

## Article 15

### **Treating Pregnant Women With Substance Abuse Issues in an OBGYN Clinic: Barriers to Treatment**

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#### **Abstract**

The intent of this article is to identify and explore barriers to treatment for women who are pregnant and are currently using or at-risk for using alcohol and other drugs. The focus is on the internal and external barriers women face and staff attitudes towards treating this population. A university-based Pregnancy and Recovery Clinic is discussed.

*Keywords:* barriers, pregnancy, substance abuse treatment

Some women experience substance use and addiction problems during pregnancy. According to the 2011 National Survey on Drug Use and Health (Gordek & Folsom, 2012), 5% of pregnant women between the ages of 15 and 44 were using illicit drugs, with marijuana being the most common. Between 2006 and 2010, 7.6% of pregnant women, or 1 in 13, reported using alcohol in the past 30 days, and 1.4%, or 1 in 17, reported binge drinking (defined as having four or more drinks on one occasion; Wong, Ordean, & Kahan, 2011).

There are many risks associated with alcohol and other drug use during pregnancy. For example, there is an increased risk of miscarriage or having babies with low birth weight, medical problems, and developmental delays. Women who drink alcohol during pregnancy put their unborn children at risk for Fetal Alcohol Syndrome (United States National Library of Medicine, 2013). Women who use other drugs, such as cocaine or heroin, risk having babies with their own physical addiction. After birth, these babies may experience withdrawal and often require intensive medical treatment and extended hospital stays (Mayat, Groshkova, Morgan, MacCormack, & Strang, 2008).

Expectant mothers with addiction issues face internal and external barriers that keep them from seeking and participating in treatment, including a lack of transportation, childcare, and health insurance (Brady & Ashley, 2005; Kearney, 1998). They also face challenges in receiving support and advocacy from their care providers, who frequently have their own biases towards this population. Healthcare provider bias may be partly due to a lack of training in treating pregnant women who are using substances (Cowan, 2003). Another contributor may be that some states have criminalized the use of alcohol and other drugs during pregnancy. Women who seek services in these states may face charges of “chemical endangerment of a child,” a Class A felony that carries a mandatory sentence of 10 years to life. This approach further adds to the stigma of seeking treatment, for fear of being arrested and losing custody of other children (Calhoun, 2012).

### **External Barriers to Substance Abuse Treatment**

Women seek substance abuse treatment less often than their male counterparts. In 2002, 30% of admissions to substance abuse treatment were women (Tuchman, 2010). Low rates of treatment entry among women reflect gender-specific barriers. These barriers discourage treatment access, retention, and completion (Tuchman, 2010). There is a multitude of external barriers that impede pregnant, substance-abusing women from seeking treatment.

A pervasive issue in the United States is that a limited number of treatment facilities accept pregnant women (Ashely, Marsden, & Brady, 2003). Brady and Ashley (2005) found that 19% of treatment facilities nationwide offered programming specific to the needs of pregnant women. Furthermore, residential (non hospital-based) and outpatient methadone clinics tended to provide “special programs” for pregnant women (p. 68). Therefore, if women do not meet the specific criteria for admission (e.g., having an opioid addiction), services are not available.

Other external barriers include lack of transportation; long wait periods for appointments; lack of child care, finances, and health insurance; having lower levels of education; and lack of work skills found in male counterparts (Brady & Ashley, 2005; Kearney, 1998). The lack of childcare, insurance, and work-related skills prevents women who are motivated to seek treatment from following through with treatment (Brady & Ashley, 2005).

Professionals who provide care to this population should keep in mind that pregnancy is often a major stressor that increases the severity of existing problems. It is essential to set realistic treatment goals and expectations that are client centered, and to address the often overlooked reasons why clients have difficulty following through with treatment goals. According to Daley, Argeriou, and McCarty (1998),

Policy and programming should be responsive to the full range of needs of this population to avoid substance abuse treatment that provides only temporary and repeated respite from drug use without any long-term impact on the lives of the women and children involved. (p. 247).

Another often overlooked barrier is that women who are addicted to alcohol or other drugs may have partners who are also addicted (Ashley et al., 2003). If one’s partner is unwilling to seek treatment, he or she may not support the pregnant partner’s choice to seek treatment. Often, partners are fearful that they will be asked to stop using.

Even if a pregnant woman is able to start treatment, having a partner at home who is still using alcohol or other drugs can be an added challenge to her recovery. In a study funded by the National Institute on Drug Abuse in 2007, 86 women who were participating in residential and outpatient substance abuse treatment were interviewed to assess positive and negative aspects of their social support network that affected their recovery. Comments about the lack of support from significant others included, “he let me use when I was pregnant”, “...urged me to use, put ideas in my head even when I was trying to stop”, and “he parties himself so he doesn’t help me much, he doesn’t push me to do what is right” (Tracy, Munson, Peterson, & Floersch, 2007, p. 273).

Often, a relationship with a significant other goes beyond being unsupportive and becomes violent (Ashley et al., 2003). The Centers for Disease Control defines domestic violence during pregnancy as “physical, sexual, or psychological/emotional violence that are inflicted on a pregnant woman.” Violence is cited as a pregnancy complication more often than diabetes, hypertension, or any other serious complication (*Domestic Violence in Pregnancy*, 2010). According to the National Violence Against Women survey (NVAW; *Domestic Violence in Pregnancy*, 2010), approximately 1.5 million women are raped and /or physically assaulted by an intimate partner yearly. In 2000, 1,247 women were killed by an intimate partner. Further, pregnant women are 61% more likely to be victims of domestic violence than women who are not pregnant (*Domestic Violence in Pregnancy*, 2010). Often, the reason cited for the abuse is the increased stress from an unplanned or unwanted pregnancy. Frequently overlooked, however, is that the pregnancy itself may have been caused by sexual abuse, rape, or denial of access to birth control (Ashley et al., 2003). Women in abusive relationships are often afraid to seek assistance and avoid revealing the extent of their problems for fear of retaliation from their abuser. This leads to isolation, problems with mood disorders, and increased use of alcohol and other drugs to mask their distress (Ashley et al., 2003).

### **Internal Barriers to Substance Abuse Treatment**

Pregnant women with substance abuse issues face many internal barriers to treatment. These include shame and fear of being judged by care providers, fear of being reported to social services and losing custody of children and public assistance resources, and co-morbid conditions such as depression and anxiety (Brady & Ashley, 2005). Marcus, Flynn, Blow, and Barry (2003) screened 3,472 pregnant women for depressive symptoms while they received services in an obstetrics setting. Twenty percent (n = 689) of the women’s scores on the Center for Epidemiological Studies-Depression scale (CES-D) suggested they were experiencing depressive symptoms. Of those, 13.8% reported receiving treatment for depression. Other significant factors associated with depressive symptoms during pregnancy were “poorer overall health, greater alcohol use consequences, smoking, being unmarried, unemployed and [having] lower educational attainment” (p. 373).

### **Caregiver Attitudes Toward Pregnant Women Who Abuse Substances**

A significant barrier to treatment for pregnant women is caregiver attitudes. Pregnant women who abuse substances are the mostly likely group to be stigmatized and

treated punitively for their addiction-related behavior. Often, pregnant women will not reveal their addiction to a medical provider, and, if confronted, they will deny or minimize their use. Pregnant women who abuse substances frequently try to hide their problems and hope for a favorable outcome. Studies have shown that pregnant women drop out of treatment when they are confronted harshly or when a medical provider attempts to scare them into stopping their drug use (Corse, McHugh, & Gordon, 1995). Corse et al. (1995) reported that over 75% of physicians, certified nurse-midwives, lay nurse-midwives, and nurses identified the greatest difficulties in working with this population are dealing with its denial of abuse and resistance to treatment. Many medical professionals do not have specific training in addiction and experience uncertainty in how to conduct effective clinical interviews and how to respond supportively to potentially disturbing disclosures by patients.

Corse et al. (1995) also conducted a qualitative study at an urban prenatal clinic exploring the impact of staff (nurse-midwives) trained in substance abuse-specific topics and in effective interviewing techniques in order to gather substance abuse-specific information from clients. After participating in training, the nurse midwives were interviewed to examine the effect the training had on their clinical interactions with patients. The following statements summarize the training's enhancement of participants' interviewing skills and its effectiveness in causing them to pay attention to and work on recognizing their own biases when talking with clients about substance abuse issues: "I realized that I had learned a lot of ways of either not finding out that people were using or convincing myself that they weren't anymore."

My interview skills have improved. I used to phrase questions like this: 'You don't drink, do you?' or 'How about drugs, you know you shouldn't do that when you're pregnant.' Now I ask about each specific substance by name. I assume there is use and make it easy for the person to tell me about it. (p. 7)

It is widely accepted that unbiased clinical screenings for substance use during pregnancy improve early problem identification and allow for referral to appropriate, specialized treatment (Chasnoff, Neuman, Thornton, & Callaghan, 2001). Despite receiving extensive medical training and being perceived as experts on medical teams, most physicians do not receive specialized training in treating pregnant women who have substance use issues (Albright, Skipper, Riley, Wilhelm, & Rayburn, 2012). Albright et al. (2012) examined medical students' comfort levels when treating women who had substance use disorders. A pre/post survey was given to 96 students during their obstetrics and gynecology rotation. All students worked in a clinic that treated women with substance abuse disorders. Half the students were then assigned to work in a residential treatment setting for pregnant women who abused substances (the study group), while the other half continued their regular rotation experience (the control group). The results showed that residents who participated in the specialized training expressed a greater comfort level in assessing and educating patients about substance abuse during pregnancy.

A growing trend that healthcare providers, counselors, and clients face is the criminalization of substance use during pregnancy. The criminalization of drug use during pregnancy began in the 1980s when the United States, under the leadership of President Ronald Reagan, began the so-called "war on drugs." Cocaine use was more popular, particularly in the inner cities, and news media began reporting on an "epidemic

of crack babies” (Scott, 2006). Despite the fact that there was no scientific evidence to support the growing belief that cocaine use during pregnancy caused certain neurological damage and other developmental problems, states began passing laws to treat pregnant substance-abusing women as criminals. This trend continued to grow during the late 1980s and early 1990s. In 1996, South Carolina became the first state in the nation to impose criminal sanctions against women whose drug abuse during pregnancy led to the injury or death of their fetus or newborn baby (Sovinski, 1997). In 1997, the landmark case, *Whitner v. State* (Lewin, 1997), found Cornelia Whitner, a young woman with multiple social and financial stressors, guilty of child abuse because her baby tested positive for cocaine. She was sentenced to 8 years in prison and offered no substance abuse treatment.

More recently, prosecutors in Alabama have taken a law designed to protect children from exposure to meth labs and begun to charge women with chemical endangerment of a child, a Class A felony that carries a mandatory sentence of 10 years to life if their baby is born with a positive drug screen, regardless of whether the child shows any signs of being negatively affected (Calhoun, 2012). Since 2006, Alabama has prosecuted 60 women. One of the most aggressive prosecutors, Mitch Floyd, has made this statement in support of his hard stance against pregnant women with substance abuse issues:

Addiction is a very powerful force. However, there is a force that is more powerful than that to me, and that is a child is helpless, and God has put one person on this planet to be the last-line defense, to be the fiercest protector of that child, and that is its mother. My wife would literally claw somebody’s eyes out - fight you to the death - for our children. I mean, that’s what mothers are supposed to do. When that child’s ultimate protector is the one causing the harm, what do you do?” (Shapiro, 2012, p. 2)

This “idealized mother myth” purports that women alone are responsible for and are the ultimate protectors of their children. There is no mention of “father” or “parent.” If women are suffering from their own struggles, such as addiction, and cannot live up to this expectation, then the answer seems to be to punishment rather than support and treatment (Shapiro, 2012).

Those who advocate for enhanced and comprehensive substance abuse services often refer to pregnancy as a “window of opportunity” for intervention because concern for the unborn child can be a powerful motivator for women to stop using and participate in treatment. While this belief is widely held, there is no empirical evidence to support it and no evidence to show that pregnant women behave any differently than other women when they participate in treatment (Daley, Argeriou, & McCarty, 1998). Daley et al. (1998) reported on a study done by the Massachusetts Medicaid Opportunities to Help Enter Recovery Services (MOTHERS) Project (1993) found that pregnant women were 1.7 times more likely to have multiple admissions for detoxification than other women in treatment. These women reported that pregnancy was a time of hopefulness and joy due to the birth of a child and the possibility of being clean and sober. However, pregnancy also was a source of stress that may have led to their relapses (Daley et al., 1998).

## **Pregnancy and Recovery Clinic**

To better understand and begin to address the barriers to recovery faced by pregnant substance abusing women, the Department of Addictions and Rehabilitation Studies at East Carolina University in partnership with the Brody School of Medicine formed the Pregnancy and Recovery Clinic (PARC). As reported by Albright et al. (2012), medical providers often do not have adequate training in the treatment of women with substance use issues. The Pregnancy and Recovery Clinic was embedded in the medical school's OBGYN clinic and staffed by doctoral and master's-level students enrolled in the Rehabilitation Counseling & Administration program and the Substance Abuse & Clinical Counseling program to provide substance abuse assessments, brief interventions (motivational interviewing), and psychoeducational groups on-site. Patients were able to access substance abuse services during visits to the clinic for prenatal or postnatal care appointments, reducing the need for additional travel or cost to receive appropriate care. PARC staff members consulted with OBGYN staff to ensure continuity of care and assist with recommendations for additional treatment.

Some factors clients reported as key in increasing their attendance were counselors' overall approach (client centered), seeing the counselor as part of the regularly scheduled doctor's appointment, having healthy snacks available during individual and group counseling sessions, and the availability of no-cost baby needs (diapers, wipes, receiving blankets, and clothing).

From the counselors' perspectives, benefits included increased client attendance, the fostering of collaboration and continuity of care with medical staff, and Medicaid's payment of patient transportation costs to the OBGYN clinic for medical/counseling appointments. Counselors also listed areas for improvement, including strengthening the medical staff's substance abuse screening skills to ensure appropriate client referrals, and increasing counselor and medical staff cross-training to ensure client-centered care and minimize provider bias (Albright et al., 2012).

## **Conclusions**

Many barriers hinder expectant mothers with addiction issues from participating in treatment. Low self-esteem, unsupportive interpersonal relationships, biased attitudes and inadequate training of medical providers, along with trends towards more punitive legal consequences can all contribute to pregnant substance abusers dropping out of treatment or avoiding it all together. The myth of the "ideal mother" compounds the already harsh standards to which these women are held and upon which they are often judged unfairly. To lessen these barriers, providers must evaluate their own biases and gaps in awareness and training and then take strong stands as advocates and supporters in order to assist clients in deriving the greatest benefit from substance abuse treatment.

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