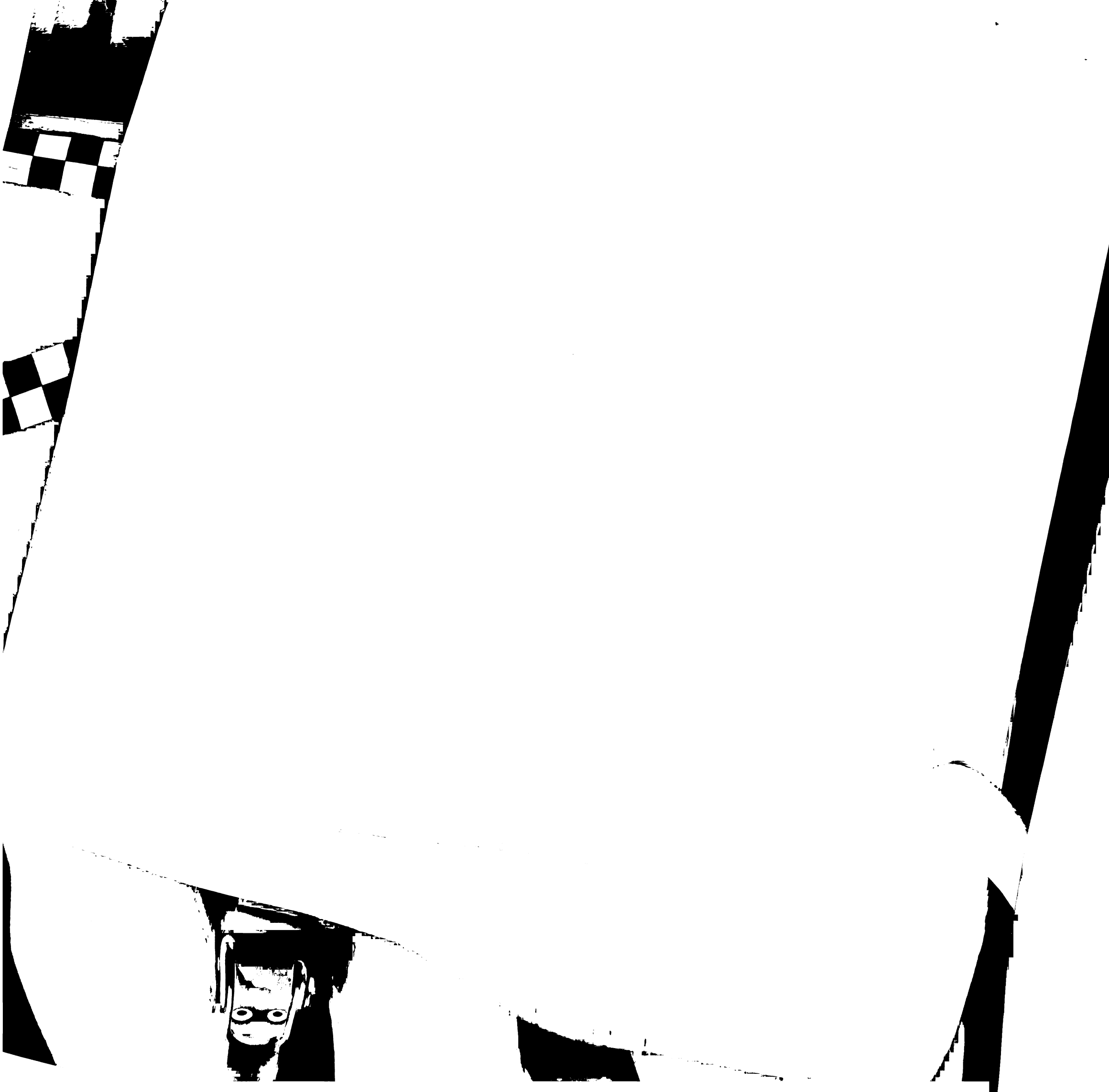
> ... I didn't want to lose my baby first of all, and I didn't want to go to jail because of it. I would be charged for distribution to a minor... Cause I seen other women got their kids put up for adoption right from the hospital, because they were pos tox ...[when asked what she thought could happen to her] The thoughts are unlimited. You know, they'd take my kid right then and there. Or put me in jail, or just paint me [as] this real bad picture of unworthy undeserving person who doesn't deserve to have a kid in the first place, you know... (Leena, age 32).
>
> I had heard so many horror stories about people coming up positive and not even seeing their baby ever, just having the baby taken straight from the hospital. And I thought that was what was going to happen (Nina, 19-year-old heroin addict).

These women also described fear of other punitive consequences by physicians, nurses and county welfare department staff if they were to seek trauma care, apply for welfare or be on probation and have an outstanding

warrant for their arrest:

> This scar, right here... he stabbed me right here, he stabbed me with the [spike-heeled] shoe. And I almost lost my eye, almost lost my, I lost my sight for like a few weeks. I never got medical attention for it. Um, you know, cause I was on the run, I had warrants out for me so I couldn't go to the hospital. I mean, just not being able to go to the hospital, you know? I mean, that's some stupid, that's stupid...I didn't want to take that risk [of a warrant check at the hospital].
>
> (Tony, psychedelics addict, 16 weeks pregnant with her first child).

In checking with colleagues working in the hospital setting mentioned in this interview, staff confirmed that in this emergency room, the setting referenced by this study participant, a warrant check will be conducted if a patient becomes violent or threatening to the staff such that police are called to the scene. In checking with a supervisor at the General Assistance Division of the Department of Human Services of this city, it was confirmed that a person who applies for general assistance will be computer-checked for outstanding warrants as a part of the application process. If the applicant



has a felony warrant, the police are notified. If there is a misdemeanor warrant, this supervisor stated the applicant would not be reported to the police. The supervisor encouraged anyone applying to clear up their warrants prior to applying for general assistance as they were not able to "aid and abet" a criminal by approving their application.

> I also know [if] you go to (city) and you go apply for general assistance down there...they run your social security number, and you on probation and you running [i.e. have a warrant], they put you in jail too. I know that for a fact. I think that another reason why I didn't go to the clinic and stuff is because, um, I think I was on the run, I think I was on probation a couple of times. My being out there...Cause they [might] take me to jail...yes they do. They put your name in and you got a warrant, you going to jail (Naomi, unemployed mother of five).

Turnings

Mandelbaum (1973) describes turnings as major life transitions, ones in which a new role is taken on and a new self-concept is assumed. A turning may be a turning point or a gradual shift and it "serves as an index to the person's conduct afterward" (p. 181). A turning may be self-chosen or ascribed and it may occur quickly or be a more drawn out process. Turnings

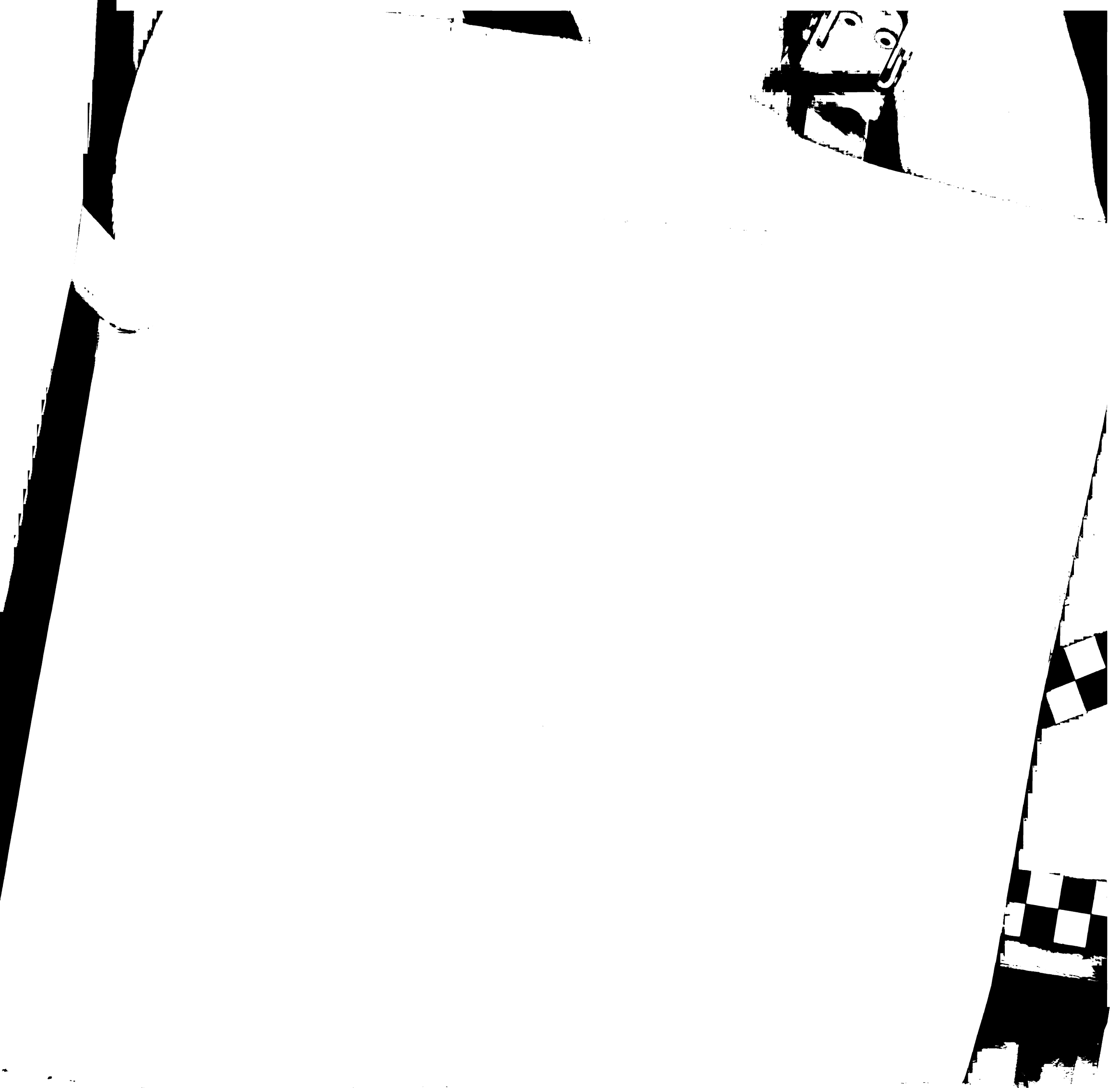
tell us about the main parts of a person's life and about the important roles and social relations as well as their "self-conception from one transition to the next (p. 181)." For the women participating in this study, the pregnancy was conceptualized as a turning. The Turning and Adaptations of this study are listed in Table 4. 6.

Table 4. 6

Turnings and Adaptations

Mandelbaum		Jessup
Turning	>	Pregnancy
Adaptations	>	Protecting custody Preserving the family Talking to God Doing the right thing

As a turning, the pregnancy was motivational for the women in having another chance to rectify their own and society's view of them as "bad mothers." Even though the pregnancies were largely unplanned ($n = 33$) among these participants, the pregnancy became a landmark in their personal



struggle for spiritual, emotional and psychological liberation and therefore came to be viewed as a positive development. The pregnancy or the baby was viewed as a chance at renewal and as a redemptive blessing.

The study participants also expressed newfound meaning in their lives in these events that they described as fated to happen in order for them to start the process of recovery.

The following eight women describe these feelings:

> I was excited. I felt immediately that I was given a second chance. Because when I lost my kids, I felt like I was being punished. Like I wasn't worthy of being a mother. So when I found out I was pregnant, I was like, oh my god. God's trusting me to give me a baby. And you know, so it was like a miracle to me... I feel like it was a miracle. A gift from God for me to change my life. And to realize that I am worthy and that I can be a good mother... When I started using, it was like, oh my god, you know, I'm not a good mother, and I don't deserve my kids, and that's why all this is happening. And if God didn't think I was a good mom [now], I wouldn't have my baby. (Celia, awaiting custody of her four-month-old.)

And this baby…this baby was the biggest thing that changed my whole thought….I just want something better, I want something better. (Tony, 19-year-old daughter of two addict parents (deceased) and 16 weeks pregnant).

I think that [my baby] was given to me as a blessing, to wake me up, and that God was trying to tell me that I need to make some decisions and I need to change my life, because I'm not going to get any more chances. I've already had two, and this is my third time. And as far as I'm concerned, three times and you're out. And I've already had two strikes. And I just, I just thought that [my baby] had to be here for a reason. God brought [my baby] to me for a reason. And I just decided I need to start changing my life. (Phyllis, former prostitute, recovering crack addict and 36-year-old mother of a two-month-old).

You know, in the midst of addiction, everything is kind of dark, you know. It is…And so for me, this had to happen to me. (Patricia, 43-year-old mother of a child with fetal alcohol syndrome).

Oh, I love her. When I hear her cry…I rush up there, and I be looking at her…be looking at me and start smiling. (Laughing). Like, "mom I just want you to be up here." And I love her to death. I love her. And I thank God for her. You know, I think He knows that I'm ready to have it…be a mom again and that's good. He's giving me another chance. (Ivy, single mother, recovering crack addict).

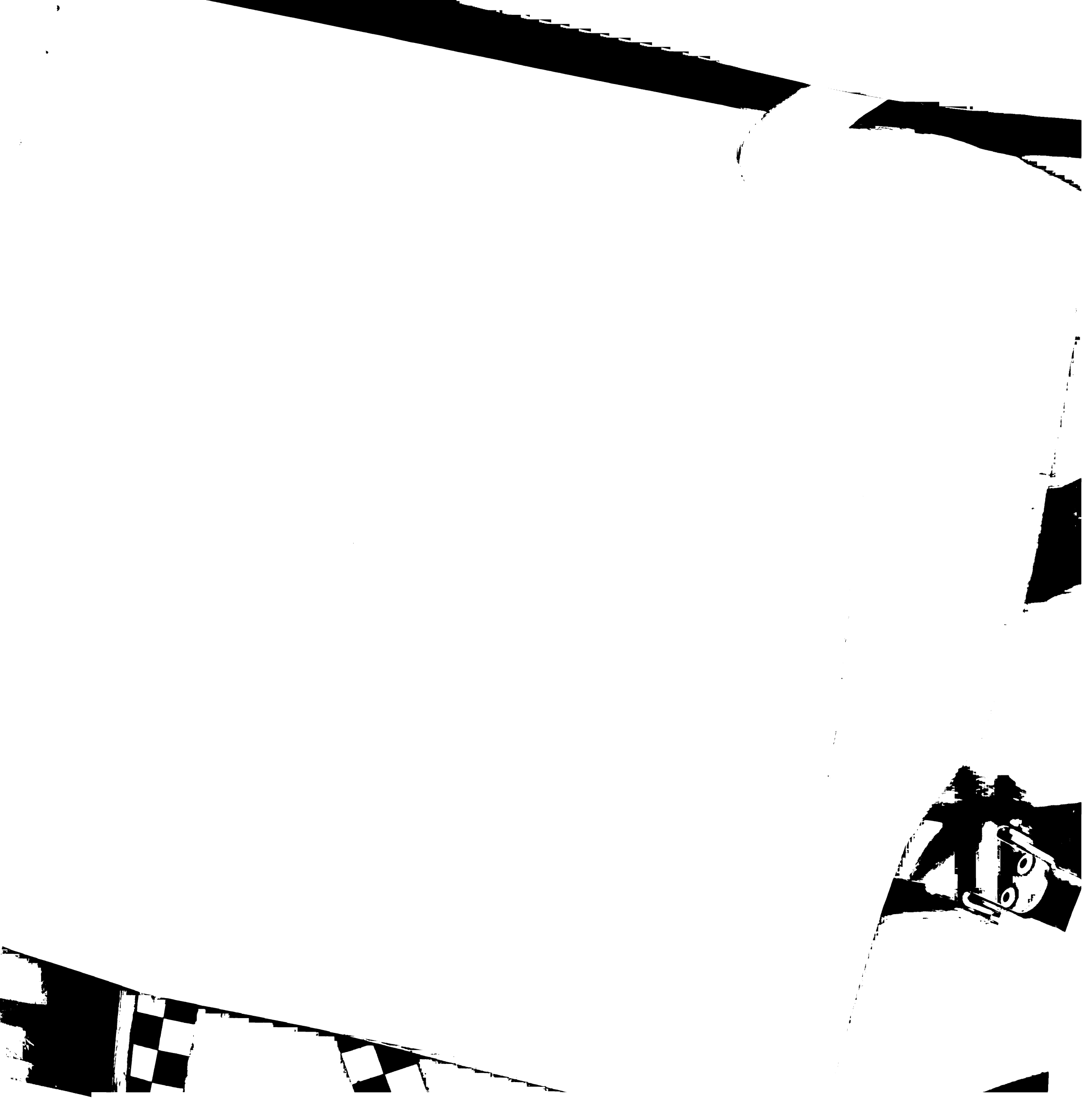
…the next morning I met my daughter. I came up with a name, Hope would be a good name…Because I feel, I truly did feel like God has given me five pounds of hope. And maybe now I can build a recovery on this, build a life on this. She's my faith that I will stick with my recovery, she's my faith in God. She's my hope that there's a better life out there… I'm doing it alone, basically. Without the man telling me, you know, exactly how it's going to be…(Francis, heroin addict in recovery).

I feel like I'm doing it, but I feel like He's helped guiding me. Like one of the girls helped me realize that…I'm lucky to be here. I'm chosen to be here. A lot of people are still out there without their

> kids, they're still using. And I'm...one of the chosen ones to be here. I got clean and sober and I get to have my baby...You know, a lot of things happen for a reason...(Emily, 23-year-old heroin addict in recovery, holding her five-month-old daughter).
>
> So, with a child on the way I guess I have something to live for. And I do, I have something to live for. Me, my child. (Annie, six months pregnant and HIV positive).

Adaptations

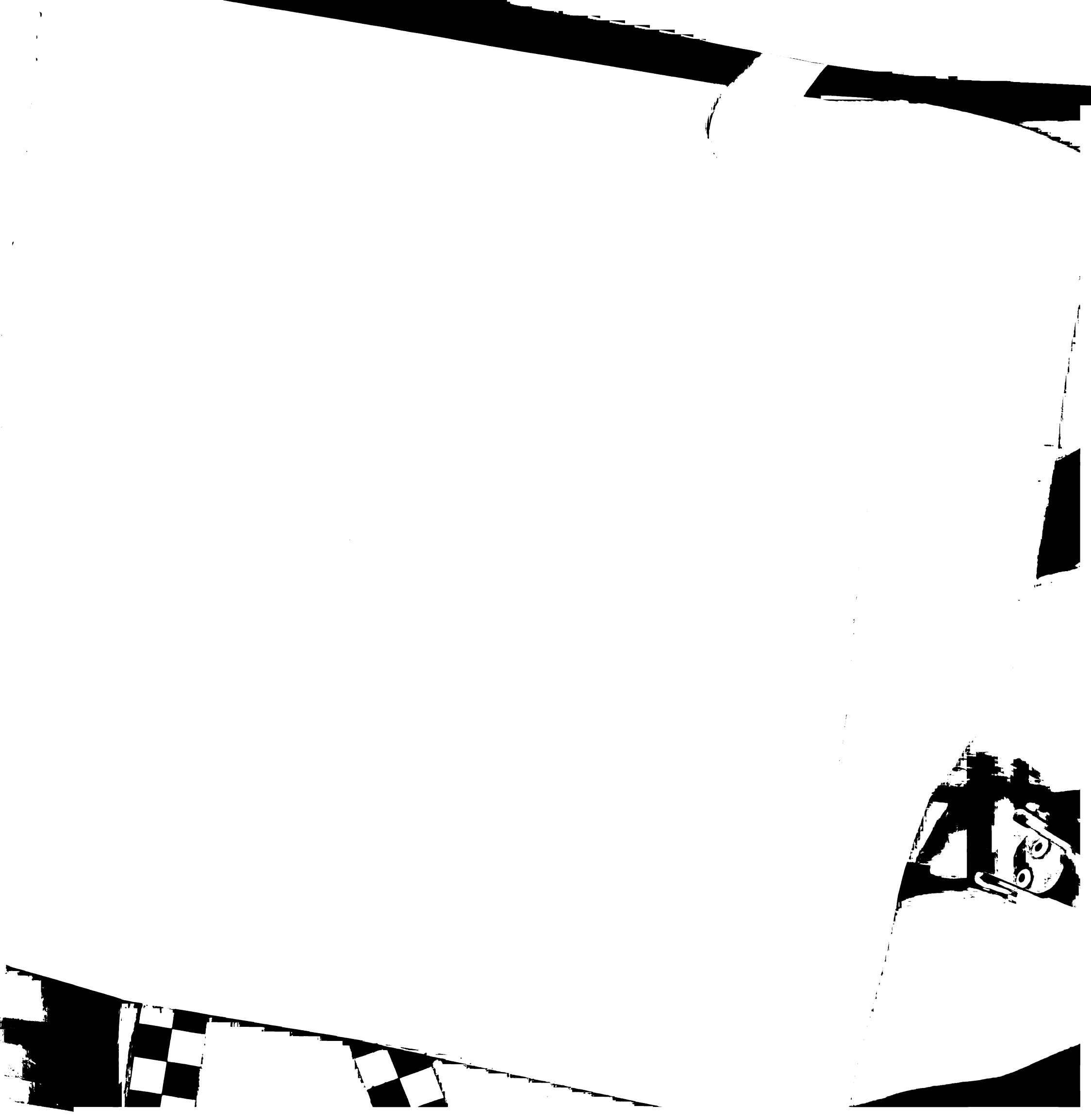
Mandelbaum (1973) describes adaptations as a person's change in their ways to maintain continuity for group participation, to fulfill social expectations, to maintain self-image and to survive. "Personal adaptations are both the source of social adaptation and also responses to it" (p.181). These alterations in behavior are the result of new and changing social conditions and have "a major effect on a person's life and on his basic relations with others" (p.181). The study participants' adaptations were various actions taken to try to have a drug-free baby and maintain child custody. These adaptations served to keep their faith in a positive outcome, to fulfill socially prescribed roles as good mothers, to avoid child welfare



actions, to preserve their families, to stay out of jail and to maintain spiritual survival.

These adaptations arose out of coping with the new life condition of pregnancy in the context of changing external conditions in society. These changing conditions were the highly charged and increasingly punitive and legal approach to the problem of drug use during pregnancy. Because of their knowledge of these punitive threats to their families, study participants engaged in a form of creative coping focused on this reality. Their experiences of pregnancy were largely occupied with managing fear, preserving the family and manifesting faith. This model of life during pregnancy stands in stark contrast to traditional role acquisition and anticipatory activities of non drug-using pregnant women.

Protecting custody. In descriptions of the period of time before treatment, the main goal cited by the study participants was to have a drug-free baby and retain custody. Worrying over possible punitive consequences, engaging with their fear and considering their options occupied a large part of their prenatal experiences. Because they had heard so much about drug-testing from so many sources (other women, health care providers, child welfare personnel, probation officers, TV and newspaper stories), the drug



test results and fall-out from the results took on a grave importance. In order to achieve their goals of a drug-free baby and custody, some women, though still fearful, chose treatment. Others devised strategies to try to have a clean drug test and others avoided care altogether.

The participants were highly motivated by the desire to keep their baby and the meanings they attached to the possible loss of the child. This woman turned herself in after a warrant was issued for her on charges of shoplifting:

> After my son's birthday, I turned myself in...and I went to court and I asked if I could come to a drug program...I'm a good mom and I know that I can be a better mom and I knew that I needed help...my Mom left me and she was never there for me. And I deserve to have a better life than what I was shown...and so do my kids...this is the first baby I'm having that I'm clean (Maria, 27 weeks pregnant).

These women spoke about choosing treatment even though they sensed that even that did not necessarily guarantee custody:

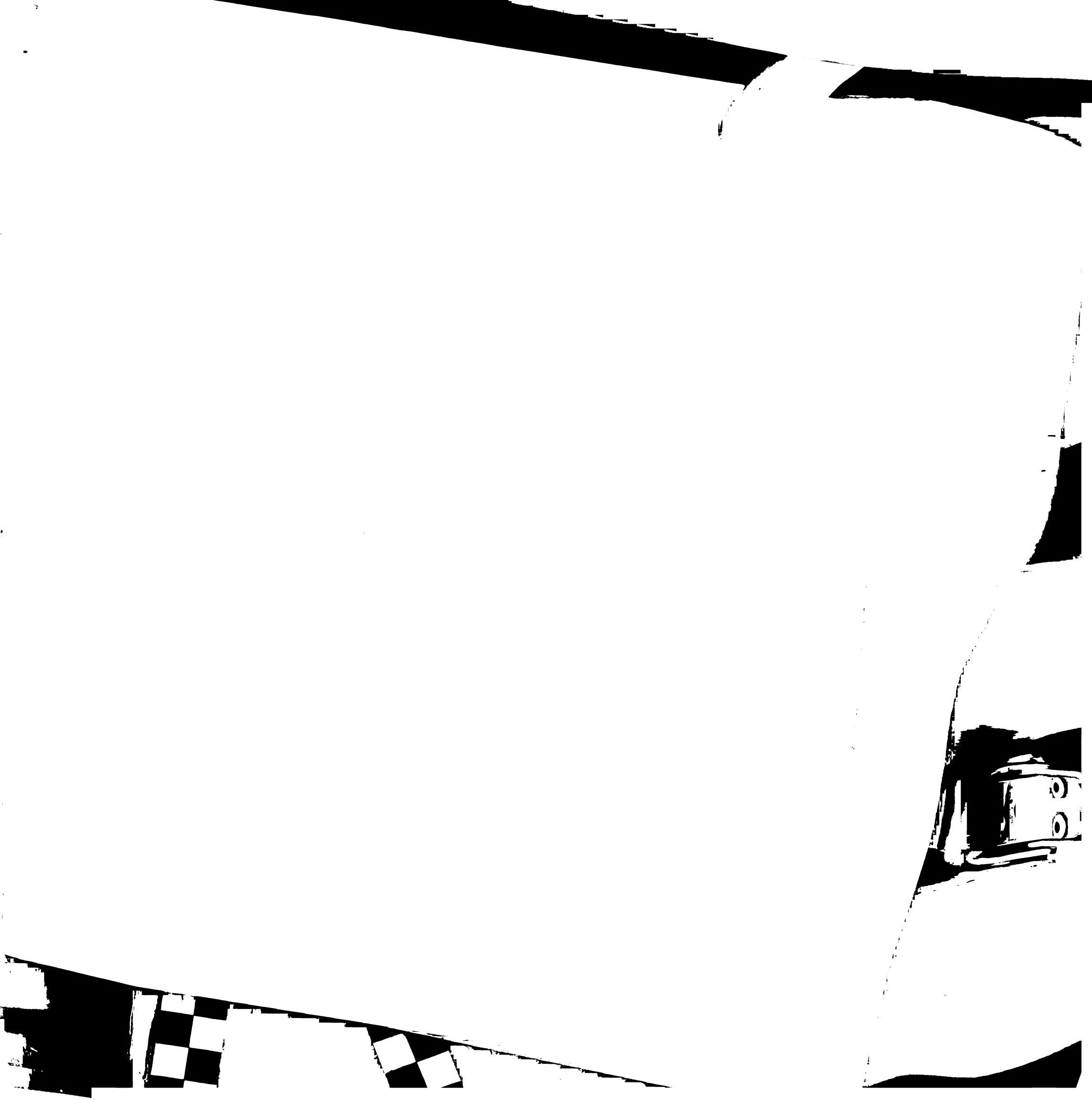
> I finally convinced myself that it's probably the best thing that I'm

getting the help as opposed to not getting the help...whatever happens at the hospital, at least I gave it a good try. Clean myself up, get my life back (Linda, 31 weeks pregnant).

Chrystal, a 36-year-old mother of eight children, entered treatment four days before her due date. Homeless, she tried to connect with services for over four weeks.

We're scared to even tell you that we're using, cause we already know that you're gonna take our baby...[what we need] is a safety net where we can be able to tell you that we're using and still be able to keep our children...for us to be able to work past the fear...I really wanted to go to [treatment]...I didn't know how to get in...by any means necessary we will get our dope. And today by any means necessary I will get my recovery.

Study participants also used strategies to try to control drug test results. These adaptive strategies aimed at having a drug-free baby included attempts at controlled use of their drugs, manipulation of the testing circumstances, and avoidance of testing through avoidance of care. This woman described the certainty of drug testing when the baby is born:



> Either way it goes, they're gonna test your baby. That's the law. They're gonna put the bag on your baby whether you want them to or not (Sherrie, mother of eight, a recovering heroin addict).

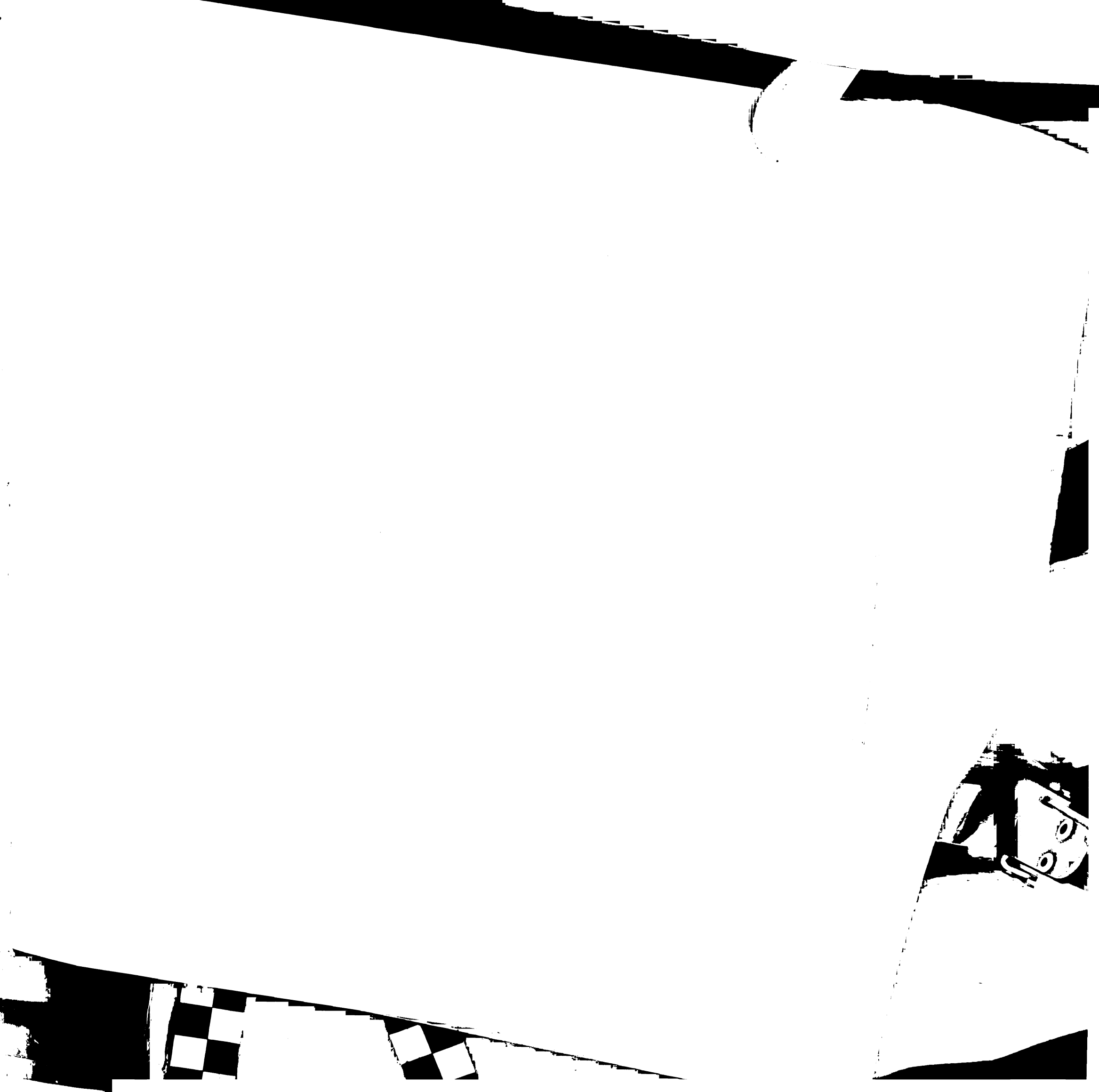
Lourdes, mother of three children and a recovering addict-alcoholic, describes how she used her drugs carefully around the time of her check-ups and the birth of her child:

> I wasn't sure what I was gonna do. That's why I watched what I was doing. I was careful. And I knew after the seventh (her due date) I could have the baby any day. So it was up to me what I was going to do...apple juice [could be added to the urine]...you hear so many crazy things...I would just not use. I knew what I had to do and when I had to do it.

Christy, seventeen weeks pregnant, told how she tried to avoid a positive drug test:

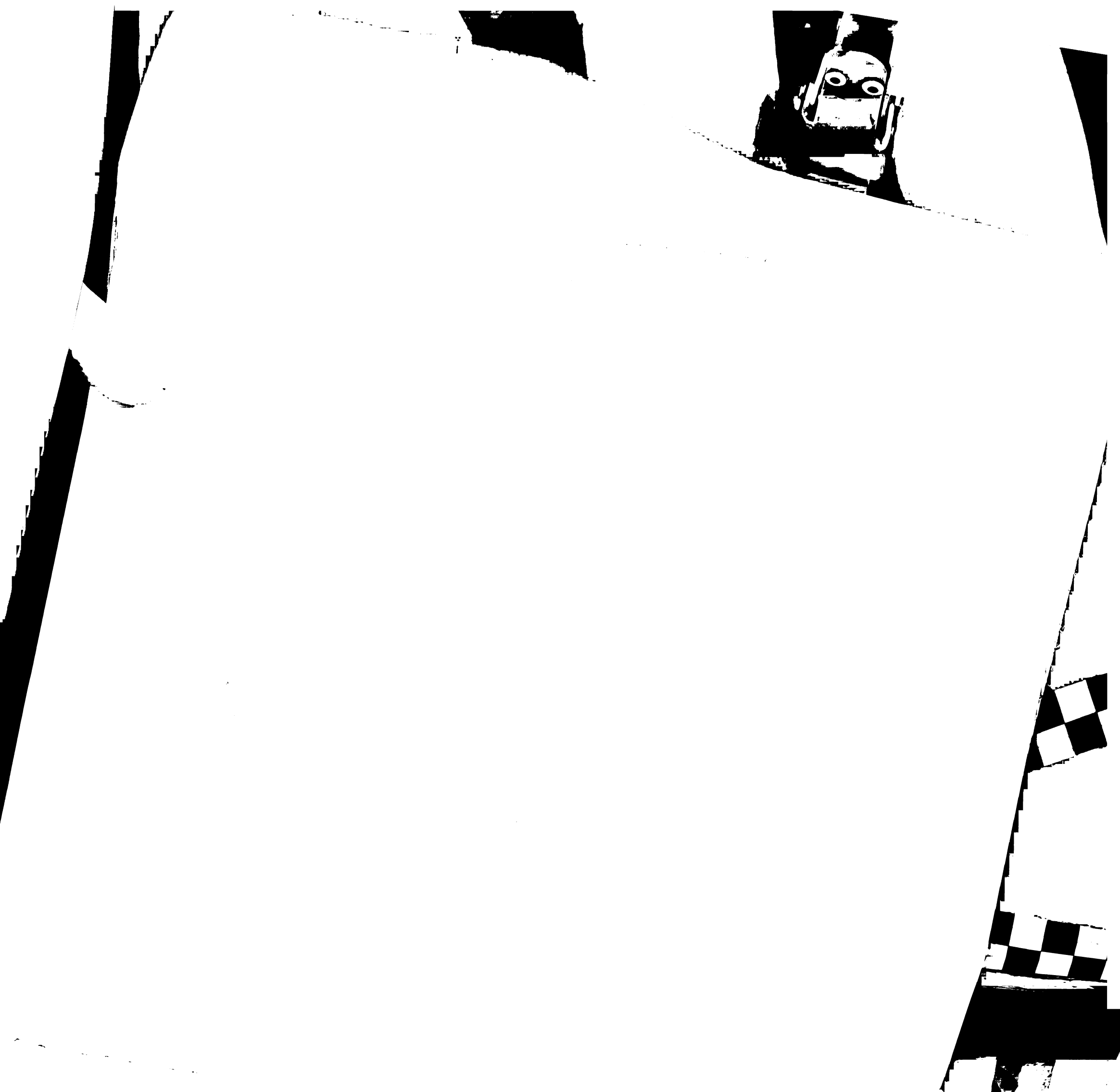
> "I was smart enough not to smoke the day before or the night before. I avoided the test..."

Nonetheless, by far, the most common adaptive strategy in attempts to keep their babies was the struggle with participation in prenatal care. On the one hand, the women acknowledged that prenatal care was important, yet they



were also conscious of being tested and very aware of the potential loss of their babies as a result of a positive test. In appearing sporadically or dropping out of care, they believed they were doing something protective of themselves and their babies; if there was no positive test, there would be no loss. These women describe what happened in their struggles about coming in for care:

> ...they told me if I come three times dirty, that you know, when I had my baby, they was gonna take my baby. And then the second time I started, I didn't go back no more (Ivy, 22-year-old single mother of two).
>
> So that's what made me think I don't wanna give my blood, I don't wanna pee-pee or something. It's gonna show up, I'm using. And that too also scared me. I also thought of jail... All that start coming to my mind...No, but it was just me. It was just coming to me. Oh my God, you know, I'll be in the [electric] chair in this! But it ain't fun. It's just the point that my mind was going, you know, in circles. I was spinning with myself. I was making myself go...with the unknown, you know. And not asking questions, not asking anybody nothing.



Just keeping all this inside (Yolanda, 35-year-old, relating why she stopped prenatal care).

... being on drugs and going to the doctors and them knowing...I just didn't want for them to think, you know, look at her, she's...on drugs and pregnant, and that's, I don't know, that was really my main thought (Vicki, mother of five and seven months pregnant).

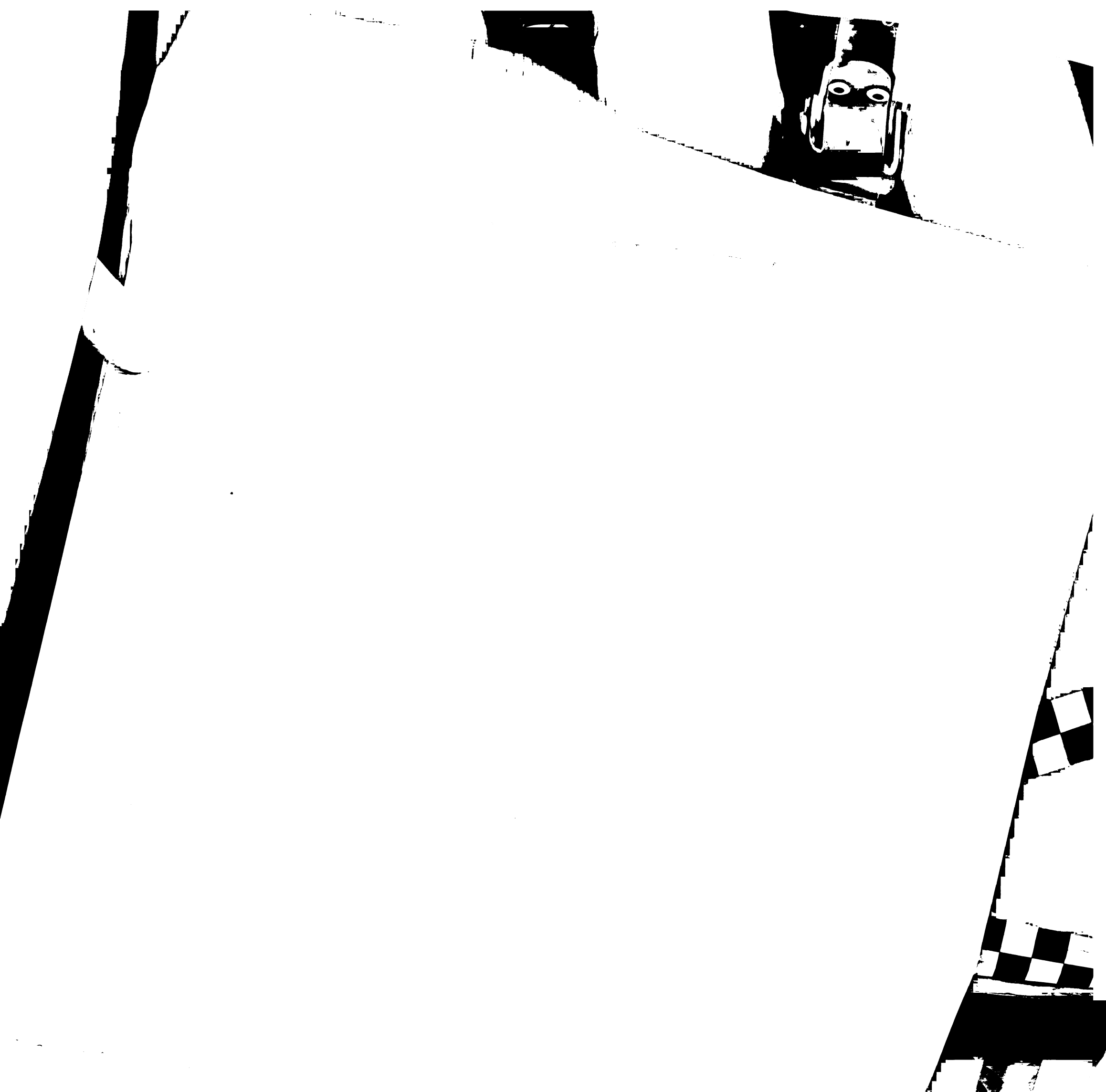
I didn't want to bring that up because I was afraid of them, you know, calling CPS and you know, investigating him, my ex, the father of the children. And I didn't want, I didn't want them to, you know, look at me as a bad person because I was still around somebody that was treating themselves like dirt. But I made everything look good on the outside, but in the inside it was really, really, really bad. (Shawna, eight months pregnant).

That they're gonna find drugs, and I know that I was doing wrong, that I did wrong for not going to the hospital, and I know I was taking drugs up to the day that I went in labor. Just scared...that they gonna take my baby. Um...that's about it...and when you on the street here,

you hear these bad things like they find drugs in the baby, they gonna take you to jail or.. they gonna take your baby, not only your baby but they gonna take the rest of your kids. So, all that's going through my mind, plus being in pain (Minerva, mother of six children).

Preserving the family. Study participants described situations wherein they tried to maintain family cohesion against all odds. In many cases, the women and their children were nonetheless subjected to lengthy separations from each other due to child welfare actions and objectives of child protection. Study participants were often suddenly thrust into crisis circumstances, making decisions and trying to appropriately respond to the child protection missions of helping institutions. They usually did this alone, without a trusted loved one, without a counselor or an attorney. The women were forced to give up custody of their children because they were perceived as a risk to them as a consequence of their disease.

Though the women described these separations and voluntary relinquishments as the most difficult thing they had ever done, they were compliant in an attempt to ultimately regain custody and keep their families together. This adaptive strategy of compliance with child welfare interventions happened in part because of the legally mandated power of the



health professionals and institution of child welfare. However, it also happened because the woman's goal was to be a mother to her child. The women wanted their children and they needed support to provide for them and be an effective and loving mother.

Because the study participants were an in-treatment sample, some women were able to retain attorneys and advocates to regain custody once they entered treatment. However, no women reported hiding, fleeing or abandoning their children. The women described how they wanted to be with their children and wanted to be a parent to them.

Felicia, a 20-year-old who was 30 weeks pregnant and the mother of three, was evicted from her home because her boyfriend took her rent money. She called child protective services herself in order to protect her children. She spoke about standing on the front porch of her former home as the child welfare worker waited for her decision. She had to decide which of her two younger children should go with her into the treatment program that was being offered and which would go to foster care:

> There was a opening for here. But the only hardest part was I had to choose one kid... (crying) I had to choose one kid...for temporarily, but I thought it would be easier for my ten-month-old than my two-

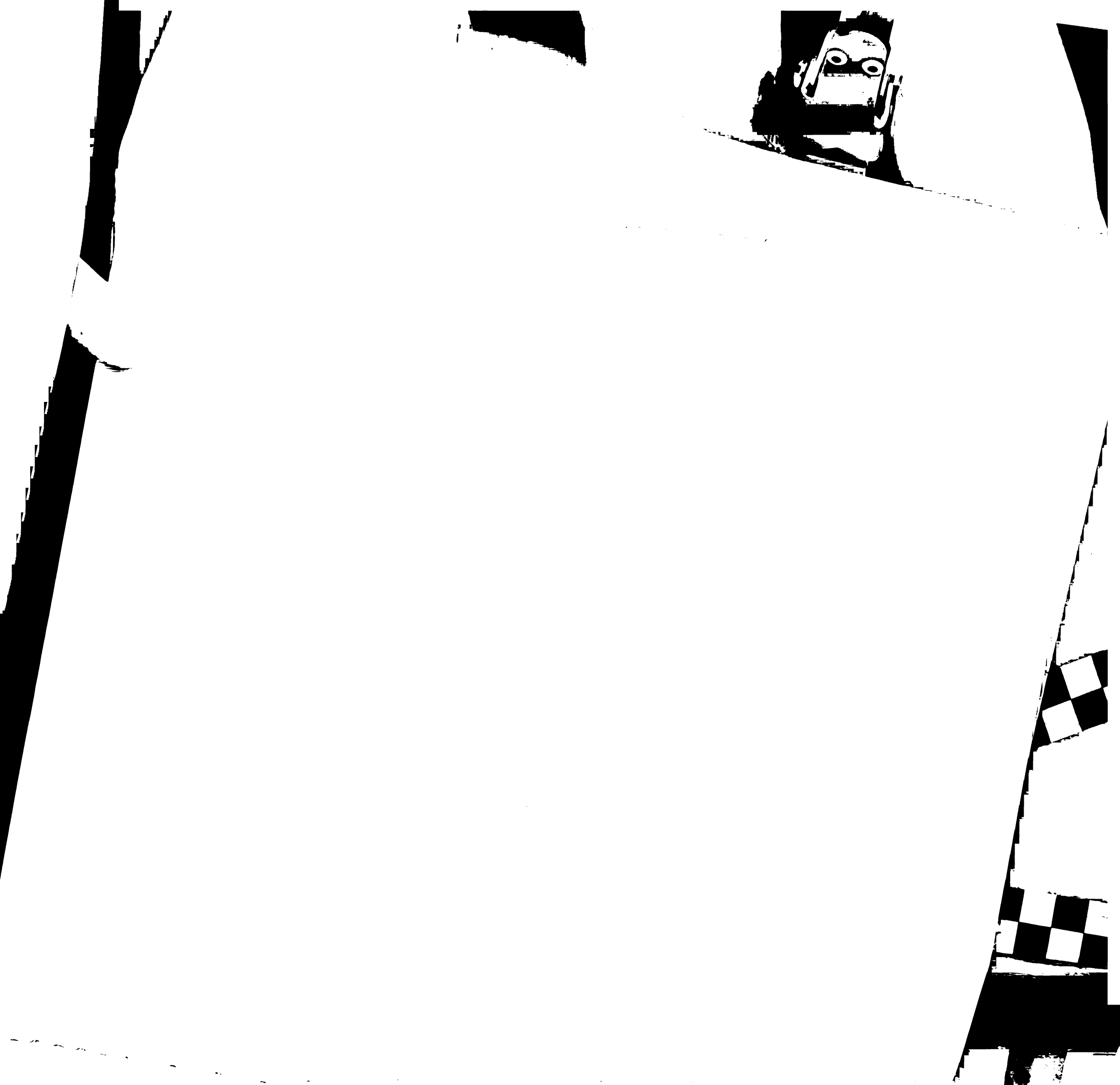
year-old because he's going through a lot right now... So on the 19th they came and got my ten-month-old, and my two-year-old came here... it's not fair...(crying) Because he's only a baby, he didn't deserve all of this...(pause, crying)...I had to do it by myself... just what I thought would be best....

Celia, a heroin addict, gave birth to her fifth child. Because she had two children placed for adoption in the past and was on MM during part of her pregnancy, she was placed on a list that circulated her name as a high-risk prenatal patient throughout county health services. During her pregnancy, she had participated in prenatal care until the middle of her second trimester, at which time she became fearful about losing her child and went back for care only sporadically. She was on court-mandated legal probation and provided twice-weekly urines for drug testing. She had legal court-authorized documentation from probation of clean urines for the entire pregnancy and attendance at self-help recovery meetings and outpatient substance abuse treatment. She was also enrolled in MM for part of her pregnancy and had not used an illegal drug since two months before she got pregnant. Now four months postpartum, Celia described the day her son was

born, when uniformed police officers came to the hospital and placed the baby in protective custody:

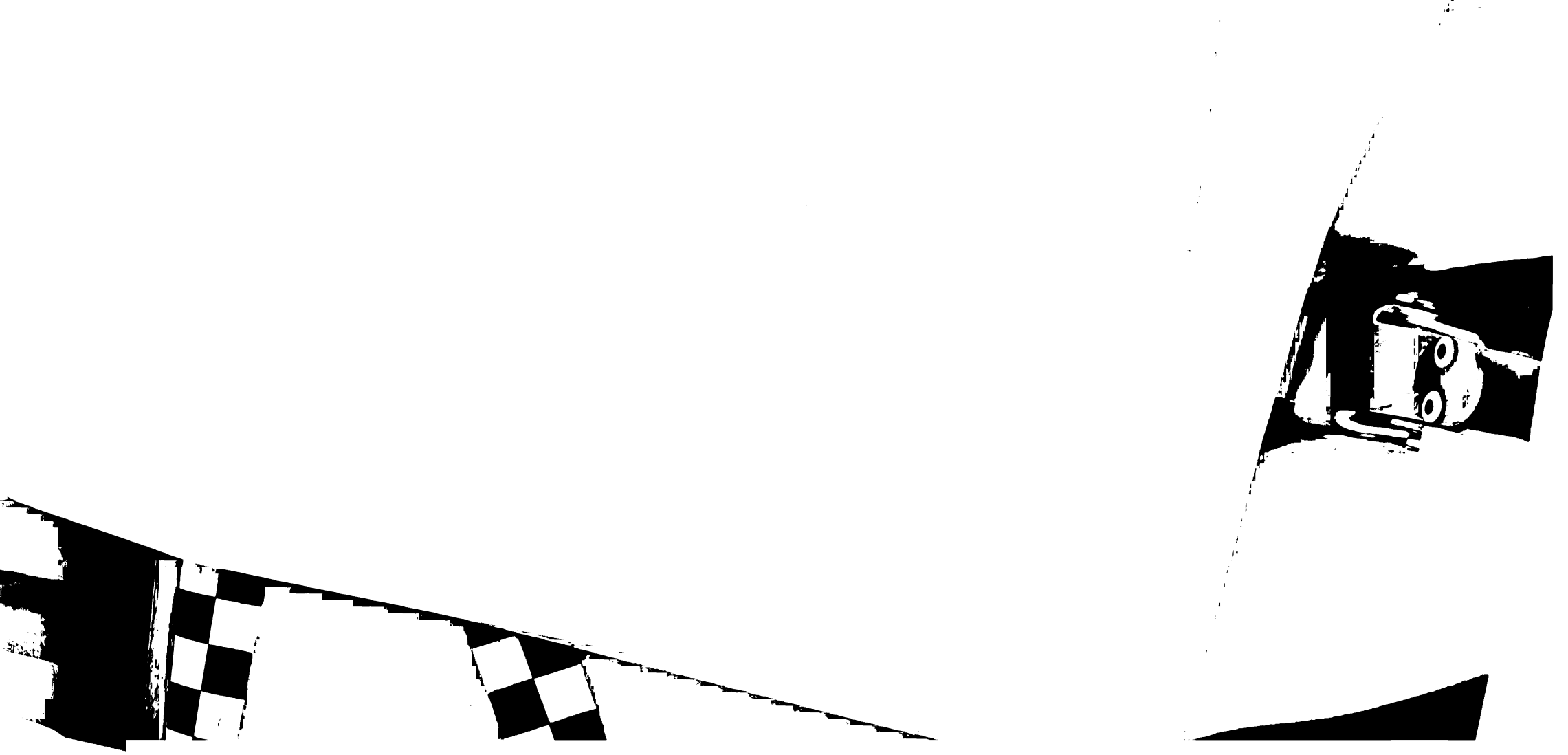
> It was a shock to me when they showed up and just took my baby...They were upset about it [that they had to take the baby], they were all upset about it. I mean, the lady, the CPS worker, she cried. She was like "it's nothing you're doing now, it's just your past. And I don't agree with it, but it's my job and I have to do it." But she got my baby sent with my sister, and I got to go home [to the sister's] with him. And then they called like a few days later, and said...you have to leave... And I couldn't be with my baby...[I was] devastated. I was like oh my...I was breastfeeding him and it was just so hard. But I knew either that, or they would take him from my sister too. Cause they told her, either you comply with the CPS laws...or we'll have [the baby] placed somewhere else.

The baby stayed with his aunt and Celia entered residential treatment as required by child welfare. She also retained a public defender and went to court to regain custody of her child. At her court appearance the judge granted reunification services, noting in his view, that she had not refused treatment as claimed by the attorney representing child welfare services.



Anita, a 33-year-old mother of five, drank alcohol and used cocaine and marijuana during her pregnancy. She started prenatal care at 23 weeks and entered treatment at 32 weeks. At that time, she had two disabled senior family members to care for and four children ages, 1, 4, 14, and 17 years old. She also had a drug-using 24-year-old brother living in the house with her. At around 6 months in her pregnancy child protective services (contacted by Anita's 17-year-old child), contracted with her to clean up her home and eject her brother due to his drug trafficking in and around the home. She cleaned up her home but the brother remained. The child welfare worker then came to pick up her younger children and promised it was for only two weeks. Child welfare removed the children to foster care. Anita had been in treatment without them for two months when she described what happened:

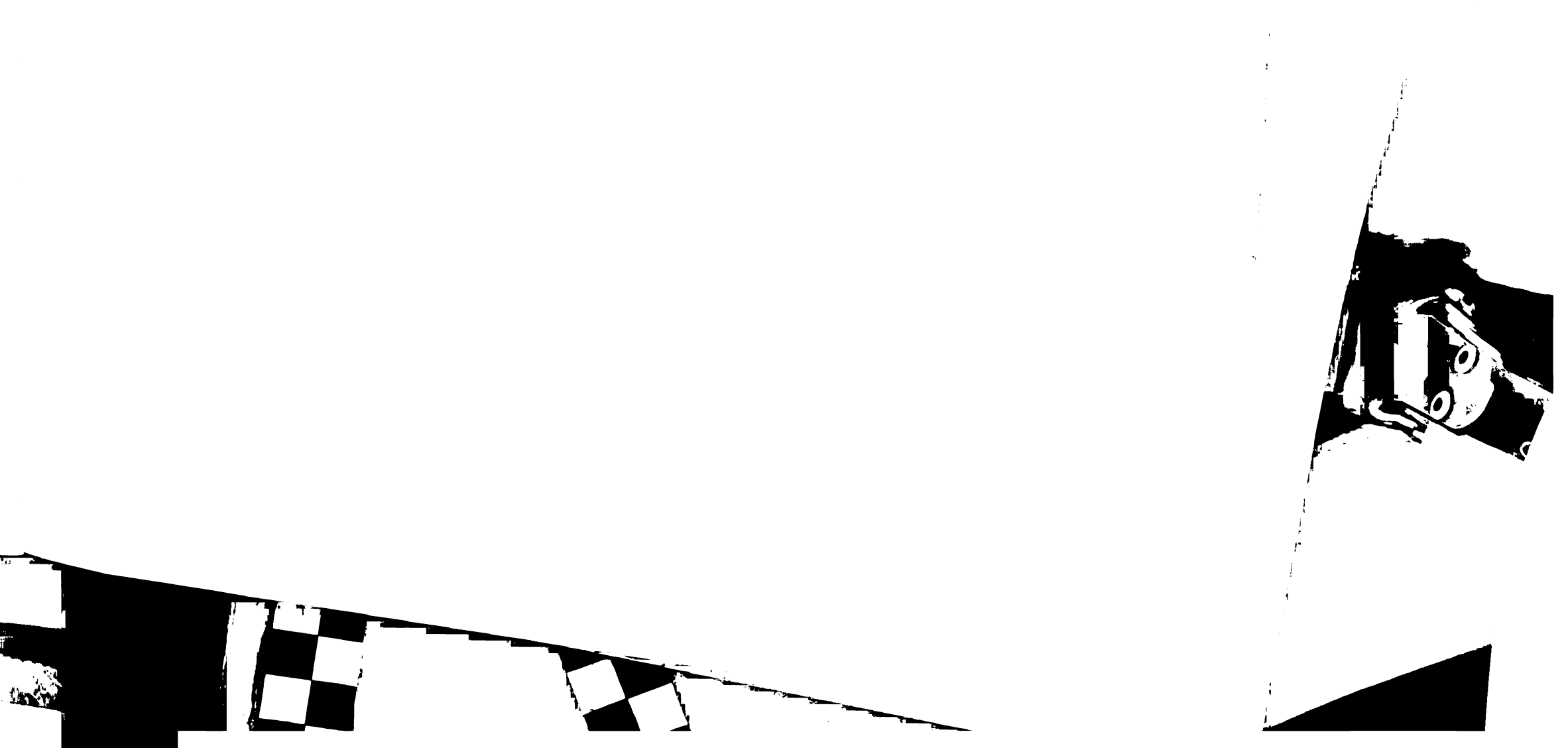
> I said...I'll leave [this house] or do whatever I have to do, but don't take my kids...[the CPS worker] said "I need you to bring the kids to me."... I ended up calling them and telling them to come get them...and that was the hardest thing for me to do, was to dress my kids and have them ready at the door. And they came and they took them...I cried for the next two days. I sat in a chair and I just cried,



and cried, and cried...my kids is my life. Without them, I feel I have no need to exist... I'm gonna do whatever I have to do to get my kids back.

Talking to God. Prayer, in the form of asking for help and making contact with a Higher Power, was a frequent activity for many of the women. These women describe the ways that "talking to God" comforted them and allowed them to persevere in difficult times:

I was so mentally beaten down...I had given it my all, and I still failed... I cried and I cried. I just went and told God that I wasn't going to cry anymore. And He said, "Yes you will..." I was grieving about this addiction, and I was just mourning and grieving ...and I just totally surrendered my will and my life to God. I just said, "I can't do this. I need to surrender my will and my life to you." And I did, and I was fortunate. I got a thirty-day bed at the detox...You know, this is new. It's a new beginning. And it feels good. I have new direction, you know...God is here, my recovery is here, and I'm here. I've been in a fog for thirty years. So, it's really exciting to start all over with a new beginning. All fresh. It's great. I think that's the

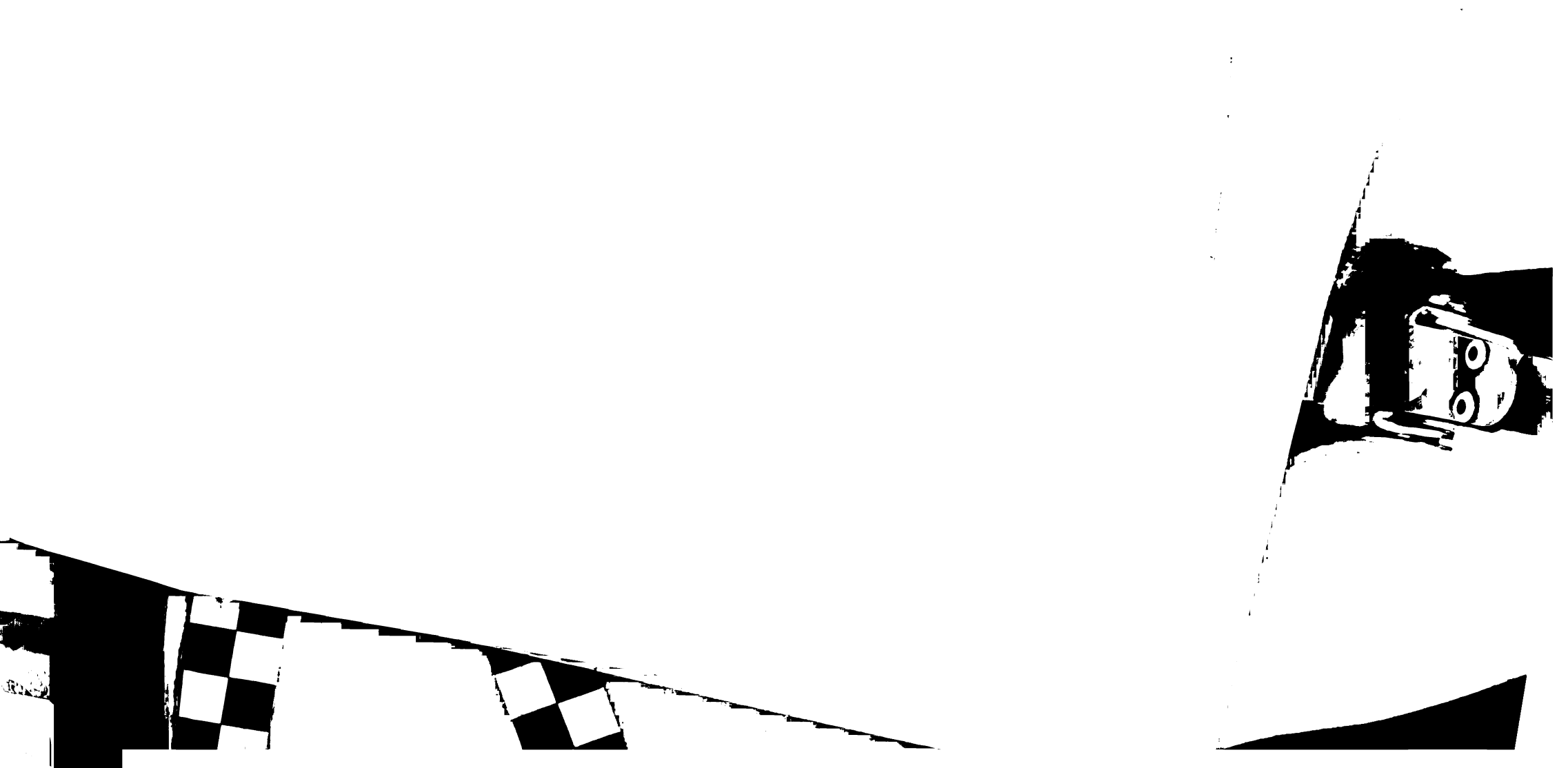


best gift that I could give [my son] right now. I can't make up for what I did while I was pregnant... [my baby] was born with FAS... (Patricia, recovering alcoholic).

I feel God is the reason I'm here today. And if it wasn't for God I wouldn't be here, I really wouldn't be. In fact, two days before I told you they raided my place, I had been praying to God to please help me, to please take all this badness away. And um, boom, it busted in. (Barbara, 31-year-old mother of five).

I prayed every single day, you know. I had to, because that's the only way I could have made it...I think that..[was] one of the reasons that my baby came through healthy, you know...I had to continue to ask God, just show me a sign, you know, please show me a sign that this baby is gonna be all right. And you know, I just kept praying every day (Sally, recovering crack addict). Doing the right thing.

Doing the right thing. The main way that women tried to do the "right thing" for themselves and their babies was to obtain prenatal care and 35 of the women sought out prenatal care. Even though the decision to stop drugs



had not yet been made, these women spoke about getting prenatal care:

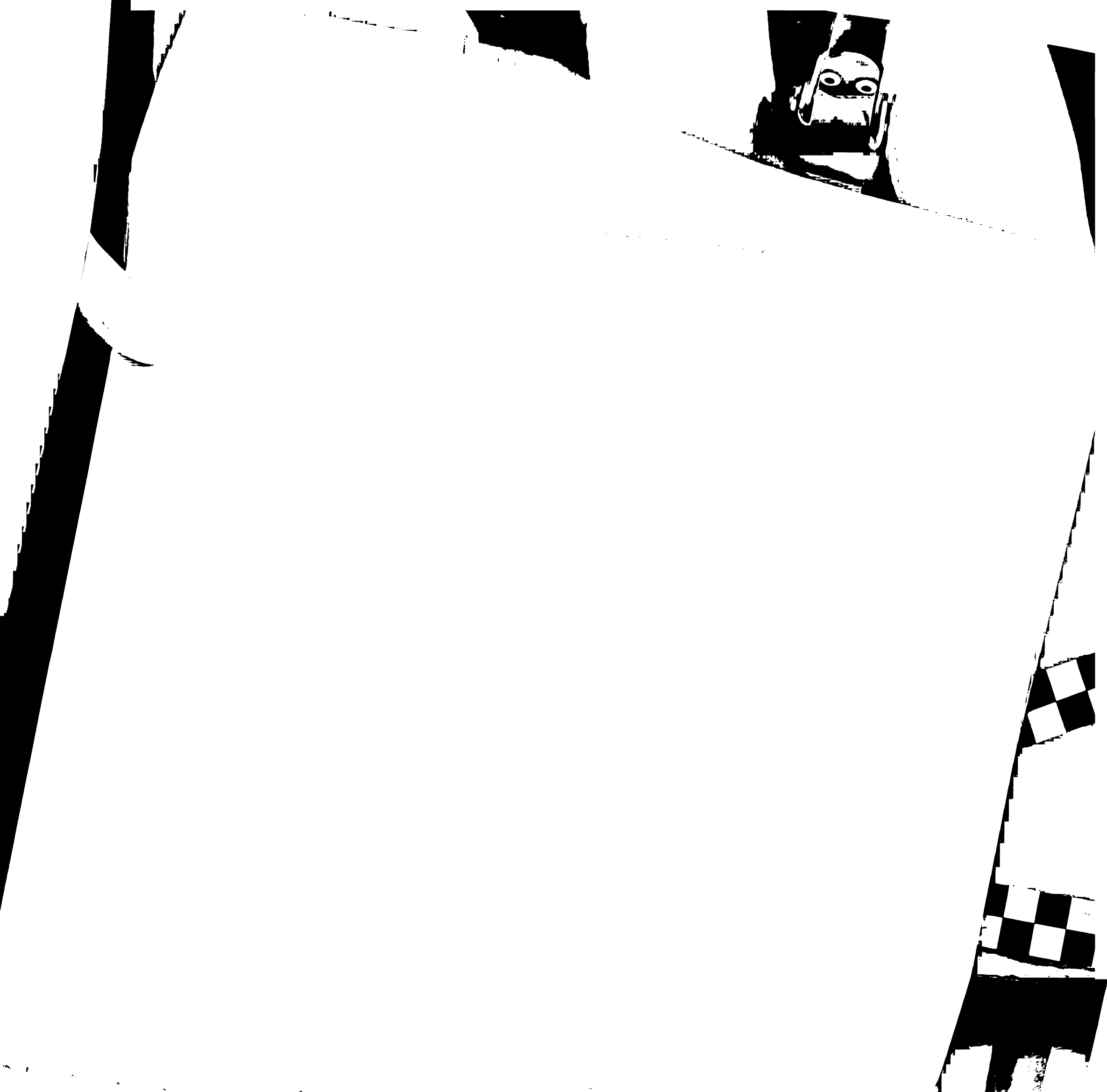
"...all I know is I need to do the right thing to take care of my child" (Annie, HIV positive and six months pregnant, committed to making every prenatal care appointment).

...as soon as I found out, then I started going. I was still doing drugs and stuff but I was still making my doctor's appointment, taking my prenatal pills every day and eating good" (Maria, 23-year-old, 27 weeks pregnant).

...when I started getting care, I was still using drugs...I was using drugs and working...after I started getting my prenatal care I never really stopped...once I finally made an appointment...and they started giving me my prenatal vitamins...it's just like something just inside of me...things just started changing within me...(Roberta, six months pregnant and started prenatal care at 16 weeks).

Conclusion

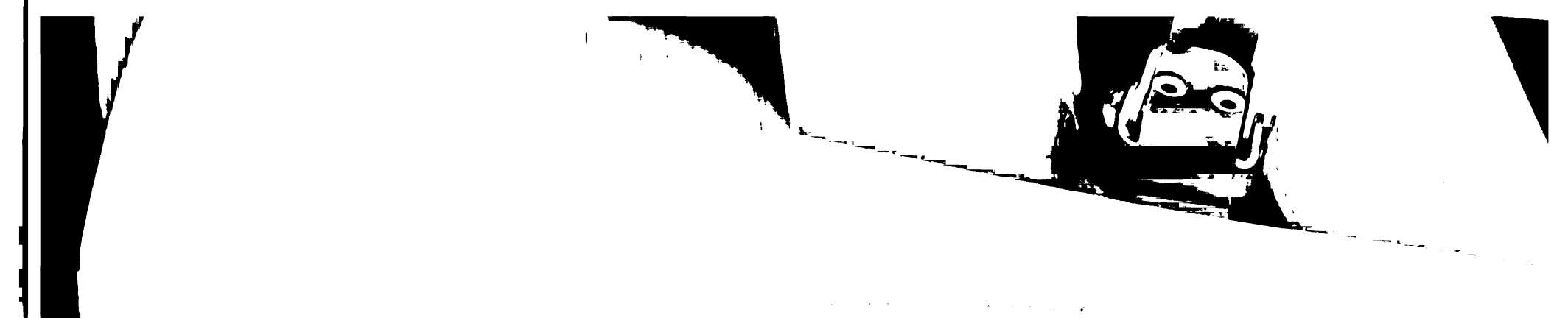
This study described pregnant and parenting drug dependent women's experiences of encountering and negotiating extrinsic barriers to substance



abuse treatment. Utilizing the framework of Mandelbaum (1973) for life history analysis, the dimensions, turnings and adaptations in the lives of the study participants vividly emerge. Mandelbaum's method is the lens through which we focus on the dynamic and adaptive aspects of the lives of these women. In so doing, traditional stereotypes of the women were shattered. The women emerged as "active doers," affected by the multiple dimensions of pregnancy and addiction and coping with immense life challenges during the turning of pregnancy.

The interviews described the experiences of these women as they spoke about what happened to them during their pregnancies prior to entering residential treatment. Their stories explained how and why they acted the way they did as well as the nature of their perceptions of, and their relationships to, socially imposed roles, conditions and choices. The narratives focused on a set of significant events in their lives: pregnancy, childbirth and mothering amidst trying and complex circumstances. With an emerging objectivity that sobriety and recovery afford, the women reflected on their complicated and often frightening but hopeful journeys toward recovery.

These stories were told by women residing in long-term therapeutic



residences and therefore, they came from a select sample of addicted women who were able to "make it" to treatment. That accomplishment distinguished them from their out-of-treatment female counterparts in ways that, though likely important, remain unknown.

Chapter Five

Discussion

Summary of Findings in Relation to Previous Research

The pregnant drug dependent women participants in this study encountered numerous environmental barriers to care that were gender related and focused on their reproductive capacity and expected mothering role. The barriers included fear of arrest and incarceration, fear of loss of newborn and older children, fear of disclosure, the status of opiate dependency, the status of pregnancy, program-based barriers, and influence from partners.

Findings from this study suggest that the current social construction of perinatal addiction has negatively influenced the socio-cultural context of care-seeking. Findings also suggest that socially induced "framing effects" (Lakoff & Grady, 1996) of the U.S. War on Drugs, media coverage, biased and unsound scientific research, punitive positions by policy-makers and actions by law enforcement negatively influenced care-seeking and other social relationships of pregnant drug dependent women. Instrumental approaches that included threats to custody, drug testing, and other legalistic forms of monitoring replaced appropriate clinical interventions for the

treatment of addictive disease. As noted by Chappell and Schnoll (1977) in their discussion of negative attitudes toward drug users among health professionals, diagnoses of addiction under these circumstances can be delayed or never made. Lack of appropriate recognition of addiction as a brain disorder requiring evaluation, treatment and insurance coverage also influenced the care-seeking behaviors and experiences of study participants.

The impact of addiction on brain function must also be acknowledged as an element wielding influence upon health, mood, behavior, cognition, and psycho-social aspects of the lives of study participants. Addiction is a brain disease (O'Brien & McLellan, 1996; Lesher, 1997) and has been described as a chronic medical illness (McLellan, Lewis, O'Brien & Kleber, 2000). Chronic use of mood-altering drugs causes significant and permanent changes in brain chemistry and performance that persist long after abstinence is achieved. The mesolimbic reward pathway in the brain is the primary site of action of mood-altering drugs and all drugs affect this region of the brain (Lesher, 1997). New users of drugs do so voluntarily; as addiction is reached, drug use is characterized by compulsion, loss of control and continued use in spite of adverse consequences (Koob, 1996). Gender differences in brain chemistry, drug metabolism and chronic effects of

substances are being examined in order to understand the varying expressions and outcomes of addiction in females and males (Tseng, 2001; Zhou, 2001; Lessov, 2001). The chronic use of mood-altering drugs among women subsequently influences relationships, psychological and emotional processes, perception and behavior, all of which occur in a social context. The biological impact of chronic drug use and the interplay between brain function and psychosocial factors must be considered in examinations of perception and behavior of addicted persons.

The Deterrent Effects of Fear

Findings in this study affirm the research of others who have examined the negative effects of punitive actions from helping individuals and institutions in response to care-seeking behavior (Poland, Dombrowski, Ager & Sokol, 1992; English, 1990; Whiteford & Vitucci, 1997). This current study expands the understanding of care-seeking dynamics among pregnant drug dependent women and provides data on specific clinical interactions and regional and local policies that negatively affected care-seeking behaviors in this sample of women.

Findings in the current study support the findings of Gazmarian and colleagues (1997) who examined barriers to prenatal care in women

members of Medicaid managed care groups. Like the current study, women cited fear of disclosure of drug use and subsequent incarceration, poor treatment by clinic and office staff, lack of rapport with providers, and lack of childcare as significant barriers to prenatal care. Findings in this current study are also similar to those of Leppert and colleagues (1996) who found that fear of disclosure, incarceration, and loss of custody were cited as barriers to prenatal care by high-risk and impoverished study participants.

Treatment Access

Findings in this study also support the research of Beckman & Kocel (1982) in their study of extrinsic barriers to treatment for women, which identified pre-admission requirements of treatment programs as a barrier. While affirming Beckman and Kocel's finding, the current study also illuminates the particular physical risks for pregnant women imposed by such requirements. Results of this study also suggest that expedited admissions to treatment could have occurred when intake appointments occur immediately after the first contact by the client, as in the studies of Stark, Campbell and Brinkerhoff (1990) and Festinger et al. (1995).

Copeland's (1992) examination of women who became sober without participating in formal treatment found that barriers included: 1) feeling

different from those they thought went to treatment, 2) the expense of treatment, 3) inappropriateness of available treatment and 4) lack of childcare. With the exception of lack of childcare, this study does not support the findings of Copeland, whose sample of women were White, middle class and alcoholic. Class and ethnic differences between study samples may account for the other variations in the barriers cited. The similar finding about childcare however, suggests that the absence of childcare is a barrier among all drug dependent women, regardless of class or ethnicity.

Findings from this study support the work of Tam, Schmidt & Weisner (1996). In their study of agency-directed referrals to alcohol treatment, criminal justice and the welfare bureaucracies (as opposed to primary care) were "feeder systems," directing referrals to smaller treatment-oriented programs. In this study, six of the 24 participants who had treatment during pregnancy found the treatment center by referrals from prenatal care providers. Those six women were referred to treatment because four of them self-disclosed and the other two were admitted to hospital obstetric units in acute opiate withdrawal. As noted in the results chapter, the remainder ($\underline{n}$ = 18) were mandated to treatment by child welfare ($\underline{n}$ =6) as a

condition for regaining custody of other older children, by judges and probation (n = 7) and by voluntary self-referral (n = 5). Among the 36 study participants, no one was admitted to treatment as a result of an intervention initiated by a prenatal care provider.

Stigma of Addiction

In studies by Thom (1986) and Cunningham et al. (1993), the stigma of addiction was noted as a barrier. In this current study, while "stigma" was not specifically articulated, all of the barriers cited describe socially inflicted stigma. Additionally, findings about health care and treatment professionals' attitudes in the current study affirm Vanicelli's (1984) historically important examination of sex-role stereotyping and lack of providers' knowledge about drug dependent women.

Demographic Barriers

As noted in the research on barriers to prenatal care by Lia-Hoagberg et al. (1990) and Poland, Ager and Olsen (1987), low socio-economic status (SES) and low levels of education were identified as barriers. As the study sample in the current study was also women of low SES and education, those may also have been imbedded barriers to prenatal care.

The influence of ethnicity in care-seeking was not a specific focus of this current study. However, similar to the findings of Sanders-Philips and Davis (1998), data from the current study suggest that social and attitudinal factors among African American study participants may have been determinants in their decisions to seek prenatal care. A secondary analysis of data is necessary to more closely examine this aspect of the findings.

Delay in Care-seeking

The current study also affirms findings from Poland, Ager and Olsen's study (1987). They cited barriers which included insurance type, attitudes toward health professionals, delays in telling others about the pregnancy and delays in suspecting pregnancy. While insurance type was not cited in this current study, attitudes toward providers, as noted in Chapter 4, were clearly cited as a barrier. Delays in telling others and in suspecting pregnancy did occur among study participants and, in addition to the other barriers cited in this study, may have contributed to delays in seeking prenatal care.

Domestic Violence

This study supports the findings of Fishwick (1990) and Amaro

et al. (1990) in their studies of drug dependent women and domestic violence, wherein drug dependent women were likely to be deterred from accessing support services. Although both studies were conducted among out-of-treatment women who might be more reluctant to disclose domestic violence issues, this current study affirms their findings of the deterrent effects family violence has on seeking care.

Findings from this study are also similar to the study of domestic violence by Merritt-Gray and Wuest (1995). Their research demonstrated that women victims of violence devise conscious and active strategies for counteracting the abuse and breaking free of it. Their qualitative research deconstructed the notion that women victims of violence passively accept abuse. In this regard, findings regarding abused women in this current study are similar to Merritt-Gray and Wuests' in that they both describe individuals and processes that challenge stereotypes about highly stigmatized women. These findings illuminate invisible activities and qualities that show the women to be resourceful and determined amidst extremely harsh social conditions.

Transformation of the Therapeutic Alliance

The Cascade of Fear

A majority of the study participants (n = 29) experienced barriers that were descriptive of an over-arching fear of disclosure of their drug use during pregnancy. The women described their relationships with health and child welfare agencies as ones in which they experienced fear, intimidation and distrust. Participants perceived these institutions as threatening and believed that if a hospital, clinic or child welfare agency identified them as a drug using pregnant woman, they could and would be met with harmful consequences. The organizations were viewed as engaged in producing a type of collaborative harm and were characterized as intimate communicants who would report to each other and who had the power to (and probably would) cause loss and pain for the women and their children. As a result the women were as fearful of going in for care as they were of not going in for care.

Disclosure of their drug use, which they viewed as inevitable even when in minimal contact with these institutions, would come about either through voluntary self-disclosure or through prenatal or at-delivery drug testing. Though study participants viewed the possible effects of disclosure as intertwined, their stories focused on the particular way they thought it could happen to them. As a result, a type of cascade effect of fear was

described by the women: once disclosure of drug use was made to any single representative of a health care or child welfare agency, they believed that any number of punitive consequences arising out of multiple local and state agencies could befall them.

These barriers made the women fearful and deterred them from substance abuse treatment and prenatal care. The fear of arrest and incarceration was expressed by study participants who had histories of incarceration as well as those who did not. Fear of loss of a child due to a child welfare action was voiced by study participants who had histories of involvement with child protective services, as well as those with no history of involvement. There was no clustering of specific fears among women with the same primary drug of abuse.

Issues about the stigma associated with disclosure followed women into recovery as well. One woman reported that she was not fully forthcoming about her addiction history with her prenatal care providers even though she was attending prenatal care from the treatment program. In one community, countywide circulation of "the list" of methadone maintained women and those with prior loss of a child through adoption was perceived by one study participant as a monitoring and controlling tool and

contributed to the fear of presenting for care. Yet, in conversation with a colleague in that community, the "list" was described as a therapeutic tool of the clinical team for purposes of identification and casefinding. However, in the narrative of one study participant (Celia), a child welfare worker explains the "list" and its accompanying automatic referral for foster placement of the newborn: these actions are not based on current conduct, but past behavior.

In a climate of fear, distrust and punishment, serious ethical conflicts are created when the role and clinical practice of the helping professional shifts from one of beneficence to one that is threatening and punitive. These actions by health care providers reduce and destroy the trust of their patients, the cornerstone of ethical practice in nursing and medicine. Punitive actions hasten the "flight from care" (Poland, Dombrowski, Ager & Sokol, 1993), thus diminishing positive benefits that could be accrued by the women and their infants through continuing prenatal care and substance abuse treatment during pregnancy.

Individuals' negative care-seeking experiences (of the past and present) also influence their choices and actions in future pregnancies. There is a wider impact as the re-telling of these experiences by active members of

the drug-using community informs "indigenous knowledge" (Atkinson, 1998) within that group of women and men and wields influence in the care-seeking behaviors of other pregnant drug dependent women.

Perceptions of Sources of Help

The women's stories vividly illustrate Thomas and Thomas' (1928, p. 572) observation that if people "define their situations as real, they are real in their consequences." The women's *perceptions* of these helping institutions caused them to flee from care. However, their perceptions were also based on a lived reality. The actual actions and words of staff in these helping institutions were substantially negative and counter-therapeutic such that the women's subsequent behavior could be construed as legitimate and reasonable. If pregnant drug users believe that sources of help are more injurious than assistive, more discouraging that facilitative, it is likely that care will be disrupted or avoided altogether.

In this study, the significance of perception is underscored as definitive in the women's help-seeking behavior. The Health Belief Model (HBM) (Rosenstock, 1966) and its critical conceptual element of perception have relevance to the findings of this study and current discussion on help-seeking behaviors. The HBM hypothesized that actions related to health

depend on an individual's perception of the remedy as beneficial to them (Rosenstock, 1966). In this study, perception was definitive in influencing the help-seeking actions of study participants. The perception of extrinsic barriers led to a judgment by study participants that the process of seeking the "remedy" was unsafe. The findings of this study support other research on fear as an extrinsic barrier for pregnant drug dependent women (Poland, Dombrowski, Ager & Sokol, 1993; Sheehan, Oppenheimer & Taylor, 1988; Leppert, Partnert & Thompson, 1996).

The Enterprise of Detection and Threats

Although the women had heard from drug-using associates that positive test results could lead to losing their babies, health care providers lent "official" affirmation as they threatened, cajoled and predicted custody outcomes in light of positive drug tests. Statements to that effect from providers were commonly heard: "after the third dirty test, you will lose your baby" or "if you test dirty, you will lose your baby" or "if you don't stop using, you will lose your baby." Drug testing was rarely utilized in the context of a therapeutic recovery-oriented intervention and threatening statements to the women served to increase ambivalence and fear about participating in care. When referrals to substance abuse treatment were made

by prenatal care providers, they also included threats regarding the loss of child custody if they did not stop using.

This integration of threats and non-therapeutic use of drug testing into providers' approaches in working with drug dependent pregnant women wastes important (and perhaps only) occasions to conduct a therapeutic intervention. During such a narrow window of opportunity, the use of drug testing as the singular diagnostic tool is misdirected, as it replaces the therapeutic relational aspects of one-on-one interaction during a physical exam and patient interview and assessment. The very time at which health care providers' compassionate understanding and help was critical to the course and outcome of the woman's pregnancy and recovery was the very moment that health care providers withdrew. They failed to act therapeutically, falling back on punitive statements and threats as their primary tools for addressing perinatal substance abuse.

Effects of Gender and Addiction

Gender and "meanings that congeal" (Casper, 1997) around pregnancy and women's responsibility for childrearing combined with the status of addiction to evoke a particular set of socially constructed responses and conditions. These responses and conditions, which acted as barriers to

treatment for study participants, included program-based policies as barriers, the status of opiate dependency, the status of pregnancy, and influence from partners.

Program-Based Barriers

Program-based barriers that obstruct treatment entry may be the result of insufficient financial resources or knowledge, exclusive admission criteria, staff-client mismatches, or public policies that restrict access. There were two program-based barriers described in this study: 1) limits on the number of children who could accompany their mothers to treatment, and 2) pre-admission requirements imposed on the women. Neither of these program-based policy barriers were identified by Allen (1995) who found only that lack of available space for admission was a barrier to substance treatment for non-pregnant women.

In this current study, limits on the number of accompanying children, primarily the result of funding deficits for staff and space, imposed wrenching conditions on admission for women. Some women were able to place children with a family caregiver for the duration of their treatment stay; yet, others did not have family able or willing to assume such a responsibility. While the development of gender-specific residential

programs for women and their children reduced barriers to treatment entry for some women (Brindis, Clayson & Berkowitz, 1995), the dearth of these programs and the usual one-child limit still blocked treatment access for any woman with more than one child. Age limits on the accompanying child (usually 0-3 years) added another barrier for women with older children.

Women with multiple children who entered treatment did so under a burden of guilt as they had to choose which child to take with them. Male models of recovery, reinforced by affirmations of individual responsibility for addiction, would classify this emotionally anguished situation as the expected "wreckage of the past" or the expected "consequences" of addiction. Yet, under these circumstances, a form of socially constructed guilt, forced by a limitation in the treatment system, further punished the women and their families for their disease. As in other studies, inadequate childcare has been continuously cited as a barrier to treatment for women with children (Grant 1997; Copeland, 1997; Anonymous, personal communication, April 5, 2001).

The other program-based policy barrier was pre-admission requirements. These requirements, purportedly imposed to evaluate treatment willingness and motivation, were highly risk-laden for study

participants. In this study, alcohol and drug dependent pregnant women were instructed (in person and over the phone by non-medical staff) to "detoxify" for a minimum of 48 hours or "until symptoms subside." In other cases, opiate dependent women were instructed to stop using heroin, go through withdrawal on their own and subjectively evaluate their clinical need for methadone. Admonitions such as these not only obstructed treatment entry, but posed serious physical risks to the woman and her fetus. Because drug withdrawal has it own inherent risks (e.g. preterm labor and delivery, intrauterine fetal and maternal seizures), medically managed detoxification, which may include fetal surveillance, is indicated (Wong, 1992). Advising women to go away, detox and then come back is a form of clinical malpractice, given the probable poor medical status of the woman and the risks inherent in that situation. Additionally, this advice discouraged and confused women who got as far as contacting the treatment program, were ready to admit themselves and were then told their admission will be delayed. Evidence suggests that prompt assessment and intake procedures facilitate quicker entry to treatment (Festinger, Lamb, Kountz, Kirby & Marlowe, 1995). For pregnant women, an immediate response aimed at

rapid admission is even more critical for the health of the woman and her fetus.

Other reasons for this pre-admission practice included the absence of health professionals in social model programs and outdated views of treatment and recovery stuck in the ideology of male models of treatment from the 1940's (Roth, 1991). In many regions, collaborative inter-agency models of care composed of all the critical elements of a continuum of care (including emergency medical and psychiatric evaluation and treatment) for pregnant addicts do not exist. Individual programs that have acknowledged the acute need for this type of support before and during treatment have sought short-term grants and hired their own physicians and nurse practitioners (V. Smith, personal communication October 15, 2000; R. Schank, personal communication, November 1, 2000). Rarely are perinatal treatment systems, medical and emergency services coordinated for case management and communication for therapeutic purposes. In regard to pregnant women, uninformed about the need for addicted persons to "hit bottom" or "face the consequences" (i.e. experience withdrawal no matter the severity) persisted within the perinatal treatment community and were a particularly pernicious form of "therapy" as humane treatment was withheld.

The Status of Opiate Dependency

In most areas of California, methadone maintenance (MM) among pregnant women (and non-pregnant woman and men) can exclude persons from residential treatment. Because there has been some degree of change in the admission policies of residential perinatal providers in northern California, there are a limited number (<6) of perinatal programs that will admit women on MM. Study participants' status as pregnant women on MM conferred barriers that disrupted and delayed treatment entry.

These barriers included the aforementioned delay in admission with advice to self-detox, medical mismanagement and misdirected child welfare mandates relative to MM participation. Of the four study participants on MM, one had a positive toxicology test at delivery after using a controlled substance to self-manage withdrawal symptoms in order to comply with the detox requirement for residential admission. As a result of this positive test, child welfare placed her infant in protective custody, in part because she had no safe place to take her child. The other three women reported methadone dosing problems including over-sedation, precipitous iatrogenic withdrawal, other erroneous physician prescribing practices and mismanagement of tapers during their pregnancies. Three of the four women did not understand

the neonatal effects of prenatal exposure to MM. These unanticipated (by the women) effects in the newborn, a source of great emotional distress, undermined trust in MM providers and obstetricians. The lack of education of the women further eroded their confidence in providers when their infants experienced severe neonatal abstinence and extended hospital stays.

One postpartum woman on MM was negatively portrayed as an active drug user by child welfare in a custody proceeding because she was enrolled in MM (and was abstinent from other drugs and participating in treatment). Child welfare attorneys recommended to the court that reunification services be denied because participation in MM was viewed as a liability for positive mothering and not as a legitimate form of treatment.

Federal Medicaid (dubbed "Medi-Cal" in California) policy regarding MM was a special dilemma for one postpartum opiate dependent woman and she described what happened when her infant was placed in foster care. Women whose infants are placed in foster care, are commonly required by child welfare agencies and family courts to continue drug treatment as a condition for reunification. Yet, under current Medi-Cal policies, individual Medi-Cal insurance is terminated if the woman's infant is placed in foster care. With the loss of a third party payor, MM programs institute a rapid

administrative taper and terminate the client from MM treatment, thus ensuring the woman will not be reunited with her child.

The treatment of opiate dependency in pregnancy is documented and clearly understood (Finnegan, Hagan & Kaltenbach, 1991; Jarvis & Schnoll, 1994): MM has been shown to increase years of survival and quality of life and decrease HIV transmission (Zaric, Barnett & Brandeau, 2000). Benefits of the use of MM during pregnancy include lifestyle stabilization (Jarvis & Schnoll, 1994). Stabilization could allow for participation in HIV preventive chemoprohylaxis, now known to significantly reduce rates of vertical transmission of HIV to the newborn (Connor, Sperling, Gelber, Kiselev & O'Sullivan, 1994). However, on-going misunderstandings and misinformation in the medical, treatment and legal community continue to prevent the appropriate and therapeutic use of methadone (Zweben & Sorensen, 1988; Koch & Banys, 2001).

The Status of Pregnancy

Pregnancy itself was a barrier to drug treatment as it confirmed a particular stigma on study participants. In addition to evoking stigma and its resultant punitive responses, the status of pregnancy also led women into circumstances and conditions noted above that made the task of treatment

entry and participation more tenuous. The women were vulnerable to entrenched service delivery systems and staff's lack of knowledge as well as the vagaries of financial policies.

In the context of weakened public policy in support of drug treatment for pregnant women and limited advocacy, substance abuse treatment programs excluded pregnant women on the claim that they didn't "have appropriate services." Even programs that purported to serve pregnant women and women with infants often struggled to accept and integrate a woman on medically indicated bedrest, to provide transportation to prenatal care and to serve nutritious meals.

Partner-based Barriers to Care

Findings in this study affirm the negative influences of male significant others in female partners' help-seeking. Similar to findings by Amaro and colleagues (1990), the power dynamics of domestic violence described by study participants, in combination with partners' substance abuse, led to circumstances that made disengagement for the women very emotionally and financially difficult. Financial dominance by male partners was a common feature of relationships, though the women were often the moneymakers. Study participants who were married or living with a partner

were also usually primarily responsible for the care of children. Rarely were male partners charged with childcare duties and rarely were partners the identified client in child welfare proceedings.

Some of the participants entered treatment in part also to flee abusive relationships and "start over." In examining women's treatment readiness, Brown, Melchoir, Panter, Slaughter and Huba (2000, p. 231) noted, "women in battering relationships may be ready to make changes to reduce their exposure to violence before admitting readiness to seek substance abuse treatment." Among the women who were subjected to physical, emotional and sexual violence by partners, these findings suggest that safety for the women and children and relief from abuse was part of the motivation for treatment.

Embedded Barriers: Homelessness, Poverty and Incarceration.

Study participants endured deprived and frightening life conditions due to poverty and homelessness. Low socio-economic status and the lack of social support were definitive in assuming help-seeking activities because resources were remote and material options extremely limited. The conditions in which many of the women lived demanded that the women be primarily occupied with daily survival for themselves and for their children.

These factors of poverty and homelessness, devastating in their impact on the women and children, have become commonplace among drug dependent persons in the U.S. (Zuckerman & Frank, 1992; Harrison, 1991). These contextual factors, embedded so deeply in the lives of the women, are highlighted here as to render them visible and meaningful for a deeper understanding of the women's experiences.

Study participants who were in jail during their pregnancies were incarcerated for an average of 10.5 weeks, almost one-third of their pregnancies. Among these women, the range of time spent in jail was 4 to 24 weeks, valuable time in the narrow window of therapeutic opportunity. Since all of these women were charged with drug-related offenses, it was clear to judges and law enforcement that these were drug dependent women who were also known to be pregnant (with the exception of three who were subsequently diagnosed by jail medical services). Yet, treatment options were not offered until a significant number of weeks of pregnancy had been spent in jail.

There is no evidence from this study or past research that incarceration for pregnant drug-using women has deterrent or rehabilitative benefit for long-term recovery in addiction or future commission of crimes.

As noted by King (1991), incarceration may actually present other risks to the fetus. Though one woman described the housing conditions of incarceration as adequate, the other women spoke of jail overcrowding, 22 hour a day cell confinements, active drug use and drug sharing by prisoners, non-nutritional food and separations from their children placed in foster care. One study participant noted that an advocate inside the county jail where she was incarcerated approached her for post-release planning. However, he was not legally able to talk with her until 90 days prior to her planned release date, i.e. treatment options are offered only after sentences have been served.

Treatment Readiness and Motivation

In the present study of extrinsic barriers, interviewing a sample of women who succeeded in treatment entry yielded particularly salient findings on treatment motivation and factors that contributed to their readiness. Treatment readiness has been construed to be a person's individual motivational status in terms of levels of admitting a problem and the desire to seek, enter and stay in care (DeLeon & Jainchill, 1986). Brown and colleagues, in response to conventional "Stages of Change" models (Prochaska &DiClemente, 1983) propose a gender-specific "hierarchy of

readiness" wherein they assert that help-seeking behavior in addicted women is based on the immediacy of their treatment issues (Brown et al., 2000, p. 231). In their work, a series of logistic regression analyses predicted entry into separate varying treatment modalities based on which issue was seen by the women as most immediately urgent (domestic, violence, HIV sexual risk behavior, substance abuse or mental health). Brown and colleagues state, "The results of the present study appear to support the hypothesis that women do not have a generalized pattern of readiness to change...that they have multiple needs and pressures, and they may be ready to change some areas, but not all, at any given time" (p. 238).

The work of Brown and colleagues (2000) has particular relevance for the present study. They posit that women's readiness for treatment is a function of their feelings about an area of their lives that they define (and therefore act upon) as most urgently requiring attention and change. This view of a woman's hierarchy of needs is in direct contrast to the work of Allen (1994b) wherein women's selection of drug detoxification alone was not viewed as a form of treatment and women who sought drug detoxification were therefore classified as "not-in treatment."

In this current study of pregnant drug dependent women, readiness

for substance abuse treatment was motivated by the universal desire to keep custody of their children. In this regard, readiness resulted in going into a program that they (or others) designated as leading to that end. This was specifically demonstrated by the women's actions and creative coping strategies as described in the previous chapter. Therefore, these findings support the work of Brown and colleagues (2000) and define a gender-specific domain of readiness among women: motivation to change for the purpose of keeping child custody. Among this sample in this study, family cohesion was a clearly stated, conscious and designated goal for pregnant and parenting addicted women.

The current social construction and representation of pregnant drug dependent women has especially relied on portrayals of them as uncaring and unfeeling toward their children. Belief in these stereotypes has affected health policy formulation, judicial decision-making, and treatment planning on perinatal addiction. However, findings from this study suggest that the desire for child custody and family cohesion is a priority and highly motivating as to cause women to seek treatment despite extrinsic barriers they defined as distinctly threatening to their safety and autonomy.

In light of those threats and other fixed extrinsic barriers, successful

entry to treatment must be equated with a high degree of motivation for, and caring about, their children. Motivation to keep custody then takes on a new meaning: the potential center of the initial therapeutic alliance, a source of motivation toward treatment and a porthole leading to the beginning of personally owned recovery that can extend beyond the role of motherhood. In light of these descriptions about the women's struggles with extrinsic barriers and adaptive behaviors, we are also lead to a re-conceptualization of what has been called "delay."

Delay

Delay in entering substance abuse treatment has been variously described as passive waiting, denial of addiction and an indication of character defects in the addicted individual (Dahlgran & Myred, 1977; Jordan & Oei, 1989; Pringle, 1982). In this study, descriptions of the women's adaptive strategies illuminated their activities in the time before treatment. This period was characterized by multiple struggles with the self, with partners, with providers, and with unknown institutions. In addition to managing their survival, the women spent time deliberating about going in or not going in for care. Faced with what they perceived as seriously dire consequences if their drug use was disclosed, they weighed options and

outcomes. During this time, they also took care of children, immediate and extended family members, partners and themselves.

Relative to the pregnancy, their entry to prenatal care and substance abuse treatment was indeed delayed. However, in a re-conceptualization of delay, the activities described by the women represent a gender-specific struggle in the process of treatment readiness for pregnant drug dependent women. In the context of punitive extrinsic barriers as described, delay became an active and protective strategy, one that was appropriately adaptive under the circumstances.

Since the women cited the desire to keep custody as their main motivation for entering treatment, it would seem that threats and warnings about loss of custody might serve as motivating. However, findings from this study suggest that punitive actions such as those were de-motivating as they instilled distrust and therapeutic ambivalence and eroded the alliance with helping professionals. This erosion of trust and confidence in providers contributed to delays in care-seeking.

One objective of research on extrinsic barriers to treatment is to affect earlier entry to treatment for pregnant women. Though this sample of women ultimately made it to treatment, entry in the first trimester of their

pregnancies could have prevented numerous medical and social consequences and complications for the women and their children.

Institutional Readiness

As a result of the findings of this study, institutional readiness emerges as another factor in delay and care-seeking behavior in pregnant drug dependent women. In their model of treatment utilization, Beckman and Kocel (1982) cite "service delivery system characteristics," and "access in the initial encounter" as influential in help-seeking. These aspects of the model are very relevant to the present findings, yet Beckman and Kocel's model examines structural barriers such as staff composition and agency services. Although they do also include "individual beliefs" (of the client), these are limited in that they are defined as being about alcohol, health and treatment. Beckman and Kocel's model was historically seminal in its rupture of traditional notions of "responsibility" for treatment entry because it included "service delivery system characteristics." As early feminist alcohol researchers, the creation of their model served not only as a critique of the existing system of treatment, but as a template for evaluating a future system which they envisioned as adequately responsive to the gender-specific needs of women.

Their model, however, does not fully account for the relational aspects of women's lives and the power of dynamic personal interaction within those care-seeking experiences. In findings from the present study, health professionals utilized punitive strategies amidst a climate of antipathy, and said and did things that caused the women to be highly fearful and ambivalent about care. The absence of institutional policy and a state of readiness on the part of institutions to provide safe, confidential and appropriate medical and psychosocial services constituted a critical factor in treatment utilization as well.

Therapeutic responsiveness of institutions must therefore be taken into account in examining delay and readiness for treatment among pregnant drug dependent women. The attitudes, actions and policies of personnel in clinics, hospitals, child welfare, law enforcement and treatment programs form a collective community index of institutional responsiveness to pregnant addicts. This index, as findings from this study suggest, has impact on delay and in turn, on women's readiness to seek care.

Quantitative instruments such as the ABTI (Allen, 1994) cannot capture the dynamic process of individuals interacting with institutions, even though Allen constructed the ABTI to account for social conditions,

individual variations in women's perceptions, and disparities in institutional responses. Other measures of treatment readiness and motivational status have also excluded the invisible effects of policy, stigma, loved ones' resistance to treatment, and other extrinsic environmentally located barriers to individual motivation (McConnaughy, Prochaska, DiClemente,& Velicer, 1989; DeLeon & Jainchill, 1986). These definitive qualitative experiences illuminated defining moments in care-seeking among pregnant drug dependent women and have clinical and policy-based implications for change.

Impact of the War on Drugs

The study findings describe the gendered psychological and social impact of two decades of the U.S. War on Drugs. Near the beginning of the War on Drugs, U.S. government anti-drug strategists characterized drug use in America as "a crisis of authority." Drug use was described as amoral behavior that destroys character, values, and relationships with others including God (National Drug Control Strategy, 1989). One continuing theme of the legacy of U.S. drug policy has been a focus on the individual drug user with attribution for addiction being moral and characterological failings.

Tactics used in waging the particular campaign against pregnant drug-using women have included vilification, prosecution and incarceration of the individual user, fetal protection initiatives, suspension of parental and reproductive rights and the creation of punitive health and public policies (Siegel, 1994; Garcia, 1993; Roberts, 1997). Public media, law enforcement, ethicists, health professionals and child welfare experts have further condemned these women as "bad mothers" who are not worthy of treatment or the custody of their children. Though recently discredited, scientists and scholars also have provided ample evidence of the damage to the fetus and to children they contend was singularly caused by women's prenatal use of drugs, primarily cocaine (Frank, Augustyn, Knight, Pell & Zuckerman, 2001; Lyons & Rittner, 1998). Women of color have been particularly vulnerable to these charges (Chasnoff, Landress & Barrett, 1990; Jos, Marshall & Perlmutter, 1995).

This multi-level punitive campaign has resulted in a seepage of attitudes and tactics of the War on Drugs into the current clinical approaches of health care and child welfare institutions to such an extent that health care providers and child welfare personnel now focus on detection and threats of punishment in the performance of their missions of health care and child

protection. While the full impact of punitive sanctions against pregnant drug using women is yet to be explored, study participants' stories provide insight into the ways their lives have been negatively affected by the punitive stance of these institutions and how these tactics have constructed an adversarial climate for treatment-seeking.

As noted by Kaskutas, Schmit and Weisner (2000, p. 329), the use of key informants such as these can elucidate "how barriers to treatment access are erected." Health care institutions have traditionally been viewed as helping agencies. Child welfare agencies facilitate child protection and offer support services to families, yet they may be more aptly described as agencies for social control. The narratives of the study participants describe these barriers and the transformation of helping resources into what has become primarily a monitoring and detection enterprise. As described by Chavkin and Breitbart (1996), moral and ethical conflicts emerge when sources of help come to be viewed by patients as dangerous and threatening. Socially located responses to the women's gender in combination with addiction also created barriers to care. The women responded to these changed social conditions for care-seeking with their own adaptations aimed at the goal of keeping custody of their children. Insights into these socially

constructed extrinsic barriers to care suggest new perspectives on the treatment-seeking experiences of pregnant drug dependent women.

Significance

Study participants provided "thick descriptions" of extrinsic barriers to treatment including their fear of disclosure of their drug use during pregnancy, fear of arrest and incarceration and fear of loss of their children. Other extrinsic barriers described by the women included substance abuse treatment program-located barriers, the status of opiate dependency during pregnancy, partner-located barriers and the status of pregnancy itself. In some cases, these barriers delayed entry to care. In other cases, they prevented women from seeking care at all during their pregnancies.

These results illuminate the experience of using drugs while pregnant during an historical era characterized by medical-legal interventions aimed at punishing this class of women. The women's gender, and "meanings that congeal" (Casper, 1998) around pregnancy and addiction evoked a particular set of socially defined responses from health care and treatment providers. The women's stories describe their perceptions and the meanings of those responses and explain how their perceptions affected their subsequent help-seeking behavior. The stories are about the women's beliefs about what

could happen and their experiences of what did happen to them when they sought care for pregnancy or for drug treatment.

Limitations of the Study

In this study, the technique of purposive (or theoretical) snowball sampling was utilized, wherein study participants were sought who would be able to directly address the intent of the study. While a critique of sampling bias could be made, this sampling strategy is the very purpose and intent of qualitative methods (Morse, 1989). Theoretical (or purposive) sampling, which ensured appropriateness of the sample, necessarily limited the breadth of the data.

In this study, sample selection was limited to women who were ultimately able to overcome extrinsic barriers and enter residential treatment. While this provided a unique perspective, interviewing out-of-treatment women who are or were recently pregnant would have provided greater breadth to the data. All study participants, with the exception of one, sought prenatal care. To identify variations in known or new barriers, it would be useful to interview drug dependent women who did not participate in treatment or prenatal care for the duration of their pregnancies. The study could also have been enriched by the inclusion of a greater number of Latina

and Native American women, a more even distribution of study participants by ethnicity and inclusion of a greater number of HIV- positive women. The presence of dual diagnoses among the study subjects was unknown. The use of psychometric instruments for determination of measures of depression or other affective disorders may have also enhanced the breadth of findings from this study.

One limitation of snowball sampling is the loss of control over the sampling process experienced by the researcher. In this study, initial recruitment went very slowly (four participants in the first month) and then as word got out to women in the facilities, suddenly 18 subjects were recruited from two facilities over a three day period. While not all of those ultimately participated and the researcher proceeded slowly into the interview process, the effort to carefully evaluate content of the data for theoretical directions and selection of subtypes of participants was challenging.

The interviews were conducted in the treatment programs and this may have limited the tone and content of the data; it also limited the time spent with study participants, as there was never sufficient time to explore all the issues raised. Two interviews with each participant would more

adequately have captured the vividness of their stories. Conducting the interviews within the program also influenced, and may have limited, participants' responses due to the philosophical intensity of the milieu. Personal responsibility for addiction is so emphasized in the treatment approach in these residential facilities, that it is questionable whether women would raise issues related to the influence of others, social factors or other concerns they had about social systems and other disincentives to treatment entry. Positive parenting, ever under scrutiny, was constantly discussed and under examination in the lives of these women. Therefore, any feelings of ambivalence about mothering or about their children may have been withheld as well. Also, as participation in the study required comfort with a verbal interview, participants were only those women who were willing and able to talk to an English-speaking stranger. On-site observation in the treatment settings would possibly have enhanced the findings.

The mean time of sobriety for the study participants was 18 weeks. Interviewing women further along in the recovery process may provide a greater breadth in the data. Preoccupation with significant events (e.g. about to learn of a custody decision, recently reunited with child, praised by program and fellow clients or recent relapse) also influenced the content of

the women's stories and may have prevented them from expressing other feelings they did not report.

The researcher is the instrument in qualitative research, and as a result the way in which questions were asked, my style of interviewing, my ethnicity and age and the fact that I am a nurse influenced the interactions with study participants. As findings accrued about the participants' lack of trust of health professionals, it seemed possible that they may have "screened" their responses to my questions.

Coding the data alone and formulating interpretive opinions from the data as a solitary enterprise had its drawbacks. The solitary endeavor was also antithetical to my social process on the topic of perinatal addiction issues. Authenticity of my conclusions was provided by study subjects, peers and treatment program staff. Yet, the sheer emotional weight of the women's experiences and the research objective of witness and conveyance of their struggles weighed heavily. Omissions, interpretive gaps in understanding and other inherent limitations of the single researcher could be diminished by use of a team approach wherein colleagues are united by philosophical kinship or diversified by varying points of view. While confidence in my

individual perspective and interpretive stance is great, the use of a team may have led to a deeper level of analysis and served the women more fully.

Finally, transferability of the findings of this study depend on future investigators' ability to accumulate empirical evidence about the similarity of their research context to the one of this study (Lincoln & Guba, 1985). History, regional policies regarding perinatal addiction, and the existence and accessibility of treatment in a community will influence the ability to generalize from these results.

Implications of Research Findings

Clinical Practice

These research findings suggest the need for provider education on clinical interventions to facilitate early entry into prenatal care and substance abuse treatment for pregnant drug-using women. Therapeutic clinical practice is likely to be achieved in settings and communities that are supportive, in principle and practice, of treatment and recovery for addicted pregnant women in lieu of punishment. In this regard, regional public policy that embraces a therapeutic approach can also encourage individual clinical settings to follow suit.

Education

Regarding education on best practice standards, particular attention should be paid to the appropriate use of MM during pregnancy. Continued misunderstandings among law enforcement officials, judges, child welfare and the medical community, put pregnant women and their infants at risk. Inter-agency memoranda of understanding and on-going interdisciplinary education should be implemented such that the appropriate use of legally prescribed MM is never viewed as a liability to opiate dependent pregnant women or their children.

Education for nurses and other health professionals should focus primarily on the dynamics of addiction and how to engage drug-using women into prenatal care and drug treatment in such a way as to capitalize on women's motivation during pregnancy. Findings of this research indicate that pregnant women have fears about disclosure of their drug use and therefore, methods that foster trust and safety are needed in clinical settings. Any clinical contact with pregnant drug using women should be viewed as a crucial opportunity to begin assessment of medical and psychosocial issues, establishing trust, explaining prenatal care and treatment options and planning return visits.

Standards of Practice

Standards of practice in the treatment of pregnant drug using women have been defined by practitioners, researchers, advocates, and the federal government (Edelstein & Kropenske, 1992; Camp & Finkelstein, 1995; CSAT, 1993; Jessup & Soman, 1994). These role-specific best practice standards should be fully implemented and monitored by nursing management in all obstetric, emergency room and community based public health nursing settings.

Disclosure

Tactics for safe disclosure about drug use during pregnancy can be borrowed from selected models of domestic violence interventions in health care settings (R. Whiteman, personal communication, May 7, 2001). In that regard, front line nurses and physicians can communicate that the clinic or other setting is a safe place, e.g. by wearing lapel buttons that say: "If you're using drugs, it's safe to talk to me." Nurses and other prenatal staff should be educated about therapeutic language in order to elicit drug histories, reduce stigma and foster therapeutic alliances with women. Drug-exposed newborns should not be referred to as "dirty" as this conveys negative meanings and values to the mothers about their infants that enhance the

shame and stigma of addiction (M.L. Ellis, May 1, 2001).

Drug testing, one tool in the assessment of addiction, should be used for diagnosis and therapeutic purposes. Threatening, cajoling or predicting outcomes on the basis of positive toxicology testing creates a hostile health care environment, reduces compliance and may drive women away from care. Full-screen testing, which includes checks for alcohol and benzo-diazepines, should be carried out when testing is done. Again, public policy support of aforementioned clinical practices should actually be in effect prior to offering this level of safety to pregnant women.

Interdisciplinary Collaborations

A public health response to perinatal addiction is one that demands a collaborative, multi-agency effort. Articulated public policy on the efficacy of treatment removes role conflicts and clinical practice dilemmas and establishes clear guidelines and clinical pathways for health care providers. In some cases, health professionals' appropriate and therapeutic practice may run counter to local law enforcement and child welfare policies. Nonetheless, modeling a standard of practice and advocacy for institutions and local policy-makers has other benefits, including improvements in patient-provider trust and positive relations with the community of addicted

women.

Collaborations between researchers on perinatal treatment issues and a community-based network of perinatal providers is indicated. This type of process has the potential for mutual enrichment and information on salient issues needing attention from providers and from researchers (Sorensen & Midkiff, 2000; Lindsay & McGuiness, 1998).

Role for Nursing

Nurses have primary roles in educating, assessing and case managing pregnant drug dependent women, and are therefore in key positions to have positive therapeutic relationships with drug dependent women at many points during their childbearing experience. Nurses also have physical access to these women through public health nursing initiatives of home visitation and community-based clinics (Littman & Ritterbusch, 1997). Findings from this research also suggest a critical role for nurse advocates in conducting outreach to homeless women, assisting women in locating treatment referrals, educating about the effects of drug exposure in the newborn, and extending hope and other forms of help to these women. Nurses can also provide leadership in interdisciplinary efforts to move agencies, institutions, communities, and government toward public policy

with authentic therapeutic value. All of these clinical activities should be viewed as strategies for harm reduction.

Health Policy Issues

Public Dialogue

Renewed public discourse on perinatal addiction and the elements of bona fide assistance to this population of women is indicated. Within the confines of a continuing national War on Drugs by the Bush administration, advocacy and treatment must continue to be the essential elements of humane treatment for this population. John. P. Walters, recently appointed by President Bush to the position of drug czar, denounced the "therapy-only lobby" in Washington, D.C. and noted that prison sentences are a key element in responding to the problem of drug use in the United States (New York Times, 2001). However, recent developments in research, legal decisions, and drug policy are indicative of increasing support for treatment and should be platforms for the expansion of the current treatment system and location and development of therapeutic options within the criminal justice system (Frank et al., 2001; Ferguson v. City of Charleston et al., 2001; Metsch, McCoy, Miller, McAnany & Pereyra, 1998).

The national substance abuse treatment budget allocation for fiscal

year 2002 is $2 billion, an increase of $100 million over the 2001 budget (SAMHSA, 2001). While this budget appears substantial, it remains to be seen if government will direct these funds to support public sector treatment initiatives and other therapeutic endeavors. Therefore, at this time, there is a need and a distinct role for leaders in nursing, medicine, and treatment to assert a therapeutic agenda nationally and locally that can appropriately utilize these allocated funds.

This dialogue should engage health care systems, child welfare, law enforcement, the judiciary, and alcohol and drug treatment systems. The dialogue should focus on a re-examination of the goals and outcomes of current policies of hospital-based interventions, drug testing, prosecution, incarceration, child welfare concurrent planning, and the use of appropriate standards of care in these settings. Interventions that seek to focus on building therapeutic relationships with pregnant drug dependent women and those that acknowledge the need to work rapidly within the narrow window of opportunity of pregnancy should be reviewed and disseminated as part of a standard of practice agenda.

Collaboration of Systems for Care

Perinatal addiction is multi-faceted problem and as such requires an interdisciplinary response. Those needing education about perinatal addiction include judges, child welfare workers, health professionals, the treatment community, public defenders, and county and state officials in alcohol and drug programs. Nurses should initiate partnerships between county and state offices of alcohol and drug programs and nursing and medical communities and addiction specialty societies for on-going education and consultation initiatives on perinatal addiction with an emphasis on MM during pregnancy. Nurses within these partnerships should identify and establish local primary care referral mechanisms so early entry into treatment via prenatal care can be facilitated.

Current changes in the treatment system, such as the California Proposition 36 (initiative for voter-supported treatment in lieu of incarceration) offer unique opportunities to establish interagency cooperation and to address the long-term sustainability of perinatal treatment programs. Welfare-to-work initiatives, emanating from county and state departments of social services should also work directly with the treatment community in order to protect treatment and recovery efforts of recovering women who participate in these welfare-to-work programs. Multiple

demands on women participants may act as barriers to treatment continuation and long-term recovery (Metsch et al., 1998; California Institute for Mental Health, 2000).

An additional objective of inter-agency collaborations should be the re-examination of clinical practices and policies, as well as pregnant addicted women's perceptions of agencies and institutions, in order to identify barriers to treatment. Programs and agencies need to examine current practices in light of these findings. Remedies include full resolution of conflicts (on a per-agency basis) about treatment vs. punishment of these women, adoption of clear policies on the intent of services and an overhaul of the current "public relations" with the community of drug dependent women.

In terms of other collaborations, similarities between the health-related issues of domestic violence and perinatal addiction are strong. Advocates within the women's addiction treatment community would do well to learn from the family violence prevention community's funding strategies, public information campaigns and health professional education and support. Domestic violence prevention advocates would do well to examine their own beliefs about addicted women and expand prevention and

research activities to openly include the issues and concerns of women with alcohol and drug problems.

Advocacy

Advocacy on behalf of pregnant drug dependent women can be conducted by individuals, organizations and government. Active advocacy includes a focus on clinical practice, expansion of the treatment system to further meet the needs of women, and legal issues surrounding drug dependent pregnant women. With regard to clinical practice issues, a women's health model of care, emphasizing health care across the life span, is indicated for drug dependent women (Woods, 1988; Star, Lommel & Shannon, 1995). That model guarantees access to all services and treatment options regardless of diagnosis or health insurance status (Taylor, 1993).

Substance abuse treatment programs that serve women and their children should be protected from budget cuts in the coming era of government withdrawal of public funding for treatment. Threats to public funding of substance abuse treatment due to shifts from federal to state responsibilities for budget allocations as well as cost-containment initiatives may soon limit women's access to care (Chavkin, Breitbart, Elman & Wise, 1998; Chavkin & Breitbart, 1997). The move in methadone maintenance

treatment from publicly supported to privately owned programs also increases the risk of harm as publicly supported treatment is lost and clients drop out (Rosenbaum, Washburn, Knight, Kelley & Irwin, 1996). Nurses and others knowledgeable about drug dependent women need to work with community agencies and with government to secure the right to treatment and full access to care.

Legal advocacy is needed for this population of women primarily in regard to issues of parental rights. In the current study, the women's fears of child welfare actions were based on accurate understandings of complex child welfare policy. Since 1998, child welfare agencies in California have adhered to a model of services planning for drug-exposed infants called "concurrent planning" (California Department of Social Services, 1998). In this model, child welfare workers develop two services plans: one for retention of custody in the context of maternal recovery and compliance, and a second plan (after maternal failure) for permanent severance of parental rights and adoption. Within concurrent planning policy, courts may act to permanently sever parental rights within six months of the birth of the child if the drug-using mother had two prior children placed for adoption. Regarding due process in the child welfare system, parents with psychiatric

conditions have legally mandated rights to due process in the provision of reasonable efforts by child welfare agencies in assisting clients to demonstrate their abilities to parent (National Council of Juvenile and Family Court Judges, 1992). These same regulations and rights to due process and treatment participation for addicted parents have recently been curtailed by concurrent planning legislation and the diminishing social stature of parents with histories of alcohol and drug problems (J. Ganz, personal communication, April 20, 2001). Legal services to these women have also been reduced as funding for legal services for the poor have been cut (U.S. Department of Justice, 1999). A climate that promotes the primacy of fetal rights is inherently threatening to the health and well-being and legal rights of pregnant addicts. Legal advocacy and advocacy for treatment is critical in these times.

In a period of legislative and policy attacks on women's reproductive rights, addicted women's behavior is more intensely scrutinized and their rights to treatment and custody increasingly in jeopardy (Roberts, 1997; Garcia, 1993). Yet, there is strong evidence for the efficacy of treatment (Brindis, Clayson & Berkowitz, 1995; Daley, Argeriou & McCarty; Egelko, Galanter, Dermatis & DeMaio, 1998; Strantz & Welch, 1995) and its

positive effects on family maintenance and enhancement of maternal knowledge and skills in childrearing (Tyler, Howard, Espinosa & Doakes, 1997).

Officials, specialized perinatal outreach programs, and treatment staff in all counties reflected in this study would likely characterize their counties as very much in favor of treatment in lieu of punishment. There has also not been a criminal prosecution of a pregnant addicted woman in northern California since the late 1980's. Yet, even in a region such as this with a general climate of acceptance and a treatment orientation, punitive practices persist as evidenced by the data from this study. Detection and discussion of all forms of those practices require consistent and active monitoring by advocates.

Treatment Program Responses

Substance abuse treatment programs and county-level drug program administrators should evaluate the effects of pre-admission requirements in terms of the impact on pregnant women's entry to treatment. Residential treatment providers should also evaluate the rationale for policies that prohibit women on MM from entering the facilities. Exclusion of opiate dependent persons from residential and other forms of treatment has been

legally construed as violation of the Americans With Disabilities legislation and could be grounds for litigation (Stoffel, 1992). County and other funding entities' support is needed to expand residential programs to include opiate dependent women through the use of additional treatment monies and the provision of appropriate education and medical consultation.

Additionally, MM programs should re-evaluate their quality of services to pregnant and parenting women. Not all MM programs want many pregnant women as clients. In MM programs where perinatal-specific programs have not been developed, staff are often reluctant to accept pregnant women due to the extensive services required by federal law, the level of staff expertise needed, the clinical complexity of problems and the extensive interagency collaboration and communication that is necessary. Often this reluctance is accompanied by the view that pregnant women are a "special population" and that pregnancy, a common aspect of women's lives and treatment needs, is nonetheless still deviant from the dominant culture (Reed, 1985).

While California's Medi-Cal reimbursement rates for MM for pregnant women are substantially higher than for non-pregnant women or men, culturally bound beliefs about the difficulty and aggravation of treating

pregnant women trump the financial incentives to "open the doors" to pregnant opiate addicts. Additionally, if a pregnant woman pays privately for her MM treatment and subsequently stops paying, she cannot by virtue of the pregnancy, be severed from care through an "administrative" taper for financial reasons. For these reasons, MM financial mechanisms relative to pregnant clients should be examined. County and state alcohol and drug program offices should examine the feasibility of designating certain MM programs as "preferred providers" for pregnant opiate dependent women.

Fetal Protection: Treatment During Pregnancy

Historically, fetal protection has been cited as the rationale for aggressive punitive interventions with pregnant drug-using women (Bragg, 1998; Horger, Brown & Condon, 1990). Yet, when instrumental approaches to perinatal addiction replace effective evidence-based practice, grave damage is done to the fetus and the woman. Under these circumstances, drug dependent women are fearful and less likely to have any treatment during the critical period of pregnancy. They are more likely (if they enter treatment at all) to be post-partum clients of law enforcement or child welfare agencies.

Though entering and staying in treatment after the birth can have

certain beneficial effects on the women and their children (Strantz & Welch, 1995; Stevens & Arbiter, 1995; Hughes et al., 1995), punitive policies diminish the opportunity for fetal accrual of benefits resulting from maternal abstinence. With more women entering treatment after giving birth than during pregnancy, the utility of treatment as a unique primary prevention tactic is lost. In that regard, fetal protection can only be achieved by means that are essentially therapeutic, offered in a clinical and legal context of maternal protection.

The preponderance of expert opinion (APHA, 1990; ANA, 1991; AAP, 1990), a recent Supreme Court ruling affirming fourth amendment protection (Ferguson v. City of Charleston et al., 2001), and research (Chavkin et al., 1998; Coles, 1993; Poland et al., 1993) assert the positive benefits of therapeutic, rather than punitive interventions for pregnant drug dependent women. In lieu of both medical and legal imperatives, fetal protection can only be legitimately pursued and achieved through maternal protection and only in the form that advocacy and treatment afford.

Maternal-child Separations

Temporary and long-term separation of mothers from their children was experienced by many of the study participants. Incomplete participation

in prenatal care or treatment during pregnancy by a drug dependent woman, considered a risk factor for child abuse and neglect, was likely to result in these separations, which included foster care or relative caregiver placements. Some study participants also lost temporary custody of their children even though they were enrolled in residential treatment.
The rationale for such practices by child welfare agencies and individuals needs careful re-examination in light of evidence that placement of the women in treatment with their children results in improvements in both (Brindis, et al. 1995; Strantz & Welch, 1997). Separations also occurred because the perinatal residential treatment system could not keep up with expedited postpartum discharge policies of hospitals due to waiting lists and necessary pre-admission paperwork.

If an adequate system of residential substance abuse treatment existed for the safe monitored placement of these maternal-child pairs, bonding and attachment in these families would not be interrupted and cost savings could accrue. The effects of foster care placement have been shown to be detrimental to children (Carnegie Corporation of America, 1994; American Academy of Pediatrics, 2000) and substantially more onerous than rehabilitative treatment and reunification of families.

Financial Support for Treatment

Issues in the financing of public sector substance abuse treatment need to be re-examined for the presence of financial barriers for women. The loss of Drug Medi-Cal among women whose children are placed in foster care is discriminatory, as Drug Medi-Cal is a requirement for treatment and is mandated by child welfare as a requirement for reunification services. Publicly financed treatment for partners may also be a way to facilitate treatment entry and retention for women (M.L. Ellis, personal communication, May 10, 2001).

Results of cost-effectiveness analyses of models of perinatal substance abuse treatment in California have shown cost savings that "more than justify the program" (State of California, Department of Alcohol and Drug Programs, 1994, p.2). Other investigators have demonstrated the cost effectiveness of substance abuse treatment in general (French, Mauskopf, Teague & Roland, 1996; Shepard, Larson & Haoffman, 1999; Zaric, Barnett & Brandeau, 2000) and for pregnant dug abusing women particularly when neonatal intensive care stays among infants of treated and untreated mothers are analyzed (Svikis et al, 1997). Similar analyses should be conducted on the current system of care for pregnant and mothering women, taking into

account direct and indirect cost savings. Non-treatment of drug dependent pregnant women has been associated with increased neonatal costs (Joyce, Racine, McCalla and Wehbeh, 1995), increased foster care placements and increased morbidity for the women and their infants (ACOG, 1990). Therefore, efforts should be made to document the financial benefits of treatment for drug dependent women.

Data Collection and Analysis

Current descriptions of the scope of perinatal addiction, related addiction and social or other health issues are limited in California by inadequate data collection and analysis. Trend analyses of treatment utilization and outcomes among pregnant women and women with children should be initiated and maintained. Cross-agency analyses of tracking treatment episodes, foster care placements, reunification practices and outcomes and utilization of other health and human services by drug dependent women and their children should be conducted by local and regional maternal and child health divisions in collaboration with alcohol and drug program administrations. Adequate descriptions of the scope of the problem and utilization of public sector services on a per-county basis allows for cost and treatment trend analyses. It would also facilitate further

evaluation of regional and community-based extrinsic barriers to treatment for this population. These data would also be critical in health planning and advocacy activities.

Future Research

Research on extrinsic barriers to treatment for pregnant drug dependent women should examine state, regional, and local policies on pregnancy and drug use and the impact of punitive policies on help-seeking behavior, treatment utilization, and indicators of maternal and child health and well-being. This research should also examine the specific impact on communities and individuals when extreme punitive measures such as legal prosecutions and convictions replace therapeutic interventions for pregnant drug dependent women.

In a recent jury trial in South Carolina, a woman was convicted of killing her fetus by smoking cocaine (Firestone, 2001). In this the first such homicide conviction of its type in the U.S., prosecutors noted that the conviction was sought because of the defendant's violation of the "fundamental responsibility," of child protection (Firestone, 2001). Yet, South Carolina ranks 42nd among states of the U.S. in overall child well-being, 2nd on low birth-weight infants, and 3rd in infant mortality (Annie E.

Casey Foundation, 2001). Contradictions between in the state's legal enforcement of child protection and its poor showing in measures of child health and well-being suggest conflicts in the stated mission of child protection. In this case, major policy issues emerge; the social context and support for care-seeking under such conditions is critical to examine. Examinations such as this should include qualitative inquiries among pregnant drug dependent women.

Future research on extrinsic barriers should be conducted among out-of-treatment and in-treatment drug dependent women. Readiness-for-change and motivational status among pregnant drug dependent women should be examined by triangulated research designs that quantitatively measure treatment utilization and women's motivation/readiness and qualitatively examine social relations between individuals and institutions. Influencing factors for treatment entry should be evaluated. These factors include mental health status, grief and loss, influence from significant others, law enforcement, child welfare mandates, health status, effects of past relinquishments of children for foster placement and/or adoption, and ethnicity. The effects of domestic violence by drug-using male partners should also be examined among drug-using pregnant women who

successfully enter treatment in order to understand the dynamics of treatment entry under those conditions. And finally biological gender differences in addiction would be important to explore.

Future research on barriers to treatment for pregnant drug dependent women should examine the impact of poverty, homelessness, and HIV status on care-seeking behaviors, including entry to substance abuse treatment. The attitudes and behaviors of health care providers in relation to non drug-using HIV positive pregnant women and their diminished participation in care have been documented (Bunting & Seaton, 1999). The combined status of drug use and HIV seropositivity and the impact on care-seeking should also be examined.

Studies that examine age of onset of addiction, trauma histories, and resilience are also indicated to evaluate the need for specific outreach and enrollment strategies. Younger primiparas may also have specific and different psychosocial issues in the process of treatment entry. Staff of helping institutions, including prenatal clinics and child welfare agencies, should be interviewed for their perspectives on drug-using pregnant women and extrinsic barriers to treatment. Further observation of the clinical and interpersonal styles of personnel in health care, child welfare, and treatment

agencies would also be useful. Issues such as staff counter-transference and attitudes toward parenting should be investigated. Research focused on the role of institutions in promoting or discouraging treatment entry for pregnant women is also critical. Directors of perinatal-specific substance abuse programs should also be interviewed to examine embedded policy issues regarding extrinsic barriers to treatment entry in the current system of treatment.

Conclusion

More research is needed to fully understand the dynamics of treatment seeking among pregnant drug dependent women. However, continued examination of extrinsic barriers to substance abuse treatment remains a priority for health policy researchers, clinicians, legislators, advocates and all who claim interest in the health and wellbeing of women and children in the United States.

Controversy and conflict regarding fetal rights and maternal responsibility have dominated the polemic of public discussion on perinatal addiction. Yet, all parties would do well to acknowledge that fetal protection starts with maternal protection. Benefits to individuals and society can result from humane and sensitive substance abuse treatment and obstetric care for

drug dependent women. In this regard, eliminating fear among drug dependent women becomes a vital ingredient of all therapeutic interventions we may conceive.

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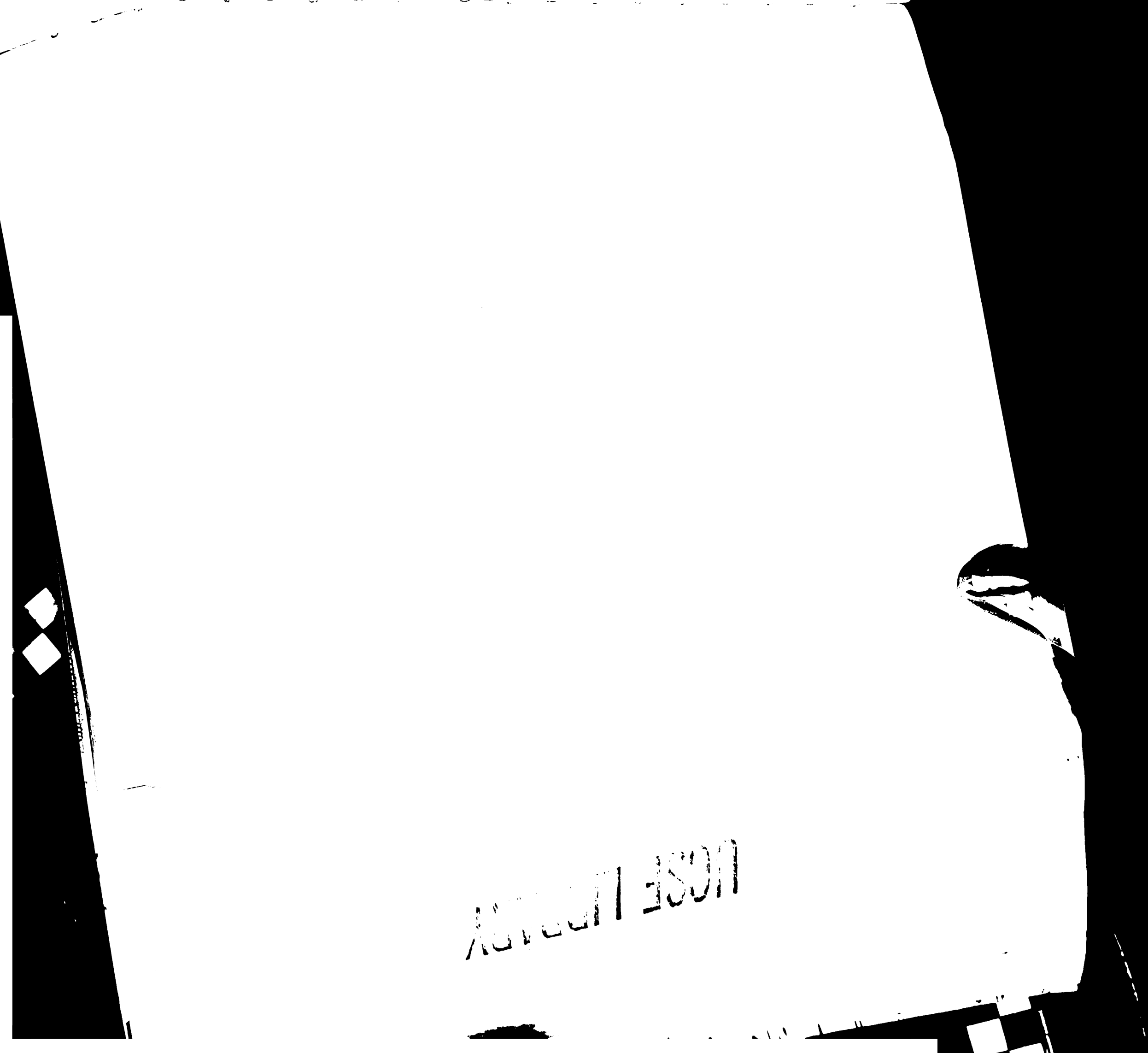

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Appendix A
Consents for Prenatal Patients: Medical University of South Carolina
Circa 1989-1990

The State of South Carolina

Solicitor, Ninth Judicial Circuit

SOLICITOR

CHARLESTON AND BERKELEY COUNTIES
COUNTY COURT HOUSE
POST OFFICE BOX 56
CHARLESTON, S.C. 29402-0056
TELEPHONE: 803-723-4714

CHARLES MOLONY CONDON

October 18, 1989

Reference: Substance Abuse During Pregnancy

TO WHOM IT MAY CONCERN:

During your recent examination you tested positive for drugs. You have been counseled about the harmful effects of drugs to you and your baby and referred to Substance Abuse and Pre-Natal Care by the Medical University. By these referrals you are being afforded an opportunity to rehabilitate yourself for the good of yourself and your baby. Please understand that by using drugs during pregnancy you are risking death or at least severe long-term harmful effects to your baby. If you fail to attend Substance Abuse and Pre-Natal Care you will be arrested by Charleston City Police and prosecuted by the Office of Solicitor.

Sincerely yours,

Charles M. Condon

CMC/aom

Charles Molony Condon
Solicitor

I have read and received a copy of the above letter.

PATIENT _____ WITNESS _____

DATE: _____ WITNESS _____

MUSC MEDICAL CENTER

Date: _____

To: _____
(Patient's Name)

_____
(Patient's Social Security Number)

From: Medical University of South Carolina Medical Center

During your recent examination you tested positive for drugs. These drugs may cause immeasurable harm to your unborn child. We have made an appointment for you at our Prenatal Clinic at _____o'clock on the _____ day of _____, 19_____. We have also made an appointment for you with the Charleston County Substance Abuse facility at _____ at _____ o'clock on the _____ day of _____, 19___. We expect you to keep these appointments.

I have read and understand this and I agree to meet these appointments for my benefit and that of my unborn child.

_____(L.S.)
Patient's Signature

_____
Witness' Signature

..EDICAL UNIVERSITY OF SOUTH CAROLINA
Department of Obstetrics & Gynecology
Maternal and Fetal Medicine
(803) 792-2864

171 Ashley Avenue
Charleston, South Carolina 29425-2233

TO OUR PATIENTS:

The increasing use of street drugs, particularly Cocaine and crack, by pregnant women is a cause for great concern. The use of these drugs has been strongly associated with complications such as the death of the baby (stillbirth), premature delivery, bleeding due to the early separation of the afterbirth (abruptio placenta), retarded growth and mental development of the baby, and birth defects. Drug abuse during pregnancy is also associated with withdrawal symptoms and sudden death (SIDS) of the infant. It is very important that you understand the risks, not only to yourself, but also to your unborn baby if you are using drugs during pregnancy.

If you are using drugs, please stop! If you are unable to stop, please let your doctor know. We want to help mothers get off drugs for the benefit of both you and your baby. We will provide you counseling about the harms of drug buse and will make arrangements for you to be seen at the Substance Abuse Clinic. We realize that drug abuse is a very difficult problem and we will do all that we can to help you.

If, however, we continue to detect evidence of drug abuse or a failure to follow recommended treatment, we will take action to protect your unborn child. The Charleston Police, the solicitor's office, and the Protective Service Division of DSS are also committed to the protection of unborn and newborn children from the harms of illegal drug abuse.

We hope that you can understand the tragedy which is being caused by the continued use of illegal drugs during pregnancy. This policy of providing warning, counseling and treatment for pregnant women using illegal drugs is the best way for us to help. For those women who fail this treatment, we must ask for help to protect the life and health of our most innocent unborn children.

Sincerely,

Department of Obstetrics and Gynecology
Medical University of South Carolina Medical Center

The State of South Carolina

Solicitor, Ninth Judicial Circuit

SOLICITOR

CHARLESTON AND BERKELEY COUNTIES
COUNTY COURT HOUSE
POST OFFICE BOX 58
CHARLESTON, S.C. 29402-0058
TELEPHONE: 803-723-6714

CHARLES MOLONY CONDON

March 26, 1990

Reference: Substance Abuse During Pregnancy

TO WHOM IT MAY CONCERN:

During your recent medical examination conducted in connection with the birth of your child you tested positive for drugs. Before your release from the Hospital, you will be counselled on the harmful effects of drug usage to you and your child, and referred to Substance Abuse Counselling. This referral will give you the opportunity to rehabilitate yourself for the good of yourself and your child. A referral will also be made to the Charleston County Department of Social Services under South Carolina Child Protection Law. DSS will determine whether the best interests of your child require the removal of that child from your custody during your rehabilitation. If you fail to complete Substance Abuse Counselling, fail to cooperate with the Department of Social Services in the placement of your child and services to protect that child, or if you fail to maintain clean urine specimens during your Substance Abuse rehabilitation, you <u>will</u> be arrested by the Police and prosecuted by the office of the Solicitor.

Sincerely yours,

Charles Molony Condon
Solicitor

CMC:fc

I have read and received a copy of this letter.

_____ Witness:_____
Patient

Date:_____ Witness:_____

Appendix B
C.R.A.C.K. Webpage

C.R.A.C.K.
Children Requiring A Caring Kommunity

www.cashforbirthcontrol.com 714-236-0217

- Problem
- Objectives
- Project Prevention
- Statistics
- Directors
- Referrals
- Media
- Quotes
- Donations
- The Family
- What's New

- Call Your Representative
- Contact Us
- Home

"Project Prevention"

CRACK'S PROJECT PREVENTION is the brainchild of Barbara Harris.

Drug addicts are no different than the rest of us in a sense that they are also motivated by money. For each volunteer of our birth control plan, the $200 CASH offer is the driving force that gets them to consider long term or permanent birth control.

Drug addicts in California have been deluged with birth control offers for years. Tubal ligations are paid for by the state, allowing women to undergo the procedure for free! Most women however, who live in this lifestyle, are unmoved by such offers.

Accepting our cash offer is just the beginning! Each woman must complete CRACK paperwork, return it to us*, make an appointment with a physician, be counseled by the medical professionals, and wait out a mandatory 30 day period required by the state. She must then keep her appointment to actually undergo the procedure. It may seem like simple tasks to us, but for a life controlled by addiction, this is a tall order!

Once she completes the birth control procedure, whish is verified by our staff, she will receive the $200.

We applaud these women for doing the right thing!

AT THIS TIME C.R.A.C.K. IS GLAD TO OFFER THESE INCENTIVES:

$200 Norplant (5 year birth control)
$200 Tubal ligation
$200 IUD
$200 Vasectomy
$200 Depo-Provera ($200 paid over the period of one year.)

* (offer good for 60 days a receiving paperwork.)

Appendix C
Extrinsic Barriers to Alcohol and Drug Treatment

Author	Barrier Study	Sample	Findings
Stark, Campbell & Brinkerhoff, 1990	pre-treatment intervention of barriers identification	callers to an outpt. tx. program (n=117; 46% ♀)	barrier dialogue> made no diff. in tx. enrollment
Cunningham, et al, 1993	examined reasons for tx. delay/non-entry	substance abusers in treatment (n=192); "recovered" w/o tx (n=92) and untx'd. active drinkers (n=62)	Untx'd. active drinkers cited stigma & self-care & minimization as barriers.
Copeland, 1997	examined barriers to tx. among ♀ who became sober w/o tx.	White, well-educated (n=32)	Barriers: lack of childcare, stigma, felt different from women in tx.
Faupel & Hanke, 1993	examined diffs. in barriers re: no hx. of tx. vs. hx. of tx.	women drug users from prison, tx. program and street.	Comparison of groups re: barriers; significant policy implications.
Beckman & Amaro, 1986	examined diffs. in tx. entry data	White women (n=67) & men (n=54) in tx.	♀had less support for tx. than ♂ & greater opposition to tx. from fam. & friends.
Festinger, et al, 1995	Examined waiting lists and impact on tx. entry	Callers to outpt. cocaine program; (n=235; 32% ♀)	Days between initial call & appt. (only sig. variable).
Cabaj, 1989	Examined tx. barriers	Gay men & lesbians (n=?)	Clients cited homophobia, ↓# gay staff & staff discomfort w/HIV/AIDS.

Appendix C (cont'd)
Extrinsic Barriers to Alcohol and Drug Treatment

Author	Study	Sample	Findings
Tam, Schmidt & Weisner, 1996	Examined large social institutions	Criminal justice system & child welfare	High # of problem drinker clients in the settings; policy implications cited.
Thom, 1986	Examined barriers to help-seeking	Clients in outpt. alcohol program (n=50; 50% ♀)	♀ had greater concern re: stigma; ♀also less likely than ♂ to cite alcohol as sig. problem. ♀ reported discouraged from tx. by spouses.
Vanicelli, 1984	Examination of attitudes, treatment outcomes "meta-analysis" & anecdotal evidence on barriers for women	Tx. staff; Lit. review 1952-1980.	Staff viewed ♀ as having poorer prognosis; lit. review reported no evidence re: poorer prognosis in response to tx.
Messer, Clark & Martin, 1996	Comparison of tx. acceptors and decliners acceptors: n = 93 decliners: n = 89	Drug-using women in a prenatal clinic;	Af.Am.♀ smokers, women who drank more likely to accept . tx.; acceptors were 6.5 times more likely to have used an illegal drug during pregnancy.
Poland, Dombrowski, Ager & Sokol, 1993	Examination of attitudes regarding prosecution of pregnant drug users.	Low-income♀ in an urban postpartum unit; n = 142; 85.2% Af.Am.;21 ♀ admitted illegal drug use during pregnancy.	Majority of sample stated women would be less likely to get prenatal care, drug tx. & drug testing if a punitive law was in place.

Appendix D

Components of Comprehensive Care for Pregnant and Parenting Women

- Advocacy
- Assessment
- Assertiveness Training
- Case Management
- Child Care
- Child Development
- Child Treatment
- Co-located Services
- Community Based Aftercare
- Counseling (Individual, Group & Family)
- Crisis Intervention
- Culturally & Ethnic Specific
- Collaborative
- Drug/Alcohol Ed.
- Educational Planning
- Family Preservation
- Family Planning
- Financial Assistance
- Specialized Foster Care
- Housing
- Legal Services
- Life Skills Management
- Medical Care
- Mental Health Services
- Detoxification
- Multidisciplinary Treatment
- Outreach
- Parenting Services
- Pharmacological Services
- Referral Services
- Relapse Prevention
- Respite Care
- Self-esteem groups
- Self-help Groups (NA, AA)
- Sexuality Services
- Social Services
- Stress Management
- Substance Abuse Treatment (varieties of modalities)
- Training & Consultation
- Transportation
- Violence/Sexual Abuse Treatment

Note: From "Treatment Programming for Alcohol and Drug-Dependent Pregnant Women," by Norma Finkelstein, 1993. The International Journal of the Addictions, 28 (3), p.1290. Adapted with permission of the author.

Appendix E
Readiness for Treatment Instruments[1]

Instrument	Author	Concept	Sample
Circumstances, Motivation & Readiness Scale (CMR)	DeLeon & Janichill, 1986	motivation for treatment; retention in treatment	therapeutic community clients
Denial Rating Scale (DRS)	Goldsmith & Green, 1988	denial; motivation	alcoholics in outpatient substance abuse treatment
Problem Awareness & Readiness for Treatment Subscale of the Alcohol Use Inventory (PART/AUI)	Horn, Wanberg & Foster, 1986	behavior, attitudes & symptoms assoc. with use/abuse of alcohol	alcoholics in inpatient substance abuse treatment
Reasons for Quitting Tobacco Scale (RFQ)	Curry, Wagner & Grothaus, 1991	motivation	tobacco dependent individuals
Recovery Attitude & Treatment Evaluator (RAATE)	Mee-Lee, 1988	profile of addiction severity	inpatient substance abusers
States of Change & Treatment Eagerness Scale (SOCRATES)	Miller & Tonigan, 1996	stages of change: problem recognition, taking action and ambivalence	alcohol dependent individuals
Univ. of Rhode Island Change Assessment Scale (URICA)	McConnaughy, Prochaska, DiClemente & Velicer, 1989	identifies stage of change	outpatient psychotherapy patients

[1] Most of these investigators have published subsequent studies that represent refinements in the instruments and reports of applications of the instruments to additional populations of persons with substance abuse disorders.

Appendix F
Study Flyer

Post until March 1, 2001

University of California, San Francisco
School of Nursing

A Study About Getting Into Drug Treatment

- **Are you at least six months pregnant or do you have a child 1 year old or younger?**
- **Are you in drug treatment now?**

Nurse researcher is seeking pregnant, drug or alcohol dependent women in residential treatment or recovery home to be in a study of what it was like for you getting to treatment.

You will receive a **$25.00 gift certificate** at Target, Safeway, Anderson's or Walmart for one interview. The interviews will take place at your program and could last up to two hours. If you are interested or want more information, please **call this toll free number** with no charge to you:

call Martha Jessup R.N. at 1-866-630-0300

Please **leave a message, with your name and phone number and the best time to call you back.** Your call will be returned within 24 hours.

Appendix G
Distribution of Study Participants by Site

Study Site	# of Participants	Ethnicity	Community
Program A	1	White	Urban
Program B	11	3 White 6 African-Am. 2 Latina	Urban
Program C	4	3 African-Am. 1 Latina	Suburban
Program D	1	African-Am.	Urban
Program E	4	4 African-Am.	Urban
Program F	3	1 White 2 Latina	Coastal
Program G	5	1 White 3 African-Am. 1 Latina	Suburban
Program H	1	African-Am.	Urban
Program I	1	Latina	Suburban
Program J	3	1 White 1 Latina 1 Native American	Central Valley
Program K	1	1 White	Suburban
Program L	1	1 African-Am.	Urban

Appendix H 1
Study Consent

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
INFORMATION SHEET

A. PURPOSE AND BACKGROUND

Marty Jessup RN, MS and Kathryn Lee, PhD are conducting a study of barriers to treatment for pregnant drug dependent women and I am being asked to participate in this study because I am pregnant or I have a child 0-12 months old and because I am drug dependent and can speak about the things in my life that made it difficult for me to seek treatment.

B. **PROCEDURES**

If I agree to be in the study, the following will occur:

1. I will be interviewed once about my experiences and my feelings about getting ready to and going to treatment.

2. If I agree, audiotapes will be made of these conversations. These tapes will be destroyed after the study is finished.

3. When results are published about the findings of this study, there may be direct quotes, but I will not be identified by name or by treatment program.

The interview will be done at the treatment program and could take up to two hours.

C. **RISKS AND DISCOMFORTS**

1. The interview might be emotionally upsetting, but I will be able to stop the interview at any time.

2. Confidentiality: Participation in research may result in a loss of privacy. However, study records will be kept as confidential as possible. No identities

will be used in any reports or publications resulting from the study. Only study personnel will have access to the files and audiotapes. After the study has been completed and all data transcribed, the tapes will be destroyed.

D. **BENEFITS**

There will be no direct benefit to me from participating in this study. The anticipated benefit is a better understanding of the barriers that make it difficult for pregnant women to get into drug treatment.

E. ALTERNATIVES

I am free to choose not to participate in this study.

F. COSTS

There will be no financial costs to me as a result of taking part in this study.

G. REIMBURSEMENTS

When the interview is completed, I will be reimbursed with a $25 gift certificate to a retail store in my geographical area.

H. QUESTIONS

I have talked to Martha Jessup/Kathryn Lee about this study, and have had my questions answered. If I have any further questions about the study, I may call them at 1-866-630-0300.If I have any questions or comments about participation in this study, I should first talk to the investigator. If for some reason, I do not want to do that, I may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. I may reach the Committee office between 8:00 am and 5:00 pm, Monday to Friday, by calling (415) 476-1814, or by writing the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0962, University of California, San Francisco, California, 94143.

I. CONSENT

I have been given a copy of this information sheet to keep.
PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether to participate in this study will have no influence on my present or future status as a patient, student or employee at UCSF.

Appendix H 2
Study Demographic Questionnaire

Barriers to Treatment for Pregnant Drug Dependent Women

Demographic Information Sheet

Marty Jessup RN, MS
UCSF School of Nursing
Box 0606
University of California
(415) 476-4668

Demographic Information **Date_____**
Sub.#____

1. Circle the number that best describes your racial or ethnic identification.

African-American.....1
Asian-American.....2
Caucasian.....3
Native American.....4
Latino.....5
Another.....6

2. Circle the number that best describes your marital status now.

Living with partner.....1
Married.....2
Separated.....3
Divorced.....4
Single.....5

3. How much formal education have you had?

No formal education or some grade school.....1
Completed grade school or some high school.....2
Completed high school or some college.....3
Completed college or some graduate school.....4

4. What is your <u>current</u> age_____years

5. Your present work situation is best described as:

Employed.....1
Self-employed.....2
Part-time work.....3
Temporary job.....4
Laid off.....5
Leave of absence from job.....6
Suspended or fired from job.....7
Unemployed.....8

Type of job_____

6. Your current income is best described as:

From job.....1
TANF.....2
From family or friend.....3
Other.....4

7. Please list your children: boy/girl, age and custody status.

1._____
2._____
3._____
4._____
5._____
6._____

8. List the times you have been in substance abuse treatment before now:
Year/Type of treatment/How long?

1._____
2._____
3._____

9. List the times you have been in mental health treatment:
Year/How long?

1._____
2._____

10. Are you currently taking any medications _____yes_____no
If yes, what are the medications for?

11. How many months or weeks pregnant were you when you entered treatment this time? _____
What is the source of information?
_____self-estimate

_____MD/RN told me
_____sonogram_____date

12. How many months or weeks pregnant were you when you entered prenatal care this time?_____

13. When is your baby due?_____

14. Do you have any medical problems?____yes____no
If yes what are they?

15. Sobriety date_____

Appendix I

Demographic Characteristics (n=36)

	n
Pregnancy Status	
Pregnant	12
Not pregnant	24
Primary Drug of Abuse	
Crack	14
Methamphetamine	5
Heroin	6
Alcohol	6
Cocaine	2
Cocaine/marijuana	2
Psychedelics	1
Marital Status	
Living with partner	3
Married	6
Separated	4
Divorced	3
Single	20
Education	
No formal/some grade school	2
Completed grade school/ some high school	19
Completed high school/ some college	15
Work Status	
Leave of absence from job	2
Unemployed	34

Income	
TANF	16
Family/friend	1
Other	8
Cal-Works	5
None	5
Custody Status[1]	
With participant in program	15
No current custody	19
N/A: first time pregnant	2
Mental Health Treatment History	
Currently in treatment	1
Currently and past in treatment	1
Past in treatment	8
Never in treatment	26
Number of Substance Abuse Treatment Admissions	
First	12
Second	9
Third-Sixth	13
Seventh or >	2

[1]Women with custody of infant and/or other children in the program may also have other children placed with relatives, in foster care or permanently adopted by others. Those with no current custody have child welfare cases pending and have children placed with relatives, in foster care and permanently adopted to others also.

Appendix J
Demographic Characteristics
(n=36)

Table J 1

Ethnicity and Trimester of Pregnancy at Entry to Prenatal Care

Ethnicity	n	Trimester no care	1	2	3
African American	20	1	9	8	2
White	8	0	4	3	1
Latina	7	0	2	5	1
Native American	1	0	0	0	1

Table J 2

Prenatal Care Participation and Condition of Entry
(n=34) [a]

Condition of Prenatal Care Entry	n	Trimester 1st	2nd	3rd
Entered prior to treatment	18	12(5)†	6(2)	0
Entered treatment first	3	2	0	1
Entered pnc as a condition of treatment	3	0	1	2
Entered pnc/no treatment during pregnancy	10	4	5(1)	1

Note: a. Two of the 36 study participants had no prenatal care. † Number in parentheses indicates number of study participants who were in jail and entered prenatal care as a condition of incarceration.

Table J 3

Barriers Cited Among Prenatal Care Seekers Independent of Jail and Treatment Participation (n=21)

	Trimester of enrollment		
Barrier	1	2	3
Fear: arrest and incarceration (5)[a; b]	7	8	1
loss of children (9)			
disclosure (11)			
Partner (1)	--	1	--
Opiate dependency (2)	2	--	--
Program-based (1)			
Other (1)	--	1	--

Note: a. Total barriers cited exceed 21 as women cited multiple barriers. b. Barriers in this group of three fear barriers were cited by a total of 16 women.

Table J 4

Gestational Age at Entry to Prenatal Care (PNC) and Barriers in No-Treatment During Pregnancy Group (n=12)

Participant #	GA @Entry to PNC	Barriers
10	16	arrest & incarceration
16	--	disclosure, death of father, skeptical re: pnc
18	6	arrest & incarceration, disclosure, loss of kids
21	--	arrest & incarceration, loss of kids
24	--	past negative MD experience
26	32	arrest & incarceration, loss of kids, disclosure, partner
27	8	arrest & incarceration, loss of kids, disclosure
30	12	disclosure & partner
32	24	loss of kids, disclosure, opiate dependency, partner
33	24	loss of kids, disclosure, partner
35	16	arrest & incarceration, disclosure, partner
36	17	disclosure

Table J 5

Ethnicity and Trimester of Pregnancy at Entry to Treatment

Ethnicity		Trimester			
	n	no treatment	1	2	3
African American	20	7	3	5	5
White	8	1	2	2	3
Latina	7	3	0	1	3
Native American	1	0	0	0	1

Table J 6

Ethnicity and Primary Drug of Abuse

Drug of Choice	Black (n=20)	White (n=8)	Latina (n=7)	Native-American (n=1)
Crack cocaine	13	1	0	0
Methamphetamine	0	1	3	1
Heroin	1	3	2	0
Alcohol	2	2	2	0
Psychedelics	0	1	0	0
Cocaine	2	0	0	0
Cocaine/marijuana	2	0	0	0

Table J 7

Drug of Abuse and Gestational Age at Entry to Treatment

Drug of Abuse			Trimester		
	n	no treatment	1	2	3
Crack	14	5	1	3	5
Methamphetamine	5	0	0	4	1
Heroin	6	2	1	2	1
Alcohol	6	3	1	1	1
Psychedelics	1	0	0	1	0
Cocaine	2	0	2	0	0
Cocaine/marijuana	2	1	0	1	0

Table J 8

Ethnicity and Custody Status in Treatment (n=34)[a]

	Child(ren) in program	No custody[b]
Black	9	10
White	2	5
Latina	4	3
Native-American	0	1

Note: a. Two women were pregnant for the first time. b. Children placed in temporary foster care, with relatives or permanently adopted to others.

Table J 9

Medical Disorders

	n
None	17
Obstetric/gynecological this pregnancy	3
Medical	12
Ob-Gyn and medical	4

Table J 10

Ethnicity and Times in Treatment

	N	First	Second	Third or More
African-American	20	6	5	9
White	8	2	2	4
Latina	7	4	2	1
Native American	1	-	-	1

Appendix K: Extrinsic Barriers

Participant

	1 J†	2	3	4	5	6 J	7	8 J	9	10 J	11 J	12 J	13	14	15 J	16	17	18
GA @ entry to prenatal care	12 wks	25	4	27	12	3	28	25	2	16	12	31	28	7	3	--	16	6
GA @ entry to treatment	34 wks	29	34	27	25	24	38	36	12	--*	24	28	40	1	13	--	20	--
Extrinsic Barrier																		
fears of arrest and incarceration				x				x		x			x		x[b]			x
fear of loss of child(ren)			x	x			x						x					x
disclosure[c]			x	x	x		x		x			x	x		x	x[d]	x	x
incarcerated[e]	x					x		x		x	x	x						
opiate dependency													x[f]					
pregnancy							x		x									
partner	x	x				x									x			
program-based							x		x				x	x[g]				
other																x[h]	x[i]	

Note: †: Prenatal care initiated in jail. * : The study participant did not receive treatment/prenatal care. b. Fear of arrest in emergency room/warrant check. c. Disclosure occurring through drug testing or verbalizing to the health professional. d. Fear of disclosing her profession (health care professional). e. Incarceration of greater than 30 days during pregnancy. f. Elected not to enroll in methadone maintenance. g. Working fulltime during pregnancy and enrolled in outpatient treatment. h. Death of father; skeptical about need for prenatal care and technology. i. Lack of education cited as a barrier.

Appendix K (cont'd.)
Extrinsic Barriers

Participant

	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
GA @ Entry to prenatal care	24 wks J	23	26	8	3	--	6	32	8 J	12	6	12	8	24	24	32 J	16	17 J
GA @ Entry to treatment	35 wks	32	--	25	1	--	8	--	--	29	24	--	--	32	--	32	--	--
Extrinsic Barrier																		
fears of arrest and incarceration	x		x[j]					x	x				x				x	
fear of loss of child(ren)	x		x		x		x	x	x					x	x	x		
disclosure	x				x			x	x		x	x		x	x	x	x	x
incarcerated																x		x
opiate dependency				x							x		x	x				
pregnancy																		
partner				x	x	x		x		x		x	x	x	x		x	
program-based				x	x[k]					x[l]								
other		x[m]				x[n]				x[o]						x[p]		

Note: j. Fear of arrest with application for welfare. k. No wheelchair access. l. Program inappropriate for pregnant women (sauna detox). m. Caretaker of multiple addicted family members and one disabled elder. n. Negative past experiences with ob/gyn providers; skepticism re: need for prenatal care and technology. o. Agoraphobia. p. Concealed pregnancy and drug use from mother and employer; worked fulltime to manage trauma related emotions.