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Report to the Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives

May 1991

ADMS BLOCK GRANT

Women's Set-Aside Does Not Assure Drug Treatment for Pregnant Women

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Human Resources Division

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The Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This report responds to your request for information on the availability of drug abuse treatment for women, particularly pregnant women. Drug abuse among women in their child-bearing years is a serious national problem. Moreover, there appears to be a substantial shortage in drug treatment for women, especially pregnant women and women who are also mothers. One 1990 survey estimates that less than 14 percent of the 4 million women needing drug treatment received such treatment.[1] The health, financial, and social costs related to the impact of maternal drug use on infants and other children led the Congress, in 1988, to encourage states to use the 10 percent women's set-aside,[2] of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant, for substance-abuse treatment of pregnant women and women with dependent children.

As agreed with your staff, we determined (1) what barriers pregnant women and mothers of young children face when seeking treatment, (2) whether the Congress has the information it needs to oversee how states are using the women's set-aside to meet the treatment needs of women, and (3) whether the states used the women's set-aside to provide for the specific treatment of drug-abusing women, pregnant women, and mothers with young children. We also identified available treatment, in seven states, for pregnant women and mothers with young children (see app. I).

Results in Brief

Despite recent national attention on the effects of maternal drug use on infants and dependent children, many pregnant women and women with children do not receive drug treatment services that meet their needs. Many of these women need unique services, such as prenatal care, child care, and parenting skills in conjunction with drug treatment.

[1]National Association of State Alcohol and Drug Abuse Directors' Survey of State Alcohol and Drug Agency Use of Fiscal Year 1989 Federal and State Funds.

[2]The set-aside was $119.3 million for fiscal year 1990.

The ADMS women's set-aside increased almost 500 percent between fiscal year 1988 and 1990. Despite this increase, the Congress lacks information it needs to determine if the women's set-aside has been effective in reducing barriers to treatment and addressing the treatment needs of pregnant women and mothers with young children. This is because the Department of Health and Human Services (HHS) has not exercised its authority to clearly specify to the states what information must be provided.

Further, the women's set-aside does not assure that funds will be used to provide appropriate treatment services to drug-abusing pregnant women and mothers with young children. This is because the women's set-aside encourages, but does not require, states to fund treatment specifically designed for these women. Of the seven states we visited, two did not use the women's set-aside funds to provide for the specific treatment needs of pregnant women or mothers with young children.

Background

One of the most troubling aspects of the current drug epidemic is the increasing number of drug-abusing women. While the extent of this abuse among pregnant women is uncertain, estimates of the number of infants born prenatally exposed to drugs range from 100,000 cocaine-exposed infants to as many as 375,000 drug-exposed infants annually.[3]

In June 1990, we testified that the increasing number of drug-abusing women and the tens and hundreds of thousands of drug-exposed infants born each year is a significant problem, requiring an urgent national response.[4] Our work at ten hospitals, accounting for close to 45,000 births in 1989, showed that drug-abusing mothers are less likely to receive prenatal care than nondrug-abusing mothers. Drug-exposed infants have significantly lower birth weights, are more likely to be born premature, and have longer and more complicated hospital stays. These infants will also need medical and social services that will cost billions of dollars in the years to come.

In addition to drug-exposed infants, we found that children who depend on drug-abusing mothers also suffer. These children are often unfed,

[3]The first estimate appeared in National Drug Control Strategy (Sept. 1989), The White House; it does not mention the number of infants exposed to other drugs. The second estimate was made by the president of the National Association for Perinatal Addiction Research and Education. Neither estimate is based on a nationally representative sample of births.

[4]Drug-Exposed Infants: A Generation at Risk (GAO/T-HRD-90-46, June 28, 1990).

unsupervised, and, in general, uncared for. They also often have emotional, as well as developmental, problems and are more likely to be subject to physical abuse.

We found evidence, in addition, that drug treatment and prenatal care can make a difference in the health of drug-exposed infants and dependent children of drug-abusing mothers. However, there appeared to be a large gap between the number of women who could benefit from drug treatment and the number of available treatment slots.

The ADMS Block Grant, administered by the HHS Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), is the primary federal program that can be used to close this gap. In 1981, the Congress consolidated into the ADMS Block Grant 10 federal grant programs for alcohol, drug abuse, and mental health services. As part of the 1984 reauthorization of this block grant, the Congress created the women's set-aside, requiring states to use at least 5 percent of the total block grant to initiate or provide "new or expanded alcohol and drug abuse services for women." In the 1988 reauthorization,[5] the Congress amended the set-aside, increasing it from 5 percent to "...not less than 10 percent for programs and services designed for women (especially pregnant women and women with dependent children) and demonstration projects for the provision of residential treatment services to pregnant women." The ADMS Block Grant statute, however, does not (1) define services "designed for women" nor (2) require that a program or service be exclusively for women. Nevertheless, the Congress increased the appropriations for the ADMS Block Grant, thus increasing the set-aside for women from $24.4 million in fiscal year 1988 to $119.3 million in fiscal year 1990, an increase of almost 500 percent.

Scope and Methodology

We reviewed the sections related to the women's set-aside in the 50 state annual reports submitted to HHS up until February 28, 1991, for fiscal year 1989, the most recent year available. These annual reports include information on state utilization of the women's set-aside for drug treatment. We also visited seven states—California, Florida, Nevada, New York, South Carolina, Texas, and Washington—to collect more detailed information for case studies on the use of the women's set-aside. These states were selected on the basis of the following criteria: (1) population size (large and small); (2) population makeup (urban and rural); and (3) geographic variability.

[5]Anti-Drug Abuse Act of 1988, P.L. 100-690 (42 U.S.C. § 300x-4(c)(14)).

In the seven states, we interviewed officials of state drug treatment programs for information concerning state assessments of (1) the needs of pregnant women and mothers with young children and (2) the funds used to treat these women. To determine the barriers to drug treatment faced by pregnant women and women with children, we also met with HHS officials from the Office for Substance Abuse Prevention (OSAP), the Office for Treatment Improvement (OTI), and the National Institute on Drug Abuse (NIDA). In addition, during our interview with OTI officials, we determined the information HHS receives to monitor state compliance with the ADMS women's set-aside.

We used a contractor to conduct five focus groups in three cities (Boston, Chicago, and Los Angeles) with women who have been drug abusers while pregnant.[6] The focus groups sought the women's views and experiences on barriers that prevented them, or women they knew, from receiving drug treatment. This information complements that gathered from officials of state and federal treatment programs.

Our review was carried out between September 1990 and February 1991, in accordance with generally accepted government auditing standards.

Critical Barriers Restrict Pregnant Women From Receiving Appropriate Treatment

A number of critical barriers restrict a pregnant woman or mother with young children from receiving treatment. These women have unique treatment needs that may include prenatal care, education and counseling on parenting issues, and the care of children during treatment.

According to state officials, the most critical barrier is the lack of adequate treatment capacity and appropriate services among programs that will treat pregnant women and mothers with young children. The demand for drug treatment uniquely designed for pregnant women exceeds supply. Women in focus group discussions concurred.

The attitudes of drug treatment providers may also act as a barrier, discouraging pregnant women from entering treatment. Almost all of the women in the focus groups reported negative encounters with health care providers, which present a formidable barrier to obtaining drug treatment or prenatal care. One woman said, "They treat me like I'm nothing, like I'm dirt, like I'm scum of the earth, the bottom of the barrel. I feel like a throw-away, a cast-off."

[6]Abt Associates Inc., Boston, Mass.

Doctors frequently ignored obvious symptoms of addiction, women said, or failed to inquire in any way about drug use. One mother, for example, said she saw three physicians before settling on the third for her care during pregnancy:

> The first one—I got up my nerve and told him right out I was an addict. It didn't seem to affect his plans for me or my baby one bit. It was like he just did not want to hear me—he ignored what I said. So I went to another doctor. He never even asked [about my drug use] and I didn't tell him.

This mother was subsequently admitted to a special program designed for drug-abusing pregnant women.

Other barriers also constrain or prevent pregnant women from receiving drug treatment. Criminal prosecution of women with drug-exposed infants, while rare, has occurred, and has created fear of prosecution among pregnant women, discouraging them from seeking treatment. A more detailed discussion of the barriers, identified by state officials and women from the focus groups, can be found in appendix II.

Data Insufficient to Clarify Use of Set-Aside Program

The Congress lacks the information it needs to determine if the women's set-aside (which increased by almost 500 percent between fiscal years 1988 and 1990) has been effective in reducing the primary barrier to treatment—the shortage of appropriate treatment for pregnant women and mothers with young children. This is because HHS has not exercised its authority to clearly specify to the states what information they must provide. As a result, many state annual reports made no mention of drug treatment programs provided to mothers. In addition, many reports did not identify new or expanded treatment programs or services for women, as statutorily required. HHS has accepted these state annual reports as complete.

For the fiscal year 1989 ADMS Block Grant annual report, HHS guidance to the states did not clearly identify what specific information was required.[7] As a result, 29 states did not report whether or not they provided new or expanded treatment for women. Yet, HHS reviewed and accepted 24 of these states' annual reports without this information. HHS

[7]The Anti-Drug Abuse Act of 1988 amended the ADMS Block Grant, requiring that states prepare and submit to HHS annual reports on their use of the ADMS Block Grant, including the women's set-aside, "in such form and contain such information as the Secretary of HHS determines...." The act also requires that states must provide, in their annual reports, a detailed description of new or expanded alcohol and drug abuse programs and services using the women's set-aside.

has not completed its review of 5 other state annual reports that did not identify new or expanded treatment for women.

We reviewed the annual reports for fiscal year 1989 and found that all states reported using at least 10 percent of the block grant for the treatment of women. For many states, however, we could not determine if the women's set-aside was used to develop programs and services specifically designed for women—whether women in general, pregnant women, or mothers with young children. In addition, we could not determine if many states used state funded programs that were intended for men and women as a means of complying with the women's set-aside. For example, three states—Arizona, South Carolina, and Utah—calculated the treatment costs of women in treatment programs throughout their states in order to demonstrate that at least 10 percent of the ADMS Block Grant was used for women. Their annual reports did not identify programs that provided treatment specifically designed for women.

Further, we could not determine the extent to which the set-aside was used to provide services for pregnant women and drug-abusing mothers. Of the 50 state annual reports, 25 made no mention of services provided to pregnant women and women with children and 24 did not identify the adequacy of the women's set-aside in meeting these women's treatment needs; 6 did not identify the amount of funds given to each unit;[8] and 7 did not identify their intended objectives. The various report formats used by the states made it impossible to aggregate the data so as to present a clear national picture of the treatment needs of women, pregnant women, and mothers with young children. The lack of these data limits HHS's ability to accurately report to the Congress how the states used the women's set-aside to provide increased capacity and appropriate treatment for pregnant women and mothers with young children.

States Do Not Know Number of Pregnant Women in Need of Treatment

The seven states we visited had not determined the number of pregnant drug-abusers who require treatment.[9] Although states are not required to determine the number of drug-abusing pregnant women, without this information, states do not have a clear picture of treatment needs and cannot make informed decisions on allocating funds needed to address their problems. Five states could give us only rough estimates as to the

[8]"Units" are not defined in the guidelines and could refer to either counties or treatment programs.

[9]Two states—South Carolina and Texas—have begun studies to determine the number of drug-exposed infants born statewide.

number of pregnant women in need of treatment (see table 1);[10] none could be sure that these funds were sufficient to meet the needs of pregnant women or mothers with young children.

Table 1: Estimates of Drug-Abusing Pregnant Women in States Visited (as of June 30, 1990)

State	Pregnant women
California	65,000
Florida	10,175
Nevada	[a]
New York	24,000
South Carolina	8,936
Texas	[a]
Washington	7,000

[a]No estimate available.

ADMS Women's Set-Aside Does Not Assure Treatment Designed for Pregnant Women or Mothers With Young Children

Although comprehensive and consistent information is lacking, our review indicates that the women's set-aside does not assure that states will fund treatment specifically designed for pregnant women and mothers with young children. This is because the set-aside encourages, but does not require, states to fund treatment specifically designed for these women. What programs or services designed for women should include was not defined.[11]

The seven states we visited varied in their use of the women's set-aside. Two states—Texas and South Carolina—did not use the women's set-aside to fund treatment programs specifically designed for pregnant women or mothers with young children. Because the costs for treating women represented at least 10 percent of the ADMS Block Grant, officials from both states said their states had complied with the women's set-aside. In Texas, none of the 721 programs are specifically designed for pregnant women or mothers with young children; only 3 will admit women with their children. In South Carolina, none of the 56 treatment programs were designed for these women.

The remaining five states—California, Florida, Nevada, New York, and Washington—did use a portion of the women's set-aside to fund select

[10]State officials cautioned that these estimates were based, at best, on indirect indicators such as the number of infants born drug-exposed at local hospitals.

[11]The phrase "designed for women" suggests that the Congress may have intended that set-aside money be used for programs and services specifically tailored to serve the special needs of women. The law does not define "designed," nor does it require that a program be "exclusively" for women.

programs designed for the treatment needs of pregnant women or women with children. On a continuum, the states funded programs and services, ranging from educational materials on the adverse effects of alcohol and drugs on the fetus to more comprehensive efforts—such as a new residential treatment program for pregnant women and their newborns, including prenatal care, parenting education, nutritional guidance, and women's support groups.

Conclusion

The Alcohol, Drug Abuse, and Mental Health Block Grant women's set-aside could help close the gap between the number of pregnant women or mothers with young children needing services and the availability of treatment services specifically designed to address the needs of these women. The lack of adequate treatment capacity and appropriate services is the primary barrier to treatment for many women.

It is unclear to what extent the women's set-aside has been used by states to address the specific needs of drug-abusing mothers. HHS does not require states to provide sufficient data to determine if the women's set-aside effectively addresses their treatment needs. Some states have chosen not to target funds for the treatment of drug-abusing mothers; the current statute does not mandate that set-aside funds be specifically targeted to pregnant women or mothers with young children.

Recommendation

To better assure that the Congress is given a clear picture of how the funds for the ADMS Block Grant women's set-aside are used, GAO recommends that the Secretary of Health and Human Services direct the Administrator of ADAMHA and the Director of OTI to specify annual reporting requirements for the states in a manner that allows for the national aggregation of reported data. States should be required to report on (1) all treatment programs for pregnant women and women with children and new or expanded treatment programs or services for women—whether women in general, pregnant women, or women with dependent children—and (2) the number of drug-abusing pregnant women and women with dependent children.

Matters for Congressional Consideration

Should the Congress decide that pregnant women and mothers with young children need special funding priority for drug treatment, it may wish to consider

- amending the ADMS women's set-aside so that states are required to spend a certain percentage of the set-aside exclusively on treatment services for pregnant women and mothers with young children and
- defining what constitutes a program or service specifically designed for women, pregnant women, or mothers with young children.

As requested, we did not obtain written agency comments on this report. However, we did discuss its contents with ADAMHA officials and OTI officials. Their views were incorporated where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the appropriate congressional Committees and Subcommittees; the Secretary of HHS; and the Director of the Office of Management and Budget. If you have any questions about this report, please call me on (202) 275-5451. Other major contributors to the report are listed in appendix III.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and Public
Health Issues

Contents

Abbreviations

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
ADMS	Alcohol, Drug Abuse, and Mental Health Services
HHS	Department of Health and Human Services
NIDA	National Institute on Drug Abuse
NIMBY	not in my backyard
OSAP	Office for Substance Abuse Prevention
OTI	Office for Treatment Improvement

Review of Drug Treatment Services, in Seven States, for Pregnant Women and Mothers With Young Children

On the basis of information given by officials in the seven states we visited, we found that in 1990, five states funded some treatment services specifically for pregnant women and mothers with young children. These services included prevention and outreach for drug abuse treatment and prenatal care.

California, New York, and Washington provided extensive services for pregnant women. These states allocated significant portions of their own funding, in addition to the ADMS women's set-aside, to address the treatment needs of these women. Florida and Nevada provided fewer unique treatment services for pregnant women and mothers with young children. On the other hand, South Carolina and Texas did not have any specific treatment services for pregnant women and mothers with young children; the women's set-aside funds, state officials said, were used for treating women in general.

Of the seven states we visited, five received grants from the National Institute on Drug Abuse (NIDA)[1] and the Office for Substance Abuse Prevention (OSAP)[2] for demonstration projects specifically designed for pregnant women and mothers with young children. California, Florida, New York, Texas, and Washington received a combined total of 44 OSAP and 9 NIDA grants.

NIDA's primary objective is to identify (1) the most effective treatment for women and (2) what type of treatment works best for particular groups of women. Grants were awarded on the basis of a proposal's research design, feasibility, and fit with NIDA's research goals. Preliminary results from the first 10 demonstration projects are expected by June 1991.

The goals of OSAP's grant program include (1) coordinating with existing treatment service systems and (2) expanding the amount and availability of treatment services for these women. OSAP awards the grants on the basis of proposals offering innovative ways of meeting its objectives.

The services for pregnant women and mothers with young children given in 1990, identified by officials in the seven states we visited, are summarized below for each state.

[1]In 1990, NIDA funded 10 5-year demonstration projects to provide treatment for rural women and pregnant adolescents.

[2]As of October 1990, OSAP awarded 101 demonstration grants nationwide to address treatment services for pregnant women and mothers with young children.

California

California funded 865 slots in 192 programs to provide unique drug treatment services to pregnant women; most were outpatient treatment slots. Of the 865 slots offered, 360 were for outpatient drug-free treatment, another 360 were methadone maintenance (outpatient), and 65 were residential slots; the remaining 80 slots were for either detoxification or day care services. For mothers with young children, the state offered 2,391 slots in 82 programs. Of the 2,391 slots, 2,024 were outpatient and 367 were for 24-hour care. California also used the women's set-aside to provide education on addiction and pregnancy to health care professionals; the state provided counseling and education components to the programs for these women.

The federal government, independent of the ADMS Block Grant and state funding, also funded 3 NIDA grants and 25 OSAP grants for drug treatment of California women; of the 3 NIDA grants, 2 are for programs in Los Angeles, one providing hospital-based outpatient services to 70 pregnant women a year and the other providing both a hospital-based outpatient clinic and a nonhospital-based neighborhood clinic, serving 100 postpartum women a year. The third NIDA grant funds a hospital-based outpatient clinic in San Diego, serving 200 pregnant adolescent women a year.

Florida

Florida's 598 public drug treatment programs, with 11,666 slots, were required to give priority to pregnant women. Most of these were outpatient slots—with 8,378 slots for outpatient drug-free treatment and 924 for methadone maintenance. There were 174 residential treatment programs, of which 26 offered unique treatment services to pregnant and postpartum women and 5 admitted women with at least some of their children. State officials did not know how many slots these 174 residential programs actually made available to pregnant women and mothers with young children. The number of children who may be admitted varies between the programs. Florida also began using the ADMS women's set-aside to reimburse the programs for providing child care and transportation, vocational counselors, and crisis intervention counselors.

Florida received two NIDA grants and eight OSAP grants for treatment of women. One of the NIDA grants funds a hospital-based outpatient clinic in Miami, serving 40 pregnant adolescent women a year. The other NIDA grant is for a nonmedically based residential therapeutic community in Tampa/St. Petersburg, serving 30 postpartum women a year.

Nevada

Nevada has established pregnant women as a priority for drug treatment, but it does not offer them any specialized residential treatment. The state funded one 11-bed transitional housing facility for women with children and, in fiscal year 1990, one outpatient treatment facility with 12 slots for pregnant women. Nevada also used the women's set-aside for technical assistance to staff programs with qualified personnel for treating these women.

Nevada did not receive any NIDA or OSAP grants for the drug treatment of women.

New York

New York provided 76 programs for pregnant women and 140 programs for women with children. New York officials were not able to identify the number of slots these programs provided.

Of the 76 programs that treat pregnant women, according to a state telephone survey of the treatment providers, the most frequently reported services provided were referral, case management, and placement services, followed by medical services. Outpatient treatment was more common than residential treatment. Of the 76 programs for pregnant women, 46 offered services in an outpatient drug-free setting; 34 offered prevention services; 21 offered outpatient methadone maintenance; and 10 offered residential drug-free services.

The state's telephone survey identified 123 programs with services for children of drug abusers and 15 programs with services to drug-exposed infants. The most common service provided to children of substance abusers was counseling, followed by education, referral, case management, and placement services; 8 programs offered day-care or nursery services. Virtually all of these services were in an outpatient drug-free or prevention setting.

Of the 15 programs providing services to the newborns of substance abusers, 7 provided medical services; 4 provided referral, case management, and placement services; 4 provided evaluation and assessment; and 4 provided day care or nursery services. Of these 15 programs, 9 were in an outpatient or prevention setting; the remaining 6 were inpatient or residential drug-free treatment.

The state of New York received three NIDA grants and six OSAP grants for drug treatment of women. One NIDA grant funded a hospital-based outpatient clinic in the Bronx, serving 40 postpartum women a year. A

second NIDA grant also funded a hospital-based outpatient clinic in New York City, serving 100 postpartum women a year. The third NIDA grant funded a hospital-based outpatient clinic in Brooklyn, serving 45 pregnant women.

South Carolina

South Carolina offered no unique treatment services for pregnant women and women with children. However, South Carolina is conducting a statewide prevalence study of drug-abusing pregnant women. In the absence of prevalence information, the state used ADMS women's set-aside funds for four women's prevention programs and also for women's counselor positions. Drug treatment is generally not sex-specific. In all, the state provided 56 treatment programs, which may be attended by both men and women. Of these, 37 were outpatient drug-free treatment; 1 was outpatient methadone maintenance; 11 were residential drug-free treatment; and 7 were detoxification programs. South Carolina does not identify the number of slots these programs provide.

South Carolina had not received any NIDA or OSAP treatment grants for women.

Texas

Texas did not provide specially designed treatment services for pregnant women and mothers with young children. The state provided a total of 32,911 treatment slots in 721 programs. Of the 32,911 treatment slots available, 21,727 were for outpatient drug-free treatment; 4,500 were for outpatient methadone maintenance; and 6,684 were for residential drug-free treatment. None of these slots were specifically for pregnant abusers or mothers with young children. Of the state's 721 treatment programs, 16 will admit pregnant women and 3 will admit women with children. The state did not identify any specialized services, nor the number of slots for programs that admit pregnant women and mothers with young children.

The state expects more programs to accommodate pregnant women when it implements a new state policy, planned for mid-1991, which will prevent programs from refusing to admit women into treatment because they are pregnant. The state is also in the process of conducting a statewide prevalence study of pregnant abusers.

In its annual report for 1989, Texas said it used the ADMS women's set-aside funds for 16 programs that provided unique treatment services for women in general. The report did not identify the number of treatment

slots these programs provided. The report also indicated that most of the funds spent on treatment for women was for women in programs that serve both men and women.

Texas had not received any NIDA grants, but received three drug treatment OSAP grants for women.

Washington

The state's 272 public treatment programs are required to give priority to pregnant women. Of the 83 programs with specialized services for pregnant women, 43 were for outpatient treatment and 35 for transitional housing, outreach, on-site child care, or hospital services. The state did not identify the number of slots for these 78 programs. The remaining 5 were residential treatment programs, with a total of 40 slots for pregnant women.

These 83 programs with unique treatment services for pregnant women are required to provide health and nutrition counseling, prenatal care, parenting training, child care, links to maternity case managers, and transportation to Medicaid appointments. The largest portion of funds for these programs came from the state's own resources.

Washington also received one NIDA grant and two OSAP grants for drug treatment of women. The NIDA grant funds a hospital-based inpatient unit, an outpatient clinic, and a therapeutic residential facility that serves 120 pregnant women a year including adolescents and young adults.

Critical Barriers to Drug Treatment for Pregnant Women and Mothers With Young Children

Critical barriers prevent (or constrain the ability of) pregnant women and mothers with young children from receiving drug treatment. These barriers include the limited programs and treatment capacity available to pregnant women and mothers with young children, as well as various barriers that discourage these women from seeking needed treatment. To learn about critical barriers to drug treatment, we interviewed treatment officials in seven states, and we used a contractor to conduct focus groups, in three cities, with pregnant women who sought treatment.[1]

Critical barriers include (1) an inadequate number of programs with the capability to treat pregnant women and women with dependent children, (2) the lack of appropriate programs to address such needs as treatment for multiple drug use, (3) difficulty siting new drug treatment facilities because community residents do not want them in their neighborhoods, (4) transportation problems, (5) attitudes and behaviors of health care providers, (6) personal factors, such as denial of pregnancy and lack of readiness for treatment, (7) legal barriers, and (8) limited community outreach.

Lack of Available Treatment

The lack of available treatment for pregnant women and mothers with young children represents a significant barrier to treatment. The demand for free or publicly funded drug treatment, state officials reported, exceeds supply. Women in the focus group discussions concurred:

> The programs aren't just out there waiting for us. "Oh, you're pregnant and you use, well we have this program for you." It's not like that. I'm seeing women that want help, seeing women that want their babies, seeing women that are desperate and trying to knock on the door, "Please help us." And the response is, "Yeah, there's not a lot we can do, not a lot of programs."

Women also reported waiting as long as 1 month for most appointments and entrance into treatment. After placing their names on waiting lists, women said they often did not get calls back from the programs. The result, said one woman, is that "...you keep fixin' [while you're waiting], then you go for an appointment and they tell you you're a bad mom for doing drugs and you don't want to go back." If immediate attention is received, however, the cycle of use, even for 1 or 2 days, may be stopped. As one woman said, "Just keeping me off the street for a day was what got me started [off drugs]."

[1] Abt Associates Inc. Boston, Mass.

Some drug treatment providers, state officials said, cited fear of increased legal liability as the basis of their reluctance to treat pregnant women. In the seven states we visited, however, officials said that they did not believe that liability was, in fact, a legitimate concern. They were unaware of increased insurance costs or lawsuits related to treating pregnant women for drug abuse. Citing the fear of liability, these officials said, was more likely a justification that providers used for turning away pregnant women because the providers were unequipped to, or uninterested in, meeting the needs of these women.

Lack of Appropriate Programs

Few existing programs—either outpatient treatment or residential treatment—state officials said, are appropriate for the unique needs of drug-abusing pregnant women and mothers, such as adequate child care services and prenatal care. Women with dependent children are less likely to obtain outpatient treatment if they do not have access to child care. In the case of residential programs, most require a pregnant woman to leave as soon as she gives birth, primarily because they lack the facilities and necessary licenses to care for infants.

There also may be fewer programs for some types of addictions than others. Among drug abuse programs, women in Los Angeles said, it was easier for heroin users to get help than for crack users. In Boston, one multiple-drug user said, on going into a program for heroin users, "[you] just say you're using heroin so that they'll admit you to detox and then you do cold turkey on the crack and [the program] don't know the baby is also withdrawing from the crack."

Siting New Facilities

The shortage of treatment programs designed specifically for pregnant women and women with dependent children, state treatment officials said, is exacerbated by the difficulty of siting new facilities in the community. The "not in my backyard" (NIMBY) syndrome makes it difficult to place a treatment program in a suitable location, away from drug-infested locales.

Transportation Problems

Treatment programs are often located in areas that are relatively inaccessible by public transportation; this can be a formidable barrier for pregnant women and mothers with young children. Almost all of the women in the focus groups used public transportation. For women in the Los Angeles group, relying on public transportation for daily outpatient treatment seemed more burdensome than for those in Chicago or Boston.

One Los Angeles woman with three small children spent 2-1/2 hours on the bus, transferring twice, to get to a program that would take her. The problem of transportation is even worse if a woman who relies on public transportation must take her child or children to a child care facility apart from the drug treatment facility.

Attitudes and Behaviors of Health Care Providers

Almost all of the women in the focus groups reported negative encounters with health care providers; such experiences present a formidable barrier to obtaining drug treatment or prenatal care. Doctors frequently ignored obvious symptoms of addiction, women said, or failed to inquire in any way about drug use. One mother, for example, said she saw three physicians before settling on the third for her care during pregnancy:

> The first one—I got up my nerve and told him right out I was an addict. It didn't seem to affect his plans for me or my baby one bit. It was like he just did not want to hear me—he ignored what I said. So I went to another doctor. He never even asked [about my drug use] and I didn't tell him.

This mother was subsequently admitted to a special program designed for drug-abusing pregnant women.

Personal Barriers to Treatment

Women in the focus groups identified denial of pregnancy and other personal factors as barriers to treatment. Many reported getting high to forget the fact of their pregnancy and their related worries. One said "[My reaction to my pregnancy was] let me use some more so I don't have to feel those feelings, so you don't have to worry about where you're going to sleep, where you're going to get your next fix." Such denial eliminates pregnancy as an impetus for seeking treatment and thus acts as a barrier. Women in every group also agreed that the addict's lack of readiness for treatment can be a barrier. To be ready, addicts say, they must often hit rock bottom, which frequently includes selling themselves to buy drugs, feeling physically and emotionally so bad that "death stares at you up ahead."

Inadequate knowledge of drugs and their effects also contributes to a lack of readiness. One woman said that she would "eat a lot of white bread, y'know like Wonder Bread," before smoking crack: "I figured all that bread would stop up the passage through the umbilical cord so the crack wouldn't get through to the baby."

Legal Barriers to Treatment

The threat of prosecution poses yet another barrier to treatment for pregnant women and mothers with young children. These women are reluctant to seek treatment if there is the possibility of punishment, which may include incarceration and losing their children to foster care. In four states, a woman can be prosecuted for child abuse by drugs passed to the fetus through the umbilical cord. In Florida, there have been two child abuse prosecutions of women who gave birth to drug-addicted babies. Such prosecutions are rare, but, state officials said, women in need of treatment are well aware of the threat; this poses a major barrier to their seeking treatment. Highlighting this fear, women in the Los Angeles focus group said, "If you go for prenatal care and your urine tests positive for drugs, then the physician must report it. If you have other kids, then they'll take your kids away. So if you have other kids, you'll avoid getting prenatal care."

Limited Community Outreach

Because personal and social barriers often discourage substance-abusing pregnant women from receiving treatment, outreach and referral services are critical in helping these women seek treatment. Hospitals and health care agencies, however, may not adequately refer pregnant women to available treatment services. Finding a program that treats pregnant women, women in the focus groups said, is very difficult. They did not know of any one source of information about the available programs that would accept pregnant women. A pregnant woman in need of treatment may have to locate and call several programs on her own before she can find one that will admit her.

Encouraging pregnant women and mothers with young children to enter drug treatment can make a difference. This was best summed up by one drug-abusing mother, who said:

> I'd like to say that since I've gotten clean ... it's affected my whole family. My son doesn't smoke crack any more and he's not pulling stereos out of cars anymore. My daughter can hug me without being stiff like a board from fear. She works today, she goes to school today. A chain is being broken. If you can get one person clean, especially a mother that has children, it affects the whole family. And my kids are educated [about] drugs, all drugs, sex; they're educated about this AIDS thing and it's broken a chain today.

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