WOMEN, BABIES, AND DRUGS:
Family-Centered Treatment Options

by

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Center for Policy Alternatives
National Conference of State Legislatures
1990
# TABLE OF CONTENTS

I. Introduction ........................................ 1

II. Substance Abuse is a Women’s Issue .................... 3
    A. Illicit Drug and Alcohol Use Among Women .......... 3
    B. Substance Abuse, Pregnancy, and Parenting ......... 4
        1. Drug Use During Pregnancy ..................... 4
        2. Effects of Maternal Drug Use on the Infant .... 4
    C. Treatment Barriers for Addicted Women ............ 6

III. Substance Abuse Among Women ............................ 8
    A. Examining Stereotypes of the Female Addict ...... 8
    B. Profile of Addicted Women .......................... 8

IV. Components of Successful Treatment Programs .......... 11
    A. Comprehensive Services ............................ 11
    B. Family-Based Services ............................. 11
    C. Staff Sensitivity .................................. 11
    D. Aftercare .......................................... 12
    E. Geographic Accessibility ........................... 12

V. Model Programs and Initiatives ........................... 13
    A. Model Treatment Programs .......................... 13
        1. Residential Programs ........................... 13
        2. Outpatient Programs ............................ 14
    B. Philadelphia: A Comprehensive System at Work .... 15
VI. Financing Substance Abuse Treatment Services......16
   A. Funding Sources..................................16
   B. Financial Payback................................17

VII. Policy Initiatives................................18
   A. Legislative Approaches that Recognize
      Addiction as a Public Health Problem...18
         1. Making a Financial Investment in the
            Treatment of Substance Abuse Among
            Women........................................18
         2. Enacting Laws Explicitly Prohibiting
            Discrimination on the Basis of Pregnancy
            in Drug Treatment Programs...............20
         3. Protecting Women Against Punitive Measures.20
   B. Legislation that Approaches Drug Addiction with
      Punitive Measures...........................20

Appendix A: Residential Treatment Programs for Pregnant Women and Women with Children
Appendix B: Model Outpatient Programs
Appendix C: National Drug and Alcohol Resources
Appendix D: State Resources
Appendix E: Proposed State Legislation

Bibliography
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I. INTRODUCTION

It is estimated that at least 22 million Americans are suffering from addiction to drugs or alcohol -- 18 million to alcohol, 4 million to illicit drugs. The results of high rates of drug use -- human suffering, wasted potential, and a mounting drain on strapped public resources -- are all too well-known. Less easily grasped are the sound and humane public policies necessary to lead us out of the drug use epidemic.

Although the stereotype is that the drug addict or alcoholic is a male, a significant number -- roughly one-third -- of those addicted to alcohol or illicit drugs are women. In order to be effective, public policies to combat the drug crisis will account for the special needs and realities of women's lives.

The stereotype of the male drug addict or alcoholic has meant that treatment programs have been designed for men. While both male and female addicts may be parents, women are much more likely than men to be the sole custodians of children. Yet few treatment facilities accommodate their clients' child care needs nor do they respond to particular problems encountered by women in our society, which are related to substance abuse; notably domestic violence and sexual abuse.

The prevalence of addiction among women has been a hidden problem in part because of the stigma attached to it. Women who are addicted face especially severe censure. The problem is particularly acute regarding pregnant addicts, who are often ostracized. The widespread and valid public concern for children born to addicted women is pervasive. This focus may result in the wholesale condemnation of those women.

That attitude leads to policies which punish women, rather than supporting rehabilitation and family assistance. Prosecution of pregnant addicted women is particularly harsh since most drug treatment programs refuse to admit pregnant women. Further, health officials report that the threat of prosecution is likely to drive pregnant addicts away from prenatal care. A similar result is reported when states terminate the parental rights of women with addicted newborns.

State legislators are key players in formulating policy to address these problems.
To assist state policymakers (especially those whose expertise is not in health policy) in their efforts, this paper provides up-to-date information on the nature and extent of the drug and alcohol problem, the unique needs of addicted women, examples of treatment modalities, model programs, and state initiatives that, according to early indicators, are having the greatest success in treating addicted women.
II. SUBSTANCE ABUSE IS A WOMEN'S ISSUE

A. Illicit Drug and Alcohol Use Among Women

Developing reliable indicators of the prevalence of drug and alcohol abuse is difficult. As a general rule, people hesitate to admit to behavior which is disapproved or illegal. In the case of drug use, the problem is complicated by the inconsistent definitions of use, abuse and addiction in different studies. Some studies count individuals who are addicted; others count individuals who have used drugs within a given time, without regard to whether they are addicted; still other studies consider frequency of use. Some studies include users of marijuana while others focus on use of drugs which pose more serious health risks, such as cocaine and heroin. The treatment of alcoholism is variable.

Despite the complexity of the data describing the number of people using drugs, we do know that illicit drug and alcohol use has reached alarming proportions among women.

- It is estimated that 5.9 million women currently use an illicit drug. Of these, 1.3 million are addicted. (National Institute on Drug Abuse, 1988a)

- Approximately 6 million American women are alcoholics or alcohol abusers. (National Institute on Drug Abuse, 1990)

- By comparison, 8.5 million men currently use illicit drugs -- 3 million of these addicted; and 12.4 million men are alcoholics or alcohol abusers. (National Household Survey on Drug Abuse, 1988a)

- Of the estimated 4 million people reportedly addicted to illicit drugs, 1.3 million -- or one-third -- are women. (National Institute on Drug Abuse, 1988a)

- Evidence exists that the gap between drug usage among men and women may be narrowing. A 1985 NIDA survey indicated that among 18-44 year-olds, two-thirds of those who ever used cocaine were male, among youth aged 12-17, approximately 50 percent were male, indicating a trend toward increasing use among females. (National Institute on Drug Abuse, 1985)

- National trends of drug use among young adults between the years 1975 and 1986 showed a convergence toward zero of the difference between usage levels of the sexes. (National Institute on Drug Abuse, 1989)
Marijuana and snorted cocaine use are more prevalent among middle and upper-income women, while crack and heroin use are more often found in low-income women. (Feig, 1990)

B. Substance Abuse, Pregnancy, and Parenting

Social attitudes and policies regarding women and drug addiction are complicated by the biological reality that it is women who get pregnant and the social reality that women still bear the bulk of responsibility for caring for children. In fact, public attention has so focused on the effects of a woman's drug use on her newborn that the harm to the pregnant woman and the many addicted women who are not pregnant is considered less often. Furthermore, current efforts to address the problem through criminal and civil punishment of pregnant women have serious implications for individual rights to privacy and for family integrity.

1. Drug Use During Pregnancy

Reliable national data on the extent of illicit drug use by pregnant women is not yet available. Available data reveal a troubling amount of drug use by pregnant women, especially in urban areas.

- The most frequently cited study, done in 1988, surveyed 40 urban hospital maternity departments. Based on these limited data, it was estimated that approximately 11 percent of births were to drug-involved women. (Chasnoff et al., 1990)

- Recent studies in urban areas, including Philadelphia and Boston, have shown that approximately 17 percent of women giving birth have traces of illegal substances in their systems.

2. Effects of Maternal Drug Use on the Infant

There are several direct effects of drugs on the developing fetus and infant: some drugs are addictive for the newborn; others are toxic and can cause direct, permanent damage to the newborn; and some are teratogenic, causing malformations of specific organs or extremities. Some of these defects may be evident at birth while the effect of others may not emerge for months or years. (Family Impact Seminar, 1990) The use of illicit drugs during pregnancy -- of heroin and more recently cocaine, especially the highly addictive smokable form called crack -- has caused considerable concern in the health care community. As a result of heroin
abuse during pregnancy, newborns are at risk of prematurity, low birth weight, and a myriad of medical complications during pregnancy and delivery. (Finnegan, 1988) Similarly, cocaine use has been found to increase the probability of spontaneous abortions, fetal death, premature labor, and low birth weight. Low birth weight is the leading cause of infant mortality and is highly correlated with developmental delays in young children.

Although the recent rise in crack use has brought public concern for drug use during pregnancy to a head, the abuse of alcohol during pregnancy is also troubling. Fetal Alcohol Syndrome (FAS), which results from heavy alcohol use during pregnancy, is the third leading known cause of mental retardation. FAS can also cause a variety of birth defects including growth deficiencies, facial malformations and defects of the central nervous system and major organs. (National Institute on Alcohol Abuse and Alcoholism, 1985) Estimates of the number of children born yearly with FAS vary widely from 1,800 to 10,000. However, FAS represents only the most severe end of the spectrum.

Approximately 36,000 children are born each year with less severe manifestations of Fetal Alcohol Effect. These children may show learning and behavioral disorders, growth retardation and difficulties with memory and attention. (Smith, 1987)

3. Effects on the Child Welfare System

Addiction to drugs undermines the ability of the individual to fulfill the responsibilities of parenthood. While this is true regardless of whether the addicted individual is male or female, in our society it is women who are more likely to be primarily responsible for the care of children. Consequently, addiction among women is putting new strains on an already beleaguered child welfare system.

The phenomenon of addicted women giving birth has given rise to the problem of "boarder babies," infants born to drug-addicted mothers. These babies languish in hospitals long after medical reasons for hospitalization have ceased. Some have been abandoned by their parents. Others cannot go home because their families cannot take care of them.

Child welfare systems are finding that more and more children are going into foster care because of problems related to parental drug abuse.
In Washington, DC, parental drug abuse currently accounts for 80 percent of children entering into foster care; in Philadelphia the comparable figure is 50 percent. (Besharov, 1990)

In New York State, 11.6 percent of children who entered foster care in 1988 were less than a month old; the majority were children of addicts. (Family Impact Seminar, 1990)

C. Treatment Barriers for Addicted Women

Limited availability of treatment programs and facilities creates a major problem for most addicted individuals. Inadequate resources for treatment translate into long waiting lists, particularly for programs which serve publicly funded clients. Waiting periods for initiation of treatment discourage addicted persons and reinforce continued drug use. (National Drug Control Strategy, 1989)

Treatment programs that do exist are often inappropriate for women. Most treatment programs are generally based on male models and make no accommodations for children, do not include family planning services or other women's health needs, and do not link with prenatal care or mental health resources. Also, treatment methods may be more confrontational and punitive than is effective with women.

Overall treatment facilities are not available in sufficient quantities. Women face special barriers to access. Only 12.7 percent of the women who need treatment get it. While women make up 33 percent of the addicted population, only 20.6 percent of treatment resources are used for addicted women. (Family Impact Seminar, 1990)

A glaring limitation on the accessibility of treatment is lack of child care.

- Of California's 366 publicly-funded drug treatment programs, only 67 treat women. Of these, only 16 can accommodate their children. Only 2 of the 87 drug treatment programs in New York City have child care facilities for their patients.

- Lack of on-site child care frequently constitutes an insurmountable barrier to treatment in both outpatient and inpatient settings. To enter long-term residential treatment, women often are compelled to place their children in foster care or with relatives with no assurance that they will regain custody.
Pregnant drug abusers have an even more difficult time securing drug treatment. Most substance abuse treatment facilities refuse to provide treatment to pregnant women because of perceived medical complications and potential liability. For instance, a 1989 survey of treatment programs in New York City revealed that 54 percent of the programs categorically refused to serve pregnant addicts. Of the remaining programs, availability was further limited because 67 percent would not accept Medicaid and only 13 percent would accept pregnant Medicaid patients who were addicted to cocaine. (Chavkin, 1990)

As a consequence of the lack of appropriate drug treatment programs, or the exclusion of pregnant women from existing drug treatment programs, many pregnant women go without treatment and medical care for the duration of their pregnancies even when they actively seek help. The limited coverage for drug treatment under the Medicaid program also is a barrier to treatment since women are one and a half times more likely than men to be dependent on Medicaid. In most states Medicaid pays almost exclusively for detoxification services and methadone maintenance. Coverage for longer-term residential services -- required by many addicted individuals for recovery -- is much more limited.
A. Examining Stereotypes of the Female Addict

A common misconception is that the typical addicted woman is poor, a minority and lives in a city. A recent survey in Pinellas County, Florida, dispels aspects of that myth and suggests that the problem is not concentrated among any one racial, ethnic or economic class.

In Florida, Department of Health and Rehabilitation Services regulations require that mothers known to have used alcohol or illicit drugs during pregnancy be reported to health authorities. To estimate the prevalence of substance abuse among pregnant women, all women who enrolled for prenatal care at any of the 5 clinics or 12 private obstetrical offices in the county were tested for drug use. Tests were performed on 715 pregnant women. Overall, nearly 15 percent tested positive for substance abuse.

This study found that the level of drug use among pregnant women is not correlated with race or socioeconomic status. (Chasnoff, et al., 1990)

Although there were no significant differences in drug use among those tested, the study did find differences in the responses of professionals to substance abuse. Black women were reported to health authorities at approximately 10 times the rate for white women and poor women were more likely than others to be reported.

B. Profile of Addicted Women

Women who abuse drugs often suffer not only from drug addictions but from a variety of psychological, social, and health problems as well. An appropriate and effective treatment program for women addresses these factors.

Numerous studies have shown that the majority of addicted women were sexually abused as children, are currently being battered, are children of substance abusers, or are depressed and suffer from low self-esteem.

- A study of over 500 opiate-dependent persons in treatment showed that 70 percent had a psychiatric disorder at some point in their lives, and of these
persons, almost 87 percent had a disorder which was separate from addiction. (This compares with 32 percent of people over the age of 18 in the general population who will experience a psychiatric problem at some time in their lives.) (Weissman, 1976)

A more limited study of depression among pregnant drug-dependent women showed them to be significantly more depressed, and less vigorous than a matched sample of non-drug dependent women (Regan et al., 1981).

Among addicted women, the incidence of childhood physical and sexual abuse, including incest, has been found to range from 40 percent to over 80 percent (Benward, 1975). Studies of addicted women have found that compared to non-addicts, they are more likely to have been victims of physical and/or sexual abuse (some studies have found the prevalence to be nearly 5 times higher).

A study of addicted pregnant women revealed that a staggering 70 percent reported being beaten as adults. Of these women, 86 percent were beaten by their husbands or partners, and the remainder were beaten by other family members, family friends or strangers. (Regan et al., 1987)

In a current study at the Prevention and Applied Research Laboratory of Human Behavior Genetics, Emory University School of Medicine, transgenerational patterns of addiction are becoming evident. Eighty-three percent of their clients report that other members of their families use alcohol or drugs; 47 percent have used alcohol or drugs with their mothers and 23 percent have used drugs with their fathers. Many of these women will return to drug-infested environments where there is little support for their recovery.

The health of women who are addicted is seriously at risk as a result of their substance abuse. Among the health problems associated with addiction are poor nutrition, disruption of the menstrual cycle, hepatitis, adult-onset diabetes and hypertension (Adams et al., 1990). An important part of any treatment program is the inclusion of comprehensive health care.

Finally, addicted women and their children are also vulnerable to sexually transmitted diseases (STDs) and AIDS. Exposure to the HIV virus can result from sharing needles with someone who is infected. In addition, to the extent that women are trading sex to sustain their habit for drugs, they have a higher risk of being exposed to STDs, including AIDS. The National Center for
Disease Control have traced the correlation between crack/cocaine use and sharp increases in the incidence of such sexually transmitted diseases as syphilis, gonorrhea, herpes and hepatitis B.
IV. COMPONENTS OF SUCCESSFUL TREATMENT PROGRAMS

The goal of a successful treatment program for addicted women is to help them conquer their physical addiction by addressing the social conditions which lead to and support their addiction, including poverty, unemployment, and lack of access to health care. These programs work to help women become emotionally and economically independent and at the same time work to preserve their families.

Effective treatment programs provide services which are responsive to the client's multiple needs and treat the whole person, not just the addiction. They must be designed to assist families by accommodating the addicted woman's parenting needs, including child care.

Components of successful treatment programs include:

A. Comprehensive Services

A comprehensive approach includes: counseling for domestic violence, sexual assault, and child abuse and neglect; mental health services; relapse prevention counseling; support groups; assistance in finding housing, employment, education and training; parenting and child development education; and comprehensive health care, including obstetric and gynecological care, screening and treatment for AIDS and other sexually-transmitted diseases, perinatal care, and pediatric care for children.

B. Family-Based Services

These services take into account a woman's children, husband, companions, and extended family members. Such programs enable families to remain together in lieu of removing children from their homes while their mothers are in treatment.

Treatment programs for addicted women with children need to plan carefully for child care (particularly important in outpatient treatment programs), and for accommodation in residential facilities which allow children to live with mothers during treatment.

C. Staff Sensitivity

Many health professionals view substance abuse not as a health problem but as voluntary, hostile and destructive behavior. (Adams et al., 1990) Professionals who provide services to addicted women sometimes find it difficult to provide care in a
non-judgmental fashion. It is critical to the success of treatment that staff attitudes be positive and encouraging rather than punitive and disapproving. (Underhill, 1986) In the absence of supportive staff, women may refuse to initiate or continue treatment. (Sullivan, 1990)

D. Services Providing Continued Support to Recovering Women After They Return to the Community

Aftercare programs are designed to reinforce continual abstinence following completion of drug treatment, promote the development of healthy, adaptive coping skills, and provide training in interpersonal, employment, and parenting skills.

Aftercare services can include community-based self-help groups as well as support through Narcotics Anonymous and Alcoholics Anonymous. Making half-way houses and transitional housing available for women with children are also an important part of aftercare.

E. Geographic Accessibility

Lack of transportation to treatment programs is often a major barrier for women seeking or continuing treatment. Transportation to the treatment program and other appointments is particularly important for out-patient programs and aftercare where a woman may lack the motivation to come to a program if it is far away from her home.
V. MODEL PROGRAMS AND INITIATIVES

A. Model Treatment Programs

Unfortunately, substance abuse treatment programs for women are largely inappropriate or unavailable. A small handful of model programs have been developed which are sensitive to the needs of women and their children and which embody the comprehensive approaches needed to address rehabilitation for women. (For contacts for programs listed in this section, see Appendices A and B)

1. Residential Programs

Numerous studies suggest that long-term residential treatment - 6 to 18 months - is extremely effective. Such treatment has been out of reach for most women because the programs generally do not make accommodations for children. Currently, only 21 residential treatment programs allow children to reside with their mothers. (a doubling in the past two to three years because of recent federal initiatives)

The Kiva Program in El Cajon, California was established 12 years ago as a result of a women's task force report that concluded that women were underrepresented in treatment because programs did not make accommodations for children. In addition to residential treatment, Kiva also offers outpatient care with child care and re-entry housing. Kiva has an unusual funding approach: 75 percent comes from state and county sources, 25 percent comes from regular bingo games that are run by the program itself.

The Cambridge and Somerville Program for Alcohol Rehabilitation (CASPAR) program in Massachusetts has been recognized as a leader in understanding the problems of women who abuse substances. It has recently expanded and is providing residential services to women and children.

Odyssey House is the only long-term residential program in New York City and has been serving women and their children for more than 25 years.

Vantage House in Lancaster, Pennsylvania, was established 10 years ago by Gaudenzio Inc. with the financial help of recovering women who believed that residential treatment for mothers with their children was an essential component of recovery.
2. Outpatient Programs

Dr. Neal Halfon and Dr. Wendy Jameson of the Center for the Vulnerable Child at Children's Hospital in Oakland, California, surveyed outpatient programs that are recognized for their treatment of women, pregnant women and mothers with children. Each of these programs attempts to keep mothers and children together whenever possible, using a community-based, family-centered approach to serving their clients.

Four of the ten programs surveyed have provided services for more than ten years and have a well documented track record. Family Center in Philadelphia, Pennsylvania; Operation PAR in St. Petersburg, Florida; Family Addiction Center for Education and Treatment in San Francisco, California; and the Pregnant Addicts and Addicted Mother Program at New York Medical Center in New York City, New York, are all examples of excellent outpatient programs.

(The other six programs surveyed were also identified as model programs but have been in operation for less than ten years. See Neal Halfon, testimony before the U.S. House of Representatives, Select Committee on Children, Youth and Families.)

Dr. Loretta Finnegan, founder of the Family Center and currently the Associate Director of the Office of Treatment Improvement of Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), has found that significant numbers of women enrolled in comprehensive treatment can be rehabilitated. Maternal and infant mortality, low birthweight and its concomitant problems can all be reduced.

The American Medical Association recognizes that dependency on alcohol and other drugs is a chronic, relapsing disease. Effectiveness is realistic only in terms of remission rather than cure. Chronic diseases such as arthritis, diabetes, and drug dependence can be measured by reduction of symptoms, improvement in ability to function or reduction of costs to society. (NIDA Capsules, 1988) A successful program is evaluated by its ability to provide addicts with the skills to cope with their addiction on a daily basis.
B. Philadelphia: A Comprehensive System At Work

Under the auspices of the Coordinating Office for Drug and Alcohol Abuse Programs of the Philadelphia Department of Public Health with funding from the Pennsylvania Department of Health, Philadelphia has developed a system for substance abuse treatment for women. Although the need for service far exceeds capacity, the program contains the major elements necessary for responsible and appropriate treatment and support; including counseling and support groups, a women-only detoxification unit, a 28-day women's residential rehabilitation programs, a 6-month residential program for single women, and 4 residential programs for pregnant and parenting women and their children (a fifth such program is scheduled to be funded shortly).

In addition, there is an intensive outpatient program that provides child care and emphasizes support services. One specialized outpatient program for pregnant women provides medical, social services and intensive counseling. Four prenatal care programs have added substance abuse counselors to their staff. Throughout the system, family planning specialists provide on-site service to women in substance abuse treatment. Further, domestic violence programs have added substance abuse counseling to their services.

Outreach services include a MomMobile (a mobile van) and a program utilizing community workers who go into neighborhoods with high infant mortality to recruit pregnant women into prenatal care programs and substance abuse treatment.

In addition, the Philadelphia Department of Public Health has developed some transitional housing programs for recovering mothers, including a program for recovering addicted women who have been victims of domestic violence. A homeless shelter for women and children has become a "clean and sober" facility.

Finally, an innovative family preservation program is being set up by the Philadelphia Department of Human Services and the Department of Public Health to provide substance abuse counseling and other supportive services to families who have been identified as having children at risk for abuse and neglect from parental drug use. These programs were developed through a creative combination of multi-level tax support and will begin admitting clients mid-August of 1990.
VI. FINANCING SUBSTANCE ABUSE TREATMENT SERVICES

A. Funding Sources

At over $1 billion in 1989, states are the major support source for publicly-funded programs. In fiscal year 1988, expenditures for alcohol and drug abuse prevention and treatment services were over $2.1 billion with states providing 48 percent, the federal government providing 23 percent, county and local governments contributing 9 percent and private insurance and other sources contributing 20 percent of the costs.

Seventy-seven percent of these funds are spent for treatment services, 15 percent for prevention and 8 percent for activities such as training, research and administration.

The principal sources of federal funding for substance abuse are Medicaid and the Alcohol Drug Abuse Mental Health Administration (ADAMHA) Block Grants. Congress has mandated that states spend 10 percent of the ADAMHA block grant on the development and expansion of prevention and treatment programs for alcoholic and drug dependent women. Since 1985, $364 million has gone to the states earmarked for services for women. Although several states have used these funds to establish and improve services specifically for women, other states have simply used this money to sustain ongoing programs. (Law and Policy Affecting Addicted Women and Their Children, 1990a.)

The federal government provides other funding resources for demonstration and research projects. In 1989, the Office of Substance Abuse Prevention (OSAP) and the Office of Maternal and Child Health appropriated $10 million to fund 45 projects which address prevention, education and treatment of pregnant and post partum substance abusing women and their children. The National Institute of Drug Abuse (NIDA) provided $6.5 million to 9 demonstration projects to provide comprehensive treatment programs for pregnant addicted women. Both OSAP and NIDA are expected to fund additional research projects in 1990-91.

States could go a long way in increasing the number of comprehensive treatment programs for women by ensuring that the ADAMHA block grant set-aside is used to create new or expanded services. According to testimony given at the House Select Committee on Children, Youth and Families hearings, Susan Galbraith, Director of the Coalition on Alcohol and Drug Dependent Women, reported that in 1985 California distributed its set-aside funds for alcohol programs through an Request for Proposals (RFP) process and over 20 prevention and treatment
programs were established. In the same state, the funds for drug treatment (which are separated from funds for alcohol treatment programs) were disbursed through the counties. Very few new efforts were established.

B. Financial Payback

The National Association of State Alcohol and Drug Abuse Directors has released a new report, "Treatment Works," that shows treatment for alcohol and other drug dependency not only works but yields tremendous financial savings to the federal and local governments.

According to the report, one study estimates for every $1 spent for drug treatment, $11.54 of social costs is saved. Another study of 10,000 people in drug treatment showed that program costs are almost entirely recouped during treatment. Economic pay-offs include crime reduction, decreased demand for social services, productivity increases, and AIDS prevention. While the report does not speak to the cost-effectiveness of treatment for women specifically, it does support the view that developing effective treatment for drug problems makes fiscal sense.
VII. POLICY INITIATIVES

There are two major approaches to policy regarding addicted women and their babies. One approach recognizes substance abuse as a public health problem driven by addictive behavior, which is best addressed through appropriate medical and social services. This approach emphasizes the need for a comprehensive program of substance abuse treatment, health care, and social support services which seeks to reduce the incidence of addiction among women, thereby protecting women and their children from the harmful effects of drugs.

The other approach treats addiction as anti-social behavior and deals with the problem punitively, through either the criminal justice system, the child welfare system or both. Criminal prosecution assumes that drug and alcohol dependency is a "willful" behavior and that criminal sanctions can deter drug use during pregnancy. The child welfare system seeks to safeguard children by removing them from homes where it is presumed a mother's drug use interferes with her ability to care for her children.

The primary focus of this paper has been to describe pervasive inadequacies in the system for treating addicted women and the need to look at long-term solutions that will provide family-centered options for treatment.

A. Legislative Approaches That Recognize Drug Addiction as a Public Health Problem

Legislative components of a broad policy initiative treating substance abuse as a public health problem include measures which: encourage development of comprehensive substance abuse treatment programs; enhance financial investment in the treatment of substance abuse among women; prohibit discrimination on the basis of pregnancy in drug treatment facilities; and encourage pregnant women to seek out treatment for drug addiction by protecting them from punitive measures.

Some states are considering legislation designed to promote the development of such programs. (See Appendix E for examples.)

1. Making a Financial Investment in the Treatment of Substance Abuse Among Women

States can also make a financial commitment to investing in substance abuse treatment programs for women as a means of maximizing the health and welfare of women, children and
their families and minimizing the long-term need for public resources to fight the resulting problems of crime, unemployment, violence, illness and death.

To improve services for women, several states have combined state dollars and federal funds such as the Alcohol Drug Abuse Mental Health Administration Block Grant Women's Set-Aside to create comprehensive treatment programs for women. Examples include programs being developed and implemented in Washington, Illinois, and Pennsylvania.

- **Washington**: Washington Omnibus Drug Act (1989 Wash. Laws Ch. 271) appropriated $5 million for treatment and support services for low-income, pregnant and post-partum women with alcohol and drug dependency problems and allocated $1 million to the Division of Alcohol and Substance Abuse for child care. The law also requires the Division of Alcohol and Substance Abuse, Division of Parent/Child Health, and Division of Medical Assistance to work together to ensure treatment intervention through the Chemically Dependent Pregnant Women Program. This case management program permits alcohol and drug dependent women to enter a continuum of treatment in any stage of their pregnancy and up to one year after delivery. (Coalition on Alcohol, 1990)

- **Illinois**: In 1989 the General Assembly approved a $44.3 million plan to combat widespread use of alcohol and drugs. $1.9 million in state funds and $2.5 million in federal block grant funds is allocated to expand services for pregnant women including social and medical detoxification, intensive patient outreach, and the establishment of residential rehabilitation and extended care facilities to serve pregnant women with alcohol and drug dependency problems. (Coalition on Alcohol, 1990)

- **Pennsylvania**: In 1989 the legislature appropriated $90 million to fund a statewide substance abuse enforcement, prevention and treatment initiative. Drug and alcohol treatment programs will receive an additional $32.6 million to expand local programs to treat priority groups which include pregnant women with alcohol and drug dependency problems and addicted newborns. (Coalition on Alcohol, 1990)
2. Enacting Laws Explicitly Prohibiting Discrimination on the Basis of Pregnancy in Drug Treatment Programs

The categorical exclusion of pregnant women by many drug treatment programs eliminates the possibility of women overcoming their addiction at a time when it is most critical. Some states, (for example New York, N.Y. Executive Law sec. 296 et seq.) have laws which prohibit discrimination on the basis of sex or pregnancy in public accommodations, which include clinics and hospitals. States without a broad public accommodations law could enact a more narrow law limited to forbidding the exclusion of women from drug treatment on the basis their pregnancy.

3. Protecting Women Against Punitive Measures

Many drug treatment and health authorities believe that the growing tendency to punish pregnant women for drug use, whether by jailing them or taking their children away at birth deters them from seeking the prenatal and drug treatment services that would protect their health and that of their baby. A number of legislatures are considering bills which would protect these women.

B. Legislation that Approaches Drug Addiction with Punitive Measures

In a number of states authorities have used existing criminal laws to punish women who use drugs during pregnancy -- with charges that go beyond the woman's use of illegal drugs. For instance, women who have given birth to infants with positive drug screens have been charged with "delivery of controlled substances to a minor," with criminal child abuse, and with homicide when the infant has died. In many instances, judges have given pregnant addicts convicted of non-drug related crimes longer prison sentences solely to "protect the fetus" from the woman's drug use during pregnancy.

In addition, civil child welfare laws -- which permit the state to remove neglected or abused children from their homes -- have been invoked solely because the mother or newborn has a positive toxicology screen.

A number of state legislatures are considering or have already passed new criminal or child welfare laws targeted at women who use drugs during pregnancy. For instance:

- In Minnesota, the criminal abuse and neglect statute has been amended to include drug use during pregnancy.
Bills introduced in four states -- Ohio, Georgia, Louisiana and Rhode Island -- would make drug use during pregnancy a felony. Ohio would have also mandated forced sterilization of women who are not able to overcome their dependency on drugs.

Seven states -- Florida, Illinois, Indiana, Nevada, Oklahoma, Rhode Island, and Utah include drug use during pregnancy in their civil child abuse and neglect statute.

Minnesota, Oklahoma and Utah require doctors to report to the state when either a woman or her newborn child has a positive urine toxicology screen.

It may seem logical to assume that prenatal drug exposure per se constitutes harm to an infant or demonstrates that the mother will not be able to care for the child. However, as not every drug is addictive, not all newborns exposed to drugs in utero will show signs of physical dependency. Positive toxicologies do not measure the extent or frequency of use, whether the mother is impaired, or whether the person will be neglectful.

Mandatory reporting and the threat of punishment may harm the very infants these measures seek to protect because they discourage women from obtaining adequate medical and social services during pregnancy. For instance, some evidence from California, Michigan, and Florida, documents the efforts women go to in order to avoid the health care system and to escape punishment. (Coalition on Alcohol, 1990 p. 5) Dr. Alan I. Trachtenberg, Medical Director, Bay Area Addiction Research and Treatment, has criticized policies that drive women away from prenatal care for aggravating health risks to newborns.

The medical community is voicing concerns about the long-term effectiveness of punitive policies. Albert W. Pruitt, M.D. speaking for the Committee on Substance Abuse of the American Academy of Pediatrics, criticizes punitive measures taken toward pregnant women, as having no proven benefits for infant health and offering no long-term solutions to the problem of addicted women. The Academy is extremely concerned that such punitive or clandestine steps discourage vulnerable women form receiving the prenatal care and social support which is crucial to their recovery. These concerns are echoed by the American College of Obstetrics and Gynecology.
Appendix A: RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT WOMEN AND WOMEN WITH CHILDREN

Jean McAlister
Kiva
McAlister Institute
810 Arnele Avenue
El Cajon, CA 92020
(619) 442-0277

The Rectory
1901 Church Lane
San Pablo, CA 94806
(415) 236-3134

Via Avanta
11643 Glenoaks Blvd.
Pacoima, CA 91331

Operation PAR (Parental Awareness & Responsibility)
10901-C Roosevelt Blvd. Suite 500
St. Petersburg, FL 33716
(813) 570-5095

The Woman’s Place
616 Gentilly Road
Statesboro, GA 30458
(912) 764-3994

Eileen Brigandi
(CASPAR) - Cambridge and Somerville Program for Alcohol Rehabilitation
Womanplace/New Day
242 Highland Avenue
Somerville, MA 02143
(617) 628-8188

Benjamin Walker
Odyssey House Family Center
666 Broadway, 10th floor
New York, NY 10012
(212) 477-9493

EMO/ARA Women’s and Children Recovery House
807 SE 8th Street
Portland, OR 97214
(503) 231-9712

Caton House/Genesis II
3945 Lancaster Avenue
Philadelphia, PA 19104
(215) 387-8808

Community House
550 West 7th Street
Erie, PA 16502
(814) 459-5853

Family House
901 DeKalb Street
Norristown, PA 19401
(215) 278-0700

Hutchinson House
Diagnostic and Rehabilitation Center
3439 North Hutchinson Street
Philadelphia, PA 19140
(215) 223-1005

Kindred House/Gaudenzia
1030 South Concord Road
West Chester, PA
(215) 399-6929

New Image/Gaudenzia
Stenton and Tulpehocken Street
Philadelphia, PA 19138
(215) 924-6322
Appendix A (continued)

Mary Bair  
Vantage House  
Vantage/Gaudenzia, Inc.  
212-E King Street  
Lancaster, PA  17602  
(717) 291-1020
Appendix B: MODEL OUTPATIENT PROGRAMS

CARE (Chemical Addiction and Recovery Efforts) Clinic  
Center for the Vulnerable Child  
Children’s Hospital Oakland  
5208 Claremont Avenue  
Oakland, CA  94609  
(415) 652-3407

Eden Center  
2115 North Wilmington Avenue  
Compton, CA  90222  
(213) 605-0650

Family Addiction Center for Education and Treatment  
Bay Area Addiction Research and Treatment, Inc.  
45 Franklin Street, Suite 2-N  
San Francisco, CA  94102  
(415) 552-7914

Healthy Infant Program  
Highland Hospital  
1411 East 31st Street  
Oakland, CA  94602

UCLA Infant and Family Services Project  
Harbor-UCLA Medical Center  
1000 Veteran Avenue, Suite 23-10  
Los Angeles, CA  90024-1797  
(213) 825-9527

The Perinatal Center for Chemical Dependence  
680 North Lakeshore Drive, Suite 824  
Chicago, IL  60611  
(312) 908-0867

Pregnant Addicts and Addicted Mothers Program  
Center for Comprehensive Health Practice  
New York Medical College  
1900 2nd Avenue, 12th floor  
New York, NY  10029  
(212) 360-7781

The Family Center  
Thomas Jefferson Hospital  
111 S. Walnut Street, Suite 6105  
Philadelphia, PA  19107  
(215) 928-8577

Project Star  
77B Warren Street  
Brighton, MA  02135  
(617) 783-7300
Appendix C: NATIONAL DRUG AND ALCOHOL RESOURCES

The Coalition on Alcohol and Drug Dependent Women and their Children
1511 K Street, NW
Suite 926
Washington, DC 20005
(202) 483-4909

NAPARE
(National Association for Perinatal Addictive Research and Education)
11 E. Hubbard Street, Suite 200
Chicago, IL 60611
(312) 329-2512

NASADAD
(National Association of State Alcohol and Drug Abuse Directors)
444 North Capitol Street, NW
Suite 642
Washington, DC 20001
(202) 783-6868

NCADI
(National Clearinghouse for Alcohol and Drug Information)
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

National Health Law Program
2025 M Street, NW
Suite 400
Washington, DC 20036
(202) 887-5310

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6245
Appendix D: STATE RESOURCES

Terri Goens, Sr. Human Services Program Specialist
Alcohol and Drug Abuse Program
State of Florida
Department of Health and Rehabilitative Services
1317 Winewood Blvd.
Tallahassee, FL 32399-0700
(904) 488-0900

William T. Atkins, Director
Illinois Department of Alcoholism and Substance Abuse
SOIC
100 W. Randolph Street
Suite 5-600
Chicago, IL 60601
(312) 814-3840

Victoria B. Crews, State Coordinator
Women’s Programs
Department of Alcohol and Drug Addiction Services
170 North High Street, 3rd floor
P.O. Box 586
Columbus, OH 43266-0586
(614) 466-3445

Susan Leiberman
Assistant Health Commissioner
Philadelphia Department of Public Health
540 Municipal Services Building
Philadelphia, PA 19102
(215) 686-5004

Mark Bencivengo
Deputy Health Commissioner
Coordinating Office for Drug and Alcohol Abuse Programs
Philadelphia Department of Public Health
1101 Market St., 8th floor
Philadelphia, PA 19107
(215) 592-5411

Jeannine D. Peterson
Deputy Secretary for Drug and Alcohol Programs
Commonwealth of Pennsylvania
P.O. Box 90
Harrisburg, PA 17108
(717) 787-9857

Kent Stark
Department of Alcohol and Substance Abuse
Mail Stop OB 21W
Olympia, WA 95004
(206) 753-5866
APPENDIX E: PROPOSED STATE LEGISLATION

A. Examples of bills which encourage the development of comprehensive programs for the treatment of addicted women

1. In California Senate Bill #2669, introduced by Senator Presley and Assembly Member Bates would provide funding for participating counties or consortia of counties to develop a single comprehensive plan for the prevention, early intervention, and treatment of perinatal substance abuse and substance exposed infants and their families. To qualify for funds, the plan would have to include:

   Substance abuse treatment services that are appropriate for the target population;

   Prenatal and postnatal care for the target population;

   Support services for mothers such as child care, housing, transportation, and related special support services for immediate and extended family members;

   Links with other available support services in the community;

   Development of a continuum of health care services including substance abuse treatment, prenatal care, family planning, preventive health care, parenting education and mental health;

   Methods for ensuring interagency collaboration and cooperation among public and private service providers;

   Methods for ensuring access to and collection of data concerning program outcomes for mothers and children.

2. Pennsylvania's Senate Bill #912, introduced in the 1989 Session, provides for the establishment of residential drug and alcohol treatment programs for pregnant women, mothers, and their dependent children, and appropriates $2 million to the Department of Health to carry out the purposes of the act.
B. Examples of bills which protect pregnant drug-addicted women from punitive measures

1. **New York** Assemblywoman Gloria Davis has proposed legislation amending the state’s civil rights law to prohibit the jailing of a pregnant women solely for the protection, benefit, or welfare of her fetus. The bill also prohibits the use of evidence obtained from a fetus in utero or from a newly born infant in a criminal proceeding against the mother or civil child welfare proceeding to demonstrate the mother’s unfitness or to prove child abuse.

2. In **California** Senate Bill #2669 overturns a California Court of Appeal interpretation in *In re Troy D.*, by providing that a positive toxicology screen on the mother prior to the birth of an infant does not alone constitute the basis of a reasonable suspicion of child abuse or neglect, triggering the state’s child abuse and neglect law. Rather, the bill would require that the positive test result be followed by further assessment to determine whether the child is at risk of abuse or neglect.
BIBLIOGRAPHY


Law and Policy Affecting Addicted Women and Their Children: Hearing before the House Select Committee on Children, Youth, and Families, 101st Congress. (1990c) (statement of N. Halfon, Children's Hospital, Oakland, CA) May 17.


