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Abstract

There is clear reason to believe that issues in regards to pregnant women and substance abuse have created many obstacles for the mothers, physicians and social workers in how they handle the situation and still follow through with their rights, responsibilities and ethical standards. There are many public health approaches, policies and treatment programs that have been utilized and developed to address this issue. This paper discusses the issues of substance abusing pregnant women and what practitioners, physicians and policy makers can do to address this ever growing problem.

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Oddly enough, my inspiration for continuing my education and earning my Master's degree comes from my mother's dreams and aspirations. She earned her Bachelor's Degree at the age of 52 and went on to start and finish her Master's before I finished my Master's. It's amazing how mother's at any age still have the ability to lead, instill drive and foster an atmosphere of lifelong learning. She is a true inspiration to me.

Lastly, a friend once told me "it's never about academic intelligence; it's always about spiritual and emotional intelligence." I couldn't agree more with this statement. As much as I am elated that I'm earning my Master's Degree, it doesn't quite compare to the relationships and growth I've experienced along the way.

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Chapter 1: Introduction

Introduction

Due to a pregnant woman abusing alcohol and other drugs, her life along with her unborn child's life can be seriously endangered by the abuse of those substances (Andrews & Patterson, 1995). The desire to respond to this issue has caused many state and local authorities to use a variety of legal actions to detect cases of maternal substance abuse and take action and coerce intervention. Some of the examples are: mandatory reporting of drug-exposed newborns to protection authorities; involuntary drug testing of pregnant women, newborns, and postpartum women; mandatory reporting of positive drug test results; involuntary civil commitment for addictions treatment; civil junctions prohibiting the use of drugs; and criminal prosecution and incarcerations. The last examples were based on a variety charges that have been used in the US for these types of cases. Some of the charges brought against pregnant substance abusing woman have been: child abuse, criminal child neglect, delivery of a controlled substance, manslaughter and reckless homicide (Tillett & Osborne, 2001). These types of sanctions placed on substance abusing pregnant women have created a vicious cycle of doubt, fear and skepticism in our system.

Statement of the Problem

There are many facets surrounding the issue of substance abusing pregnant women and the realistic options they have when faced with prosecution and or treatment. Not only do they have rights, responsibilities and ethical issues, health care providers and social workers do as well. The true question lies in whether the fetus has equal rights as the mother and if so, how do we determine what is fair, ethical and just? If we require

women to abstain from alcohol and/or illegal drug use during pregnancy, should it be required of us to offer education and treatment that accommodates the needs of a pregnant woman?

Purpose of the Review

This review will investigate information related to the history of pregnant substance abusing women and possible implications regarding the prosecution of the mother, public policy treatment options. Topics included are the rights, responsibilities, and ethical issues of pregnant woman, health care providers and social workers. Specifically this paper discusses public health approaches, policies and treatment options and lack thereof. The rights of pregnant woman versus the rights of the fetus have long been debated in regards to ethical and legal issues among health care providers, policy makers and legal officials.

Methodology

This literature review study was consisted primarily of studies from the fields of family social science, public policy and chemical health. Initial searches were conducted at the University of Wisconsin-Stout library using the Ebsco Host data base in 2010 and 2011. The researcher analyzed literature categorically into four main groupings: history of substance abuse during pregnancy in the U. S., rights, responsibilities, and ethical issues, public health approaches and policies, and treatment options and alternatives. The findings from this review of literature have been synthesized and recommendations for public policy given.

Chapter II: Literature Review

History of Substance Abuse during Pregnancy in the U.S.

Drug use in this country is not a new phenomenon, in fact, legal use of opiates in America has a 200-year-old history and cocaine has been around since the 1870's (Lester, Andreozzi, Appiah, 2004). In the 1940's and 1950's two drugs used during pregnancy to prevent nausea and miscarriages were thalidomide and diethylstilbestrol (DES). Both were later known to have caused deformities and adenocarcinoma (a cancer affecting glandular tissue) of the vagina in daughters born to the women taking this medication. Licit and illicit drug use, diet, and behaviors of pregnant women have been under heavy scrutiny ever since. The issue of drug use during pregnancy gained attention in the 1960's when public attention focused on the possible harm to the fetus. In the 1970's research detailed the harsh effects of fetal alcohol syndrome (FAS) including dimorphic features, growth retardation, central nervous system problems, long term retardation and developmental delays (Lester et al., 2004). The first response to this was requiring labels on all alcoholic drinks warning of birth defects. In the 1980's crack cocaine had become dangerously popular and cheap. The heightened awareness came in response to the emergence of the crack epidemic and babies were labeled "crack babies". This soon became a moral as well as public health issue that forever changed the way we think about pregnant women and substance use. Cocaine was used for many ailments, used in coca cola and helped with depression until numerous proposals for laws against it sprung up in 1910. They claimed that it contributed to violence, paranoia, and collapsed careers (Lester et al., 2004).

Substance abuse during pregnancy is generally understood to be harmful, but there is still limited research regarding just how harmful it is (Tillett & Osborne, 2001). National statistics show that many pregnant woman smoke tobacco (18%), drink alcohol (9.8%), and use illicit drugs (4%) (Jones, 2006). According to Gumby and Shiono (1991), currently there are as many as one in three infants that may be exposed to alcohol and other drugs in utero, although rates vary by drug and geographic area (as cited in Andrews & Patterson, 1995). In one study, cocaine itself did not seem to sway the incidence of low birth weight and prematurity, but did act as a marker for other problems including alcohol abuse, smoking and violence. All of these other problems are capable of causing fetal harm (Tillett & Osborne). Even having one drink a day during the first three months of pregnancy is associated with a 2-point drop in overall IQ by the time the child is 10, according to a report in the June issue of Alcoholism: Clinical and Experimental Research (Gorman, 2006).

Along with all the reasons stated above, there are a few other reasons why states have such vested interest in addressing problems of substance abuse by pregnant women. One of the most basic notions is the state has an obligation to its people to provide for their welfare. It is also a financial issue that states encounter when dealing with the outcome of the infants health due to the mother's drug use. After birth, children born to substance abusing mothers are at greater risk for neglect, abuse, and abandonment therefore requiring intervention of child protective services (CPS) or juvenile services at cost to the state (Lester et al., 2004). First year costs to states can be as high as $50,000 above the average cost of usual births and expenses for public assistance and foster care for each year after can be as high as $20,000.

According to the Center for Reproductive Law and Policy, "at least 200 women in more than 30 states have been arrested and criminally charged for their alleged drug use or other actions during pregnancy (Tillett & Osborne, 2001). As of September 1, 2010, fifteen states consider substance abuse during pregnancy to be child abuse under civil child-welfare statutes and three consider it grounds for involuntary commitment to a drug and alcohol treatment facility (Substance Abuse Reporting and Pregnancy).

Each state has its own requirements in regards to evidence they use for drug exposure to the fetus or newborn in order to report to child welfare. Some examples are: a single positive drug test, newborns that are "demonstrably adversely affected" by prenatal drug exposure and an infant must be "addicted" to an illegal substance at birth. The accurate identification of prenatal drug exposure is important to understand the nature and scale of the problem and to determine appropriate medical and psychosocial intervention. The many methods to detect drug users are: interview, self-administered questionnaires, intake history, urine testing of mother and infant, testing of infant hair and meconium. Unfortunately, many of these avenues have been found to be inaccurate and understated. In a sample in which 43% of mothers tested positive of illegal drugs during pregnancy, only 11% admitted illegal drug use and another report found that self-report misclassified 24% of cocaine users identified by urine toxicology (Lester et al., 2004). And in yet another study, 38% of mothers denied illegal drug use during pregnancy yet the infant's meconium was positive.

It is vital for practitioners to understand the importance of the legal and ethical implications involved when dealing with substance abusing pregnant women. One of the great debates is establishing "fetal rights" and determining laws that define a fetus as a

"person" with separate interests in which they have equal to or greater than those of their pregnant mother. There are multiple statutes that are used to prosecute pregnant substance abusing women. They have used delivery of a controlled substance to minors in a creative way. Prosecutions in these cases narrow in on the minute after birth before the umbilical cord is cut (Lester et al., 2004). This allows for the child to be considered a person under the Fourteenth Amendment and entitled to full and equal protection. The child is also still attached to the drug using mother allowing the child to still be receiving drugs through the bloodstream. Child abuse is yet another avenue used to prosecute substance abusing women. Cases tried using abuse and neglect statutes revolve around the issues of whether or not the fetus can be considered a child in the eyes of the law and whether the mother's actions before birth fall into the category of abuse and neglect. Some mothers who have given birth to a still born in the third trimester have been charged with manslaughter, though this prosecutorial strategy has never resulted in a conviction. An alternative to prosecution is involuntary detention into a treatment program, which has been argued to be the best available mode of administering punishment, rehabilitation, and deterrence.

For example, in July of 1997, a bill was introduced to the Wisconsin Assembly to grant judges the authority to order pregnant women into inpatient treatment for drug and alcohol abuse. It also required health professionals to report such behavior to the proper officials, but that portion of the bill was amended and passed in both the houses of the Wisconsin State Legislature. In 1998, this was signed into law by Governor Tommy Thompson and since the law was passed, at least one woman has been detained for treatment against her will. In Florida, a woman was charged with delivery of a controlled

substance and this was a felony drug charge with a possibility of a 30 year sentence and the evidence used was a positive newborn urine toxicology screen (Chavikin, 1990) Most of the criminal actions such as "child endangerment" and "delivery of a controlled substance" have typically been unsuccessful because courts have ruled that these statutes were not intended to apply to the ingestion of drugs by a pregnant woman (Andrews & Patterson, 1995). Prosecution in these types of cases requires that some of the pregnant woman's Constitutional rights, for example, confidentiality, bodily integrity, privacy, and possibly the pregnant woman's liberty, be set aside to prevent risk to a fetus that the woman has chosen to carry.

Overall, the majority of state courts have found that criminal prosecution of pregnant woman for the effects of their drug use on their fetus, are impermissible. Prosecutions based on state drug delivery have also failed (Stone-Manista, 2009). Despite the unlikelihood of these prosecutions, there are still many in favor of them. The three that stand out are: 1) criminal prosecutions will have a deterrent effect in that the pregnant woman will deter from drug use in her future pregnancies and she will set an example for her peers, 2) pregnant, substance-abusing women should be prosecuted because they are deserving of punishment, and 3) improvement of maternal and fetal health outcome due to greater prenatal medical care and monitoring.

Rights, Responsibilities and Ethical Issues

In regards to rights, responsibilities, and ethical issues, it's not only dealing with those of the pregnant woman but also of the medical practitioners and social workers that she is working with. This is multi-faceted look at three key players; pregnant substance abusing women, health care professionals and social workers.

Pregnant Substance Abusing Women

According to Saltzman and Proch, (1990), the foundations for the pregnant woman's constitutional rights are the due process and equal protection clauses of the Constitution, which are stated in broad, general terms: "nor shall any State deprive any person of ……liberty….. without due process of law; nor deny any person within its jurisdiction that equal protection of the laws" (as sited in Andrew & Patterson, 1995, p. 58). The Constitution protects a variety of rights that may be affected by state interventions in relation to substance abuse during pregnancy. Examples of this are: criminal incarceration or involuntary commitment to treatment affects the right to physical liberty; legally mandated drug treatment affects the right to refuse health care; legal requirement that physicians disclose confidential medical information affects the right to privacy and the right to association; and removal of a newborn affects the right to the care and custody of one's own child. Along with this, many fetal protection laws affect the right to reproductive privacy. The fetus does not have comparable rights under the Constitution and the Supreme Court has held that when the Constitution was written, basic human rights to "persons", it did not intend to include fetuses with in the scope of that term. States will still take action to protect the fetus and the person that the fetus will become as long as the actions do not impose on the constitutional rights of the mother. The Constitution also requires that laws be equal, that all persons in similar situations be treated alike. This principle is particularly important when dealing with the issue of substance abuse and pregnancy because many of the women targeted with this issue are from low-income neighborhoods and primarily of color. But this also deals with the issue of which drugs we are considering. Interventions only address users of certain

drugs, for example cocaine, and pregnant abusers of legal substances such as alcohol, nicotine, and prescription drugs are unaffected by coercive state programs. When dealing with pregnant woman who abuse alcohol or cocaine is of great concern because it parallels perceived differences in consumption by racial and social groups. Cocaine use is typically associated with people who are poor and African American, and alcohol is regarded as the drug of choice for people who are white and of higher – income status. A law may be unconstitutionally discriminatory if it targets African Americans, even if the factual perceptions on which it is based are incorrect. According to Paltrow (1991), current data demonstrates that use of potentially harmful substances during pregnancy is spread across all social and racial groups, 80% of the woman who have been prosecuted, lost custody of their children, or otherwise been detrimentally affected by state intervention have been members of nonwhite ethnic groups (as cited in Andrews & Patterson). Public policy and law makers must give particular attention to guarantee that groups that have typically been disadvantaged by the law (that is, women and nonwhite people) are not again being unlawfully singled out.

In regards to the women's responsibilities, it is important to also view the women's perspective in regards to prenatal drug screening and the influence it has on prenatal care attendance and engagement. Typically, women do not want others to know that they are using during pregnancy due to their feelings about themselves. They describe feelings of guilt, shame and embarrassment regarding their actions (Roberts & Nuru-Jeter, 2010). After a provider identifies them as a drug user they view the provider as a source of punishment rather than a source of protection. Due to this view, many seek prenatal care late in the pregnancy if at all. If a woman is using she will skip

appointments and schedule follow up's around her use. Her responsibility as a mother-to-be is now challenged because she feels threatened by the providers that are needed for prenatal care.

Health Care Professionals

In regards to health care professionals, the general principles that guide them include a responsibility to save or preserve life, relieve or minimize suffering, and avoid harm (Tillett & Osborne, 2001). It is the responsibility of the health care provider to acquire informed consent for procedures, which are given in the provision of health care. Pregnant women are often viewed as the patient and therefore due appropriate care, support, and confidentiality. Health care providers have a duty to maintain confidentiality and respect autonomy. They also must follow the informed consent process, involving disclosure, understanding, and voluntariness; and the must respect a patients right to refuse treatment (Jos, Marshall, & Perlmutter, 1995). Kieffer-Andrews define autonomy as the ability to self-govern; to be one's own person, without constraints either by another's action or by psychological or physical limitation. For the most part, detection policies are not being implemented, although hospitals serving poor communities are more likely to have such policies. Difficult questions arise when developing these policies resulting in state and health care providers having conflicting claims when dealing with the mother and the fetus. What are the appropriate detection policies? Is informed consent required for testing? What are the sanctions if substance abuse is detected? There are many hospital administrators that believe that formal policy is not needed for prenatal drug exposure. Reasons for this belief: the feeling that health care workers always seek drug use information from appropriate patients, the patient is

educated and recommendations for appropriate action are given. Many also believed that drug detection was of lesser significance than other pregnancy related problems. Administrators do not appear to be leaders regarding policy on this issue; policy development is often left in the hands of a concerned nurse or pediatrician.

Social Workers

As for ethical obligations of social workers when dealing with pregnant women who have a substance abuse issue, the NASW (National Association of Social Workers) Code of Ethics requires that the worker make every effort to enable maximum self-determination on the part of clients and to ensure client confidentiality and privacy (Andrews & Patterson, 1995). Laws and policies that require a social worker to report positive drug test results and initiate involuntary treatment violate these obligations. Clients must be informed that if they disclose an issue of substance abuse during an assessment, it may lead to criminal prosecution. According to Turkheimer and Parry (1992), typically, coercive actions are based on the client's danger to self or others or grave disability and a determination that the client is incompetent, in these cases due to a severe addiction, to make decisions that protect the well-being of herself, her fetus , or the community (as cited in Andrews & Patterson). Hutchinson (1992), observed that the use of authority with involuntary clients poses challenges to social workers because it involves competition among three professional values: (1) individual liberty, (2) the duty to aid vulnerable persons, and (3) protection of the common good (as cited in Andrews & Patterson). The expectation of social workers to prevent discrimination against any group of persons is in conflict when legal actions that treat pregnant women differently from other citizens such as fathers and other men and women, such as forcing them into

treatment is considered discriminatory. If a mother has a substance abuse addiction, it still does not guarantee that the newborn will have problems and it also does not take into account that the father may have contributed to the fetus's and infant's conditions through transmission of drug effects or toxins in the sperm. The question that then arises is, whether to participate in action that deprives a mother of her liberty when threat to life or health is uncertain and the cause of the threat is also unknown.

Public Health Approaches and Policies

Public health refers to the science of preventing disease, prolonging life and promoting health through organized efforts and informed choices of society, organizations, communities and individuals. From this, policies and alternative treatment options are developed and implemented.

Clinical Model

The clinical model focuses on the client/doctor relationship and walking the fine line of protecting the mother and the fetus. In regards to the clinical model, the clinician's obligation is to the pregnant women and her fetus (Jos, Perlmutter & Marshall, 2003). The issue at hand is whether or not the clinician focuses on the needs of the patient or lessens the commitment to the patient autonomy in order to protect the interests of the fetus. The goal of the clinical encounter is to align the interests of the mother and fetus and treat them as one. It makes it difficult to provide service to them as one when the mother engages in behavior that compromises the well being of her fetus. The patient's rights are at risk in this situation when political pressures are on the clinician to report such behavior. By requiring physicians to report any evidence of substance abuse during pregnancy may possible deter pregnant women with substance abuse problems to admit

these behaviors and seek treatment. This puts the therapeutic relationship between the medical provider and the patient at risk. In one study, women who abuse drugs did not trust health care providers to protect them from social or legal consequences and avoided or emotionally disengaged from prenatal care (Substance Abuse Reporting and Pregnancy). Seeking medical care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. Addiction is a chronic, biological and behavioral disorder with genetic components. Mandatory reporting my medical professionals only dissuades women from the proper care needed. Medical care professionals have a great amount of opportunity for substance abuse intervention. Three key areas that they may have an effect on are: adhering to safe prescribing practices, encouraging healthy behaviors by providing education and appropriate information regarding drug and alcohol use and its effects and identifying and referring patients already abusing drugs to addiction treatment programs. Minnesota requires that physicians report suspected prenatal drug abuse and authorized involuntary civil commitment. There are 24 states that have laws permitting commitment and at least 12 states have passed legislation mandating the reporting of positive newborn toxicologies to social services. Due to these issues, many pregnant substance abusing women are often alienated form the medical institution because of distrust, fear of arrest, child removal and shame about their substance abuse.

Public Health Model

The Public Health model is quite different than the clinical model which focuses on the individual. The Public Health Model focuses on the well-being of a population and is typically preventative using a wide array of professional and nonprofessional services.

The ethical standards in regards to the public health model are equitable treatment, social justice and cost effectiveness, which all are a result of the obligations to members of the community or public jurisdiction.

Treatment initiatives continue to focus on improving access to clinicians through coercion, instead of focusing on serious population-based public health initiatives that cover multiple issues regarding a child's health. Overall, it is the core postulation that fetuses are best protected by criminal law that underscores community-based public health efforts to promote the safety of children.

One public health model that provided a different framework was the Reciprocal Obligation approach. In response to the need for public policy regarding pregnancy and substance abuse, licit vs. illicit drugs and mother vs. fetus, the reciprocal obligations framework is a possible answer (Jacobson, Zellman & Fair, 2003). This approach argues that the state (representing the fetus) and the pregnant woman have obligations that outline the limits of what the state can do to intervene and nature of the pregnant woman's response. This framework is based on the public health model, meaning that its focus is on prevention and treatment, not criminal sanctions. It also emphasizes the improved outcomes of the mother and fetus. From a policy perspective, pregnancy is an opportunity to detect substance abuse and learn of other risk factors for fetal health, since most pregnant women seek prenatal care. Prenatal substance exposure (PSE) can therefore be detected at many different stages of the pregnancy leaving ample time for intervention. But if it is not detected until birth, the state or health care workers would not be able to intervene to help prevent harm to the fetus, by then, it's too late. With this framework the state and pregnant woman have obligations to each other and to the fetus.

Here is the groundwork for this approach. If the woman decides not to terminate her pregnancy, both the state and the pregnant woman must act in the best interests of the fetus. For example; despite the state having direct interest in increasing birth outcomes, it cannot intervene with impunity because its actions must take to heart the pregnant woman's rights, just as the pregnant woman, cannot reject the state's intervention by demanding her privacy rights to the exclusion of her to the fetus. This approach also substitutes the mother vs. fetus conflict for an approach of mutual obligation to optimize maternal and fetal health outcomes. The key players of this framework cannot assert any of their rights or interests before meeting a reciprocal obligation. The key is to balance the array of right, interests, and obligations present in these relationships. This public health approach can be used at time during the process to clarify the proper interventions once the state has met its obligations.

A program developed at the Medical University of South Carolina (MUSC) exemplifies the public policy model in that it was created to ensure appropriate management of patients abusing illegal drugs during pregnancy (Jos et al., 1995). First the patients were required to learn about the harmful effects of substance abuse during pregnancy and were informed that for protection of the unborn children, the Charleston police may be involved. For women who met certain criteria, they were required to undergo urine screening for illegal drugs. Once obtained, the samples entered a legal chain of custody. If positive, the Charleston police would file a criminal report and an arrest warrant would be issued if the patient failed to keep scheduled appointments for substance abuse therapy or prenatal care. Any patient who delivered a baby who tested

positive would be arrested following her medical release and the child would be taken into protective custody.

In the first year of screening, 119 pregnant mothers tested positive. Those in favor of this policy believed that the threat of arrest would provide an incentive to participate in treatment programs. A result of the policy lead to a particular population being targeted: the poor, mostly African-American. This also was the reason behind the 1993 lawsuit against MUSC. This lawsuit was brought about by three of the women who were incarcerated by the Interagency Policy. This policy went against patient's constitutional rights to privacy and liberty, right to refuse medical treatment, and the right to procreate.

Treatment Options and Alternatives

If a pregnant woman seeks substance abuse treatment, there are few options for her and when there are options, other obstacles stand in the way. For instance, if we demand incarceration and treatment, is it even possible? As for punitive treatment of pregnant mothers with substance abuse issues, most public health organizations, including the American Medical Association, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, the American Society of Addiction Medicine, and the American Nurses Association, rebuffs the imposition of criminal sanctions as inappropriate to the care giver's role (Jos et al., 1995). Five metropolitan areas were surveyed in 1994, and 294 drug abuse treatment programs were existent then (Osborne & Tillett, 2001). Of these, 64%- 100% accepted pregnant women, however, payment methods were found to significantly limit access to these programs. As of 2010,

only 19 states have drug treatment programs for pregnant women, and only four give priority accesses to pregnant women.

Holistic Approach

The few drug treatment facilities in the US accepting pregnant women often do not provide child care, account for the woman's family responsibilities, or offer affordable treatment. Besides the issue of substance abuse, many women have a plethora of other issues that need to be addressed for treatment to be successful. Other risk factors include: mental health problems, histories of physical or sexual abuse, serious medical problems, poor nutrition, relationship problems and deficits in social support (Milligan et al., 2010). In response to all of these needs, it is recommended that substance use treatment programs address women's physical, social, and mental health needs through prenatal services, parenting programs, child care and other child-centered services. Reasons for this recommendation are as follows: integrated programs may reduce barriers to engaging and remaining in treatment, integrated interventions may have a synergistic effect and parenting and child development services may increase maternal motivation and reduce substance use. The Centre for Substance Abuse Treatment has suggested that treatment that addresses the full range of a woman's needs is directly related to increased abstinence and improvement in other measure of recovery, including parenting skills and overall mental health. Treatment that addresses the addiction only may well fail and contributes to a higher potential for relapse. For example, in Albuquerque, only one residential program accepted pregnant women but did not accept Medicaid. Few programs offered child care. There is limited data published in regards to the effectiveness of interventions designed to reduce substance abuse during pregnancy.

Most of the treatment programs used today were designed using male- based recovery models, which may not generalize to pregnant women. There is little empirical evidence that traditional models are effective with pregnant women and even less research on treatment of women of low socioeconomic status. Despite this, there is considerable agreement that effective treatment should include residential care, inpatient and outpatient services that are gender specific and that also offer educational and vocational services along with transportation and childcare (Jos et al., 2003).

There is much evidence showing that typically substance abusing women have limited economic resources, are less educated, receive little social support, and have difficulties securing housing (Pajulo, Suchman, Kalland & Mayes, 2006). Their pregnancy is often unplanned, and they suffer from depression and anxiety, have low self-esteem and feel shameful and guilty. On top of all of these issues, several major changes are required of them at this point in their life. They have to make room for a child in their mind, take responsibility for the child, give up their substance use, reach for a new social circle of friends, and deal with practical life arrangements and authorities.

Mother/Child Relationship Approach

Once the child is born, the substance abusing mother and her child tend to be difficult regulating partners for each other (Pajulo et al. 2006). The exposed infant often has an impaired ability to regulate its state of wakefulness, sleep, or distress and needs a mother's help. At the same time, the mother typically has a reduced capacity to read the child's signals and a reduced tolerance level for coping with an irritable baby. This makes for a very fragile situation that turns into a cycle and may lead to withdrawal from interaction and increased risk for child neglect and abuse. All of these points lead to the

conclusion for the need to grow the child/mother relationship. Another new treatment approach is focused directly on the mother-child relationship (Pajulo et al., 2006). This approach emerged after clinical experience in a residential setting pointed out that a woman's relationship with her children is a critical factor in her efforts toward decreasing her use and understanding just how profound of an effect her use has on her children. This approach uses the term reflective functioning (RF) which refers to the psychological processes underlying an individual's capacity to mentalize. Mentalizing refers to the capacity to understand oneself and others in terms of mental states (such as feelings, beliefs, intentions and desires), and to reason about behaviors in regards to those states. The two main goals of this treatment are to support the mother in her efforts towards abstinence at the same time supporting her relationship with her child. This is based on the clinical findings that a substance abusing mother has difficulty keeping her baby in mind and stay emotionally connecter to her baby. A residential format allows for intense supervision and daily situations between the mother and her child that foster a natural and rich working relationship.

Women-Only Programs

Some studies have shown that women-only (WO) programs are more likely than mixed gender programs to have specialized services for pregnant women such as child care, prenatal and postpartum care (Hser & Niv, 2006). They have also shown that in WO programs, women have stayed longer in treatment and were more likely to complete treatment. Factors that contributed to completing a program were support services such as child care, parenting classes and vocational training. All of those services empower and educate the mother to be a better parent and believe in herself. These specialized

women's programs focus on empowerment and supportive approaches to treatment instead of confrontational approaches. Another reason woman may seek out a WO program is that they feel less intimidated and concerned about feeling stigmatized in such settings. In mixed gender settings, pregnant substance abusing woman tend to feel the stigma that is felt by being a pregnant substance abusing women (Jessup, Humphreys, Brindis, Lee, 2003). Higher rates of completion in residential treatment are also contributed to factors such as: live in accommodations for kids, treatment including provision of family therapy, individual counseling, family services, case management, pregnancy related services, parenting skills training, vocational training and aftercare.

When pregnant women are concerned about protecting the health of their infants, programs that strengthen the mother's apprehension through outreach and education and promote her voluntary entry into treatment may be more effective than the traditional model (Andrews & Patterson, 1995). Since drug addiction often occurs simultaneously with violence, poverty, and medical/psychosocial deficits, treating this complex illness can offer improvement in many areas of life that are impacted by drug use and thereby improve the maternal and infant outcomes. These underlying issues previously stated, associated with drug use, along with poor nutrition, environmental toxins, disease and inadequate housing and health care may cause more harm to the fetus than the drugs (Jones, 2006). Coming from a proactive approach to these issues also creates less of a burden and has little effect of the women's constitutional rights.

Chapter III: Discussion

This is a real problem with real answers. The entire system must work together, the substance abusing mother, social worker and health care professional. The current system is not working. It is only increasing the mistrust of substance abusing mothers, creating unhealthy pregnancies due to lack of prenatal care and forcing everyone involved the inability to establish trust, rapport and healthy working relationships with one another.

Health care professionals, social workers, politicians and the pregnant substance abusing woman face many issues in regards to treatment and actions that need to be taken to care for the mother and her fetus. Many of the sanctions and policies adopted have threatened the Constitutional rights of the mother and have forced professionals to cross that fine line in regards to ethical standards. Efforts to address substance abuse during pregnancy should focus on preventive, educational, and voluntary treatment services that respect the mother's rights and are fair to all clients (Andres & Patterson, 1995). Efforts to ensure treatment entry from prenatal care can be enhanced by intervention models that depend on positive and supportive attitudes of providers, transportation services, on-site substance abuse assessments, peer support and case management (Jessup, Humphreys, Brindis, Lee, 2003). Despite the advancements that have been made to provide appropriate treatment for substance abusing pregnant women, we are still a long way from addressing all of their needs. For the most part, detection policies are not being implemented, although hospitals serving poor communities are more likely to have such policies. So many questions arise when developing these policies that the state and health care providers end up having conflicting claims when dealing with the mother and

the fetus. What are the appropriate detection policies? Is informed consent required for testing? What are the sanctions if substance abuse is detected? There are many hospital administrators that believe that formal policy is not needed for prenatal drug exposure. Those reasons are: they feel that health care workers always seek drug use information from appropriate patients, when a health care worker learns of a patient's drug us, he or she would educate the patient and recommend appropriate action and patient's presented with this information would immediately change their drug use behavior. Many also believed that drug detection was of lesser significance than other pregnancy related problems. Administrators do not appear to be leaders regarding policy on this issue; policy development is often left in the hands of a concerned nurse or pediatrician.

In addition to concerns with policy, treatment programs leave much room for improvement. More programs must be developed that focus on the needs of a pregnant substance abusing women. Historically, treatment programs have been designed using the male only model, which offers little regarding the needs of pregnant substance abusing women. We must also be aware of insufficient programs out there that provide voluntary drug treatment to pregnant women; especially those who require public assistance. The state does have considerable interest in protecting children from serious harm caused by their parents, but they must be able to demonstrate that: this interest outweighs constitutional rights in regards to a certain type of treatment, the reason for intervention is likely the cause of the parental harm, the intervention is likely to prevent or lessen the harm and less-intrusive options were not available. Overall, more needs to be done in an effort to provide treatment options for pregnant substance abusing women.

Recommendations for Public Policy and Treatment Options:

1. Education is the key, not punishment. Instead of fear, the substance abusing pregnant woman will become empowered to take care of herself and her unborn child. Knowing the facts is half the battle.
2. Detection policies without the fear of arrest or incarceration can only lead to further prenatal treatment and positive pregnancy outcomes. There has to be an option for the pregnant mother to receive treatment as opposed to incarceration.
3. Holistic approach to treatment offers many issues to be addressed that are not normally apart of traditional treatment. Substance abusing mothers need to address not only their addiction but issues of guilt, shame, mental health problems, histories of physical or abuse, poor nutrition, relationship problems and deficits in social support.
4. Barriers to treatment must also be addressed. Transportation must be provided along with child care. Treatment as an option is useless, unless we provide all the necessary accommodations needed.

Need for Further Research

The issues surrounding substance abusing pregnant women are not going away or diminishing. It is our responsibility to educate, build trust and offer options that benefit the mother to be and her unborn child. Further research will allow us more educational opportunities and treatment options that are not being offered today.

Conclusion

This literature focused on obstacles pregnant substance abusing women, physicians and social workers face regarding their rights, responsibilities and ethical issues. Public health approaches, policy and treatment programs are in place to address these issues but lack the appropriate direction and accommodations needed for a successful pregnancy for a substance abusing pregnant women. Further research is needed to successfully address all of the issues surrounding substance abusing pregnant women.

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