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Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women

by

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and

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The use of illicit drugs has increasingly been recognized as one of the major problems facing our society, even to the point of generating a "war on drugs." But while the rhetoric may have a new ring, the war has been fought using varying strategies for more than a century with little success. This Article briefly reviews the American drug experience since the mid-nineteenth century A.D. One important historical aspect of this experience involves drug use by women. Despite male domination of the "drug scene" during the twentieth century, the number of female addicts has increased dramatically in recent years, giving rise for the first time to gender specific drug issues.

Maternal drug use is associated with significant morbidity and increased mortality in offspring. This Article reviews these adverse outcomes, which are both medical and social in nature. Recognition of the problems and the widespread societal disruption caused by drugs, especially crack cocaine, has engendered a sense of national frustration. This in turn has led to increasingly punitive efforts directed against women who use drugs. This Article briefly reviews and criticizes these punitive efforts, and also surveys alternative approaches to the problem, including legalization, an increased role for Child Protection Services, and expanded comprehensive treatment programs. Finally, the authors explore

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the positive benefits derived from this last approach and propose criteria for an effective supportive treatment model for drug using women.

I. Drugs in America: A Brief History

Although media coverage surrounding "crack" cocaine use may suggest that our country is fighting its first war on drugs, the problem of illicit drug use has existed in America for over 150 years. This country's first experience with a major drug of addiction involved opium. Opium use probably dates to about 4000 B.C. in Sumeria. Other ancient cultures known to have used opium include Egypt, the Swiss lakeside cultures, Crete, Cyprus, Persia, and Greece. Opium reached China during the seventh century and subsequently spread to India. Growing trade between India and China in the seventeenth to nineteenth centuries resulted in major opium use in China. This set the stage for the opium problem in the United States.

In the early nineteenth century, when physicians had limited ability to treat patients pharmacologically, opium was a basic ingredient in many medications. This widespread usage no doubt contributed to opium's popularity as a therapeutic agent. Prescription of opiates became common as part of medical therapy because opiates reduce gut motility. Thus, they were widely prescribed during episodes of cholera in 1832-1833 and 1848-1854 and dysentery in 1847-1851.

Following the Opium Wars of 1839-1842 and the Treaty of Tientsin in 1858, China was opened to the world market and large numbers of Chinese workers emigrated to America as the United States continued its westward expansion. The difficult working conditions these immigrants faced drove many to opium dens for gambling, prostitution, and drugs—during this period an estimated 20-25% of Chinese workers in America smoked opium. Although contacts between Chinese and whites initially were very limited, transfer of opium from the immigrant workers to

2. Id. at 48.
3. Id. at 47.
5. D.T. Courtwright, Dark Paradise: Opiate Addiction in America Before 1940 55 (1982). Gut motility means the normal movement of the intestines. Since diarrhea is associated with increased gut motility, opiates were (and continue to be) used to treat such conditions.
6. Id. at 46.
7. Id. at 67.
8. Id. at 70.
whites began to occur after 1870, primarily through underworld contacts.\(^9\)

The Civil War further contributed to the rise in opium use, as approximately ten million opium pills and 2.8 million ounces of opium powders and tinctures were distributed to Union forces alone.\(^{10}\) Following the war, a large number of veterans became dependent on opium to soothe painful and inadequately treated wounds.\(^{11}\) The development of the hypodermic syringe during the Civil War also led to increased use of morphine,\(^{12}\) the principal alkaloid of opium, which had been isolated in 1817.\(^{13}\) Like opium, morphine was originally used to treat a wide variety of conditions, including hiccoughs, neuralgias, alcoholism, chronic respiratory disorders, dysentery, malaria, syphilis, rheumatism, postoperative conditions, insomnia, anxiety, and fatigue.\(^{14}\) In addition to its multiple medical applications, nontherapeutic applications of morphine developed, and it found use as a stimulus to the imagination for artists and writers, as a substitute for alcohol,\(^{15}\) and even as a birth control measure.\(^{16}\) Of special relevance to women was the use of morphine for dysmenorrhea (painful menstrual periods) and "nervous disorders," leading to the iatrogenic\(^{17}\) addiction of many women during the nineteenth century.\(^{18}\) In the mid-nineteenth century, 60-75% of the opium-morphine addicts in the United States were women—primarily white, twenty-five to forty-five years old, middle to upper class, mainly housewives and teachers but also prostitutes, nurses, and doctors' wives.\(^{19}\)

By 1900, however, much progress had been made against chronic morphine use. The progress resulted from a variety of factors: the prevalence of many infectious diseases was diminishing due to improved sanitation and public hygiene;\(^{20}\) unscrupulous physicians were coming under increasing control;\(^{21}\) better diagnostic precision had led to decreased nonspecific morphine use;\(^{22}\) Civil War veterans who were morphine addicts

\(^9\) Id. at 71.
\(^{10}\) Id. at 55.
\(^{11}\) Id. at 55-56.
\(^{12}\) Id. at 46.
\(^{13}\) Id. at 45.
\(^{14}\) Id. at 48-49.
\(^{15}\) Id. at 59.
\(^{16}\) Id. at 60. Opium produces amenorrhea (abnormal stoppage of the menses). Id.
\(^{17}\) "Iatrogenic" means resulting from the activity of physicians.
\(^{18}\) COURTWRIGHT, supra note 5, at 48.
\(^{19}\) Id. at 41.
\(^{20}\) Id. at 52.
\(^{21}\) Id. at 53.
\(^{22}\) Id. at 52.
were dying off; milder analgesics were being developed; and doctors were becoming better informed as to the dangers of morphine and were joined by legislators in the institution of new legal restraints.

As public pressure to control opiate use mounted, state and local governments began to initiate legislation in the 1870s. These efforts, initially aimed at controlling opium smoking among the Chinese, did not lead to decreasing drug use and succeeded only in driving opium smoking underground. By the 1890s, despite the growing national concern over opium use, the incidence of opiate addiction in the general population had increased seven-fold from less than 1 in 1000 in 1842 to almost 5 in 1000. This result illustrates the futility of attempting to outlaw drug use absent a comprehensive strategy to reduce drug demand.

The close of the nineteenth century also saw a dramatic increase in national concern over cocaine use. In fact, cocaine use was hardly new. A raw, impure form of cocaine, derived from the leaves of the coca plant growing in the mountainous regions of Peru and Bolivia, had been chewed by the Inca Indians for at least 5000 years. Cocaine did not reach Europe, however, until brought there by the Spaniards in the sixteenth century. In 1866 an American chemist, John Styth Pemberton, developed a patent medicine, "French Wine of Coca, the Ideal Tonic"; when marketed as a soft drink, it was called Coca-Cola. But despite its early availability, cocaine aroused little interest until popularized and promoted by Sigmund Freud as a cure for various maladies in his 1884 paper, Uber Coca [On Coca]. It became widely used as a topical anesthetic, promoted by physicians and pharmacists as part of their unregulated therapeutic armamentarium. In literature, the drug gained notoriety through the character of Sherlock Holmes, whose case solv-
ing brilliance was often attributed to the mind expanding properties of cocaine, to which he was addicted.

By the late nineteenth century, cocaine had become very popular, finding usage as a general tonic for conditions such as melancholia, hay fever, sinus problems, and as a reported cure for opium, morphine, and alcohol addiction.\textsuperscript{34} The drug’s stimulant properties led to its use in sodas, wine, and cigarettes.\textsuperscript{35} Many physicians became addicted to cocaine because of their need to remain awake for long periods of time and to combat stress related conditions such as headaches.\textsuperscript{36} Among males the highest rates of addiction were among doctors; it is estimated that about 12,000 addicted physicians lived in the United States at the turn of the century.\textsuperscript{37} Soon, recognition of cocaine’s potential for addiction lent support to initial legislative attempts to control its use.\textsuperscript{38}

The growing use of cocaine in the white population was accompanied by an increasing use of the drug among blacks.\textsuperscript{39} Fear that blacks would “overstep their bounds” under the influence of cocaine and move into white society further increased pressure to control cocaine use.\textsuperscript{40} Proponents of legislative controls introduced and perpetuated the myth that cocaine would make blacks resistant to bullets and foster violence, including sexual violence against white women.\textsuperscript{41}

Thus the early twentieth century saw a convergence of factors, including recognition of the drug’s addictive properties, disenchantment with physicians’ and pharmacists’ uncontrolled use of patent medicines, and racist fears, which increased political pressure to control cocaine. State laws were considered necessary because it was thought that federal drug control legislation would be unconstitutional.\textsuperscript{42} Typical of these new legislative efforts was an 1898 Houston, Texas ordinance, imposing a twenty-five to one hundred dollar fine for any unauthorized sale of cocaine, morphine, or opium.\textsuperscript{43} As a result, at the turn of the century, a higher percentage of addicts were considered “disreputable.”\textsuperscript{44} For these reasons the turn of the century marked a turning point in the social transformation of the American addict.

\begin{footnotes}
\item[34] Musto, \textit{supra} note 4, at 7.
\item[35] Id.
\item[36] Courtwright, \textit{supra} note 5, at 50.
\item[37] Id. at 50.
\item[38] Crittenden & Ruby, \textit{supra} note 33, at 17.
\item[39] Musto, \textit{supra} note 4, at 7.
\item[40] Id.
\item[41] Id. at 6-7, 43-44, 254-55 n.15.
\item[42] Id. at 9-10.
\item[43] See Courtwright, \textit{supra} note 5, at 176 n.137.
\item[44] Id. at 61.
\end{footnotes}
Increasingly, illicit drug use was seen as a national problem. The perceived need to pass antidrug legislation was made more urgent by the United States' emergence as a world power and its concomitant assumption of international responsibilities. The United States participated in the Shanghai Commission of 1909, the first coordinated attempt to impose international controls on all drugs. Attempts to pass federal antidrug legislation were made in 1909-1910, but these failed. The dangers of drug use, however, were becoming increasingly clear to the American people and to Congress. President Taft's 1910 statement to Congress reflected this growing national concern: "The misuse of cocaine is undoubtedly an American habit, the most threatening of the drug habits that has ever appeared in this country . . . ."

As one response to this threat, for the first time some states began to institute drug treatment programs. In 1912, Dr. Charles Terry established a free narcotic maintenance clinic in Jacksonville, Florida for heroin, morphine, cocaine, and laudanum addicts; this clinic became the forerunner of our current methadone maintenance programs. Finding that 55% of his patients had been addicted by physicians, Dr. Terry became a vocal critic of disreputable physicians and pharmacists. Model drug treatment programs were also established in other states, especially New York, which already had attracted a large percentage of the country's addicts. One such program, based on narcotic maintenance, was housed in the New York City Health Department building on Worth Street. But despite these initial attempts to offer drug treatment to addicts, continued pressure to outlaw drug use culminated in the Harrison Act of 1914, landmark federal legislation which imposed strict controls

45. Musto, supra note 4, at 35-36. These interdictive measures lead to a decrease in the amount of opium available for consumption. This development was, however, unassociated with a reduction in demand, leading instead to a three to ten-fold increase in the price of opium. Courtwright, supra note 5, at 83.

46. E.g., H.R. 25241, 61st Cong., 2d Sess. (1910) (Foster Bill would have taxed and regulated the production, manufacture, and distribution of certain habit forming drugs).

47. Musto, supra note 4, at 44.


49. Musto, supra note 4, at 97-98.

50. Id. at 98-99.

51. In 1920, 9 of 10 heroin addicts, mainly belonging to the lower middle and lower classes, lived around New York City. Courtwright, supra note 5, at 89.

52. Musto, supra note 4, at 156-58.

53. Anti-Narcotic Act of 1914, 38 Stat. 785 (1914) (repealed 1970). The constitutionality of the Harrison Act was upheld by the Supreme Court in 1928. Nigro v. United States, 276 U.S. 332, 354 (1928) (holding that it is not an undue invasion of the State's police power for Congress to require any person selling specified drugs to do so in pursuance of a written order
on physicians using narcotics to treat patients. The Harrison Act provisions, in conjunction with the general opposition to drug maintenance therapy that its enactment reflected, led to the closure of many drug treatment centers. This in turn led to the growth of a black market drug trade.

It was during this period that heroin use first became a major problem. Heroin had been introduced in 1898 as a cough suppressant. Although heroin originally was considered safe and nonaddicting when taken orally or by sniffing, the potential for heroin addiction increased as injection techniques became safer. Heroin's popularity also grew, as cocaine use declined under the pressure of anticocaine legislation and rising prices. By 1920, heroin was firmly rooted in the underclass, the majority of users being young men.

While the Harrison Act represented the first comprehensive criminalization of opiate use, two 1919 Supreme Court cases, United States v. Doremus and Webb v. United States, supported prosecution of a physician for administering opiates to a patient and further advanced the antitreatment stance of the government. This severe antidrug posture was compatible with profound changes occurring in post-World War I American society. During the war, addiction had been perceived as a threat to our national morale and security. In the war's wake, Congress passed the Eighteenth Amendment, while liberalism gave way to fervent nationalism.

As pressure to control drug use mounted, the involvement of the federal government in the regulation of the drug trade also grew. By the early 1920s, no state treatment programs remained; the federal gov-

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55. COURTWRIGHT, supra note 5, at 107.
56. Id. at 87.
57. Id. at 108.
58. Following passage of the Harrison Act, most states passed anticocaine legislation, driving cocaine underground. Its use became confined mainly to movie stars, jazz musicians, and wealthy thrill seekers. Crittenden & Ruby, supra note 33, at 14, 17.
59. COURTWRIGHT, supra note 5, at 88-89.
60. 249 U.S. 86 (1919).
61. 249 U.S. 96 (1919).
62. For example, pressure to regulate drugs in New York crystallized in a 1917 report to the state legislature by the select Whitney committee, which stated: "The problem of narcotic drug addiction has passed all bounds of reasonable comprehension in the state of New York and in the United States [and has become] the greatest evil with which the Commonwealth has to contend at the present time." MUSTO, supra note 4, at 112.
63. Id. at 183.
ernment had succeeded in centralizing drug control authority. After a period of preliminary efforts aimed at drug treatment, governmental policies focused instead on interdiction and elimination of drugs in America. Because of earlier physician involvement in prescribing narcotics and because of this new focus on interdiction, treatment, which generally consisted of dispensing and maintaining morphine, became politically unpopular.\textsuperscript{65}

The 1930s in America saw the creation of "Federal Narcotic Farms," which ostensibly were treatment centers, but in reality were akin to prisons run by the Public Health Service under the vigilant supervision of the Justice Department and the Federal Bureau of Narcotics.\textsuperscript{66} Interdiction efforts based upon wide ranging international agreements continued to drive up black market prices during the 1920s and 1930s.\textsuperscript{67} Heroin—cheap, easily cut and adulterated, more potent than morphine, and sniffable—was becoming very profitable.\textsuperscript{68} Its use spread throughout the underworld and underclass, and by 1940 the heroin addict was described as a lower-class, intravenous "junkie."\textsuperscript{69}

In the 1940s, the purported link between crime and drugs fueled national movement toward a punitive approach to drug use, resulting in harsh penalties for nonmedicinal use.\textsuperscript{70} This trend culminated in the passage of the Narcotic Control Act of 1956,\textsuperscript{71} which was extremely harsh on drug dealers, allowing imposition of the death penalty for an adult caught selling heroin to anyone under eighteen years of age.\textsuperscript{72}

In the 1950s, however, a different, treatment based approach to drug addiction gained popularity as the legal and medical communities began to reassess the impact narcotics had had on health and society. This movement stemmed from the recognition that a long period of interdiction efforts, harsh penalties, and reduced treatment options had failed to significantly reduce drug use in the United States. In the early part of the century, the criminal model had prevailed and physicians were prose-

\textsuperscript{64} See id. at 182.
\textsuperscript{65} This view persists to some degree today, finding expression in antimethadone and antineedle exchange sentiment.
\textsuperscript{66} MUSTO, supra note 4, at 204-06.
\textsuperscript{67} COURTWRIGHT, supra note 5, at 108.
\textsuperscript{68} Id.
\textsuperscript{69} Id. at 113. The word "junkie" derives from the fact that addicts in New York in the 1920s sold "junk" as a means of supporting their habits. Id.
\textsuperscript{70} MUSTO, supra note 4, at 230.
\textsuperscript{72} MUSTO, supra note 4, at 231.
cuted for prescribing drugs to addicts. Organized medicine, which initially had joined in condemning any treatment placing opiates in the hands of addicts for self-administration, now reversed itself. The American Medical Association (AMA) now urged decriminalization of the addicted status and the development of comprehensive medical and social treatment.

This shift in national focus continued during the 1960s, furthered by the election of President Kennedy, who led a successful campaign for massive infusions of capital into mental health programs. In its 1962 landmark decision, Robinson v. California, the United States Supreme Court classified addiction as a disease and not a crime. The growth of the National Institutes of Health during the 1960s reflected the public's desire to more fully understand the effects of drug use. The 1960s also saw the relaxation of minimum sentences for drug related crimes, increased funding for research, and the dismantling of the interdiction oriented Federal Bureau of Narcotics, whose functions were transferred to the Departments of Justice, and Health, Education and Welfare.

Despite the advances, the debate between those favoring treatment and those favoring punishment continued. Some professionals advocated complete withdrawal from drugs to treat addiction; others argued that treatment by supervised maintenance or detoxification constituted a sound approach. Significant support for the latter approach was provided when Drs. Vincent Dole and Marie Nyswander, working at Beth Israel Hospital in New York City, demonstrated that chronic heroin addicts maintained on oral methadone showed renewed interest in themselves and in constructive social activity. Correspondingly, the Narcotic Addict Rehabilitation Act of 1966 stressed rehabilitation rather than criminalization. The numbers of addicts needing treatment,
however, already surpassed the resources available. In 1968, the Bureau of Narcotics and Dangerous Drugs was formed, given a large increase in budget and staff, and assigned an agenda calling for increased enforcement and regulation.

In 1970, after nearly a century of unsuccessful governmental attempts to control the drug problem, President Nixon declared drugs "Public Enemy Number One" and created the Special Action Office for Drug Abuse Prevention. Congress granted this Federal superagency a $100 million budget, with the aim of providing treatment, including the modality of methadone maintenance, for every addict who desired it. Accordingly, the original small methadone treatment group at Beth Israel grew to include 135,000 clients by 1974, but unfortunately the original successes of Dole and Nyswander were not replicated consistently.

Methadone's failure as a "quick fix" solution, combined with the legacy of hostility toward medical dispensation of drugs, led to disillusionment with this treatment modality. As a result, methadone programs were saddled with increasingly complex sets of regulations that changed the supportive client-therapist relationship to one which frequently was adversarial. Blurred by political and racial overtones, the controversy over maintenance versus abstinence raged, despite the fact that abstinence programs consistently had been shown to fail and that maintenance programs were much cheaper. Dr. Dole had anticipated the difficulties that would be encountered as methadone programs expanded, for he had always viewed the key therapeutic element to be the personal relationship between therapist and client. The patient was to be viewed as an individual; one whose craving for heroin could be blunted with methadone. Then, treatment in the clinic setting would allow the patient to re-establish self esteem and dignity, and assume a productive place in society.

85. Musto, supra note 4, at 239.
86. Id. at 240.
88. Id.
89. Id. at 1001.
90. Id.
91. Id.
92. Id.
93. Id.
94. Id.
remain the mainstay of treatment for opiate addiction in the United States today.95

In the 1970s, at about the same time that a therapeutic approach to opiate addiction was becoming institutionalized, cocaine re-emerged with a vengeance.96 The reasons for this resurgence were varied. The popularity of marijuana and other “soft” drugs in the 1960s made people casual about cocaine, which unfortunately had acquired the reputation of being a “soft” drug—nonaddicting, safe, and short-acting.97 Cocaine use, glamorized in films and rock music, attracted a large subculture.98 Contemporaneously, the dangers of amphetamine began to be recognized (reflected in the slogan “Speed kills”), and many amphetamine addicts switched to a supposedly “safer” stimulant, cocaine.99 Finally, in the early 1970s the shrinkage of the heroin market led “tightly organized and well financed heroin operators” to move into the cocaine trade.100

During the 1970s, cocaine was mainly snorted by the middle and upper classes as a mild stimulant in social settings.101 In the 1980s, however, a new form of cocaine—“crack”102—appeared on the street, bringing devastating medical and social consequences.103 Crack grew rapidly in popularity because it was cheap, easily prepared by middle-line distributors, smokable (thus avoiding the use of needles), and highly addictive.104 Crack became firmly rooted in urban ghettos by 1985, then spread rapidly to suburban and rural America.105 The number of those

95. Musto, supra note 4, at 249.
96. Crittenden & Ruby, supra note 33, at 14.
97. Id. In 1967, a standard textbook of psychiatry devoted only four paragraphs to cocaine related problems, noting that withdrawal was accomplished easily. See COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1009 (Alfred M. Freedman et al. eds., 1967). This view was reinforced in a 1978 psychiatry textbook, which minimized the effects of cocaine. See George E. Vaillant, Alcoholism and Drug Dependence, in THE HARVARD GUIDE TO MODERN PSYCHIATRY 567, 575 (Armand M. Nicholi, Jr. et al. eds., 1978). By 1988, however, the dangers of cocaine were more fully recognized in a five page discussion in a psychiatry text. See TEXTBOOK OF PSYCHIATRY 337-42 (John A. Talbott et al. eds., 1988).
98. Crittenden & Ruby, supra note 33, at 14.
99. Id.
100. Id. at 17. Between 1969 and 1974 cocaine seizures increased seven-fold, but control of importation remained difficult since the routes of supply were so varied. Id. at 14, 16.
101. Id. at 14.
102. The name refers to the popping or cracking sound made in its preparation. Cregler & Mark, supra note 28, at 1496.
104. Cregler & Mark, supra note 28, at 1496.
who had tried or used cocaine grew from an estimated 5.5 million in 1974 to approximately 20 million in 1985.106

In the 1980s and early 1990s, our national drug policy has featured both interdiction of drug shipments, primarily those from Latin America,107 and increased law enforcement efforts.108 These policies of attempting to reduce supply rather than focusing on reducing demand have met with limited success.109 But while it has been suggested that the total number of cocaine users has been dropping recently, hard core chronic use has not diminished.110 In addition, heroin use, which had remained relatively constant for nearly two decades, recently began to increase again.111 In conjunction with increasing dislocation of the family unit and rising levels of poverty and homelessness, this newest epidemic has added more complexities to an already disorganized and ineffective national drug policy.

II. Women and Drugs

As noted earlier, drug use by women, primarily through physicians' prescriptions, was relatively common in the nineteenth century. Prior to the Civil War, there were more female addicts than male addicts in the United States.112 Male addicts came to dominate the "addiction scene" from the late nineteenth century on,113 but recently the proportion of addicted women has begun to rise again. In the 1960s and 1970s the proportion of women in the addict population rose from about 14% to about 30%,114 and the percentage has risen even more rapidly during the recent crack epidemic.115 Thus, although alcoholism and drug abuse

112. COURTWRIGHT, supra note 5, at 36.
113. Id. at 89.
have been viewed primarily as a "man's disease," increased attention recently has been paid to, and concern expressed over, women's substance use and abuse. An examination of the literature reveals two dominant, but contradictory themes surrounding the issue of women and substance abuse: (1) anger and blame directed at women who use alcohol and other drugs; and (2) continuing neglect and a consequent lack of treatment services. This conflict has impeded both the identification of women with alcohol and other drug problems and their access to treatment.

Despite this conflict, program development for substance using women has shown some progress. The mid-1970s saw the establishment of forty-one alcohol treatment programs for women sponsored by the National Institute on Alcohol Abuse and Alcoholism. Around the same time, the National Institute on Drug Abuse (NIDA) initiated research and program development specifically addressing the needs of women addicts. Surveys of drug treatment programs and profiles of addicted women indicated that the male oriented programs were often not supportive and sometimes even were hostile to women clients, employed a confrontational "therapeutic" style uncomfortable for women, and directed them into gender stereotyped tasks and training promising little compensation or likelihood of success. Moreover, the programs effectively limited or precluded many women's access to treatment by not addressing the environment of sexual exploitation and violence in which female addicts often live, not teaching reproductive options or providing prenatal medical services, and not making any provision for care of addicted women's children. A 1979 nationwide survey found only twenty-five drug treatment programs that described themselves as specifically geared to female addicts. More than half of the women treated in these few special programs reported that they did not receive gynecologic care, while three-fourths reported not receiving contraceptive counseling. The survey also indicated that the majority of treatment programs focused on the needs of nonminority women—interviews with

116. Courtwright, supra note 5, at 88.
118. Id. at 485.
119. Id.
121. Id. at 18-20.
122. Id. at 7.
123. Id. at 18.
547 women clients revealed that black females comprised only 16% of the clients served in the drug-free modalities, whereas white women constituted a disproportionate 78% of the clients.124

Through the 1980s the recognition that substance using women had special treatment needs led to specific set-aside requirements in federally funded programs for these treatment needs. In early 1990 President Bush and William Bennett explicitly acknowledged this in their National Drug Control Strategy, which sought to increase Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) funding from $477 million to $577 million to serve an additional 28,000 patients per year.125 This was coupled with the creation of the Office for Treatment Improvement, a branch of ADAMHA, which would work in part to “strengthen treatment programs, especially those for pregnant addicts and their infants.”126 The document also acknowledges the problem of “drug-impaired pregnancies,” and provides funds for both the Office for Substance Abuse Prevention (OSAP) and NIDA to support demonstration projects for prevention, education, research, and outreach to pregnant substance abusers.127

As new concerns involving treatment issues for women have developed, particular interest in the special problems facing pregnant drug users has arisen. The birth of increasing numbers of drug exposed infants in the late 1960s and 1970s heightened concern over perinatal drug effects. The case for comprehensive care was further fueled by the emergence of the women’s movement.128 Thus, in 1975 one hospital-based program in New York City (Pregnant Addicts and Addicted Mothers—PAAM) recommended that a multiplicity of services be provided to pregnant addicts in recognition of their unique complex medical and social needs, with an emphasis on maintaining the mother-infant bond.129 This approach had become feasible with the recent development of methadone maintenance treatment.130 The fortuitous development of this new form of treatment, just as the drug problem was expanding again in the 1970s,131 led to the establishment of multiservice programs modeled

124. Id. at 9.
125. NATIONAL DRUG CONTROL STRATEGY 30 (Jan. 25, 1990) (recommendation from President Bush to Congress).
126. Id.
127. Id. at 32.
130. See supra text accompanying note 83.
131. Suffet et al., supra note 128, at 15.
on New York’s PAAM in a number of large cities, including Chicago, Detroit, Houston, Philadelphia, and San Francisco.\footnote{132}

In 1974-1975 multiservice programs received a large infusion of federal funds, an indication of the country’s commitment to providing care for pregnant addicts.\footnote{133} Despite these efforts, by the late 1970s many treatment programs were not accepting pregnant patients and many drug using women were finding medical care unavailable.\footnote{134} The revolution in the form of treatment which has become available, therefore, has not been matched by a revolution in the availability of such programs.\footnote{135} There are several reasons for this. One explanation for the specific exclusion of pregnant women from treatment was medical uncertainty over optimal medical management during pregnancy, set against the backdrop of an obstetric malpractice liability crisis.\footnote{136} Eventually, however, a consensus did form that women enrolled in methadone maintenance treatment programs show improved pregnancy outcomes compared to heroin addicts or methadone addicts not in treatment.\footnote{137} Since data are inconsistent as to whether infants born to heroin addicts fare worse than those born to unsupervised methadone addicts, the improved pregnancy outcomes for methadone-maintained patients are thought to reflect the lifestyle changes and improved access to services associated with program participation.\footnote{138} Nevertheless, general treatment programs have not proved conducive to successful treatment of pregnant women for several

\begin{itemize}
\item \footnote{132} Id. at 18.
\item \footnote{133} Id. at 19-20.
\item \footnote{134} Id. at 20.
\item \footnote{135} Id. at 18.
\item \footnote{136} Initially, the medical debate centered on the use of methadone for detoxification or maintenance of pregnant heroin addicts. In the early 1970s, the Food and Drug Administration initially recommended twenty-one day methadone detoxification during pregnancy, then withdrew its recommendation. Chavkin, supra note 117, at 485. Accounts appeared in the obstetric and pediatric literature of stillbirth and fetal compromise associated with maternal withdrawal from narcotics. Jose L. Rementeria & Nemesio N. Nunag, Narcotic Withdrawal in Pregnancy: Stillbirth Incidence with a Case Report, 116 Am. J. Obstetrics & Gynecology 1152 (1973); Frederick P. Zuspan et al., Fetal Stress from Methadone Withdrawal, 122 Am. J. Obstetrics & Gynecology 43 (1975). Obstetricians voiced concern about detoxification during pregnancy unless biochemical monitoring of fetal status could be assured, while clinicians disagreed about the optimal dosage of methadone during pregnancy. \textit{Id.} at 46. Some clinicians argued that the dose had to be sufficiently high to prevent relapse and use of illicit drugs, while others supported lowering the methadone dose to reduce the severity of neonatal abstinence. Joan Ellen Zweben & J. Thomas Payte, Methadone Maintenance in the Treatment of Opioid Dependence, 152 W. J. Med. 588, 592-93 (1990).
\item \footnote{137} Loretta P. Finnegan & Ronald J. Wapner, Narcotic Addiction in Pregnancy, in Drug Use in Pregnancy 203 (Jennifer R. Niebyl ed., 2d ed. 1988); Rita G. Harper et al., The Effect of a Methadone Treatment Program upon Pregnant Heroin Addicts and Their Newborn Infants, 54 Pediatrics 300 (1974); Suffet & Brotman, supra note 129, at 199.
\item \footnote{138} Harper et al., supra note 137, at 304.
\end{itemize}
other reasons. Since most addicts traditionally have been male, young, and criminally deviant, treatment approaches have focused on that population.\textsuperscript{139} Moreover, methadone maintenance, because of cost concerns, became a "bare bones" treatment model, lacking the multidisciplinary approach needed to address the complex needs of pregnant addicts.\textsuperscript{140} Finally, the attitude of caregivers, including obstetricians, sometimes has been punitive and hostile toward pregnant addicts, who are considered difficult, noncompliant patients.\textsuperscript{141} But whatever the reasons, the unavailability of comprehensive treatment on a wide scale represents a national failure.

III. Impact on Pregnancy and Infancy

The nation's failure to contain its drug epidemic, combined with the increased use of newer drugs such as crack and the increasing proportion of female drug users, has had a major negative impact on pregnancy outcome in the United States. Never before have we been forced to deal with so many compounding adverse drug related factors, such as poverty, homelessness, inadequate prenatal care, suboptimal maternal nutrition, alcoholism, sexually transmitted diseases, and medical-obstetric complications. Each of these poverty-linked factors is known to be associated with poor pregnancy outcome; the combination of these high risk factors has jeopardized the futures of thousands of young women and drug exposed infants.\textsuperscript{142}

A. Common Factors

(1) Incidence

New York City figures reflect to some degree the increase in drug use during pregnancy in urban America. In 1980, 1 of every 137 newborns had a birth certificate notation of \textit{in utero} drug exposure.\textsuperscript{143} By 1988, the number of drug exposed newborns had risen to 1 in 33 births.\textsuperscript{144} Cocaine exposure dominates these statistics, with a more than twentyfold increase over the decade.\textsuperscript{145} Other cities, including Boston, Los Angeles, and San Antonio also experienced large increases in births.

\begin{itemize}
  \item \textsuperscript{139} Suffet et al., \textit{supra} note 128, at 21.
  \item \textsuperscript{140} \textit{Id}.
  \item \textsuperscript{141} \textit{Id.} at 22; see Chavkin, \textit{supra} note 115, \textit{passim}.
  \item \textsuperscript{143} \textit{Maternal Drug Abuse—New York City}, \textit{City Health Info.} (New York City Dep't Health), Sept. 1, 1989, at 2 tbl. 1.
  \item \textsuperscript{144} \textit{Id}.
  \item \textsuperscript{145} \textit{Id}.
\end{itemize}
of drug exposed newborn infants between 1986 and 1989. Although national figures are impossible to establish accurately, and underreporting of drug use is acknowledged, it is estimated that between 300,000 and 475,000 babies are born annually following intrauterine drug exposure.

(2) Infant Mortality

In New York City, pooled data from 1979 to 1988 shows an overall infant mortality rate (death before the first birthday) of about 13 per 1000 live births. In contrast, drug exposed infants were three times more likely to die; the infant mortality rate for that group was 40 per 1000 births. Much of this excess mortality was due to complications associated with low birth weight, as well as with medical conditions such as AIDS and Sudden Infant Death Syndrome (SIDS). The impact of prenatal drug exposure on infant mortality has been most marked in the black population, which already suffers the highest infant mortality rate in New York City. Infant mortality rates in New York City's forty-one geographically defined areas range from 4.6 per 1000 births in a white upper middle class area to over four times higher, 18.4 per 1000 births, in a predominantly poor black area. It is impossible at this time, however, to separate the direct effects of drug exposure from drug associated lifestyle patterns that independently raise infant mortality rates.

(3) Low Birth Weight

Low birth weight (under 2500 grams, or 5 pounds, 8 ounces) is closely linked to higher neonatal and infant mortality rates. In New York City from 1979 to 1988, approximately 8% of all births were low birth weight babies. This figure increased five-fold, to nearly 40%, for drug exposed infants. Again, the impact was most noticeable among

149. Id. at 16.
150. Id. at 16-17.
151. Id. at 23.
152. Id. at 11.
153. Id. at 9.
blacks. Within New York City's forty-one geographically defined neighborhoods, the percent of low birth weight infants ranged from a low of 4.5% in a predominantly white middle class area to a high of 16.8% in a predominantly poor black area. Not surprisingly, the geographic areas with high rates of low birth weight were the same areas with high infant mortality rates.

(4) Sexually Transmitted Diseases

AIDS poses a growing threat to drug using women, who may acquire the human immunodeficiency virus (HIV) through needle sharing or through unsafe sex practices such as prostitution, trading sex for drugs, sex with drug users, or increased random sexual activity associated with cocaine use. The major source of pediatric AIDS infection is vertical transmission from mother to child, either prenatally, postnatally via breast feeding, or most commonly, perinatally via infected body fluids. By 1990, 2390 cases of pediatric AIDS had been reported, the vast majority of which have been linked to maternal drug use. Recently AIDS was ranked as the ninth leading cause of death among one to four year-old children and seventh in the fifteen to twenty-four year-old group, and it is expected that AIDS will enter the top five causes of death in one to four year-olds by the year 1992. At that time, an estimated one out of every ten pediatric hospital beds will be occupied by a child with AIDS. AIDS takes a disproportionately heavy toll among minority groups.

154. Id. at 10.
155. Id. at 20.
156. Id. at 23.
158. CENTER FOR DISEASE CONTROL, U.S. DEP'T OF HEALTH & HUMAN SERVS., HIV/AIDS SURVEILLANCE: U.S. AIDS CASES REPORTED THROUGH AUGUST 1990 (Sept. 1990). An anonymous HIV seroprevalence study in the late 1980s revealed that 0.16% of all newborn babies in upstate New York were HIV positive, i.e., had passively acquired maternal antibodies. Lloyd F. Novick et al., HIV Seroprevalence in Newborns in New York State, 261 JAMA 1745, 1745 (1989). Approximately 20-30% of those infants have developed or will develop AIDS. Antonia C. Novello et al., Final Report of the United States Department of Health and Human Services Secretary's Work Group on Pediatric Human Immunodeficiency Virus Infection and Disease: Contents and Implications, 84 PEDIATRICS 547, 547-49 (1989). Other known rates of HIV neonatal, and therefore maternal, positivity are 0.7/1000 in New Mexico and 0.3/1000 (suburban) to 8/1000 (inner city) in Massachusetts. American Academy of Pediatrics, supra note 157, at 484.
159. Novello et al., supra note 158, at 548.
160. Id. at 547.
161. Id. at 549.
162. Id.
and Hispanics comprise 10%, respectively they account for 49% and 29% of children with AIDS.\(^{163}\)

In addition to its devastating impact on rates of HIV infection, drug use in the general population is felt to be associated with a marked increase in cases of primary and secondary syphilis.\(^{164}\) Tellingly, cases of congenital syphilis recently have skyrocketed; reported cases increased 95% from 1987 to 1989 to the highest yearly total since penicillin was introduced.\(^{165}\) In New York City, there were less than 60 cases of congenital syphilis per year from 1980 to 1986, but in 1987 this figure rose to 147 cases and in 1988 it escalated rapidly to 357 cases.\(^{166}\)

(5) Child Abuse and Neglect

The number of cases of child abuse or neglect reported in New York City tripled from 1986 to 1988, when it totalled 52,568.\(^{167}\) Part of this increase is attributable to mandatory reporting requirements, which are based on the assumption that drug exposed infants will, if discharged, be subject to neglect, abuse, or physical harm.\(^{168}\) These policies have led to an increase in babies boarding in neonatal intensive care units and hospital wards, and to overcrowding of foster care facilities. The number of children in foster care increased from about 23,700 in 1977 to almost 40,000 in 1989.\(^{169}\) Approximately 50% of infants under two years of age in “boarder” status were placed there because of maternal drug use.\(^{170}\) Recently, New York City child protection services personnel began an active campaign to “case manage” drug using women during pregnancy, thus hoping to reduce family disruption.\(^{171}\)

\(^{163}\) Id.

\(^{164}\) Peter Kerr, Crack and Resurgence of Syphilis Spreading AIDS Among the Poor, N.Y. Times, Aug. 20, 1989, § 1, at 1.


\(^{166}\) New York City Dep’t of Health, Congenital Syphilis: Its Prevention and Control, CITY HEALTH INFORMATION, June 1989, at 1.


\(^{168}\) Id.


\(^{170}\) N.Y. SENATE COMM. ON INVESTIGATIONS, TAXATION, AND GOV’T OPERATIONS, CRACK BABIES: THE SHAME OF NEW YORK 9 (Dec. 20, 1989) [hereinafter SENATE COMMITTEE].

B. Specific Medical Issues

In addition to the general adverse effects that illicit drug use has on mothers and infants, different classes of drugs have specific effects on mothers and infants. However, since most drugs cross the placenta easily, and polydrug abuse is common, the individual effects of specific drugs may be difficult to establish definitively. The following two sections examine the specific effects of opiates and cocaine.

(1) Major Opioids

Maternal opiate use during pregnancy retards fetal growth and increases the likelihood of a low birth weight baby. However, recognition of the opiate using mother may be difficult if she does not provide an honest history. And fear of referral to a child protection agency or to a law enforcement official may lead a mother to conceal past or active drug use. A disrupted social environment, indicated by lack of prenatal care or homelessness should prompt a complete evaluation of possible drug use, because methadone maintenance during pregnancy is known to reduce medical complications and reduce perinatal mortality commonly associated with the use of street drugs.

The major opioids include heroin, morphine, methadone, codeine, and meperidine. Heroin has a major negative impact on fetal growth, whereas methadone, especially at higher dosages, is associated with more normal fetal growth and higher birth weight. Heroin also reduces brain growth in utero, a factor that prejudices the child's ultimate neurologic outcome. Neither heroin nor methadone is reported to cause either a general increase in congenital malformations or a specific dysmorphic syndrome in offspring. Transition from intrauterine life is generally accomplished smoothly under methadone maintenance, but

174. Finnegan & Wapner, supra note 137, at 210; Harper et al., supra note 137, at 304; Suffet & Brotman, supra note 129, at 20-21.
178. Kandall, supra note 172, at 403. A dysmorphic syndrome is a set of physical and external anomalies that can be grouped together as a "syndrome."
may be jeopardized when street heroin use or polydrug use dominates the pregnancy.179

After birth, infants chronically exposed to opiates in utero develop an abstinence syndrome,180 with significant morbidity and even risk of mortality if it is misdiagnosed or improperly treated.181 Heroin is not stored in large amounts by the fetus, and withdrawal begins shortly after birth, usually within twenty-four to forty-eight hours.182 Withdrawal from methadone is more variable and unpredictable, since methadone is stored by the fetus and released from tissue stores in an unpredictable fashion.183 Withdrawal from opiates is characterized by a number of indications, including: (1) central nervous system abnormalities, such as irritability, increased tone, tremors, excessive abnormal crying, and occasionally seizures; (2) gastrointestinal signs, such as vomiting, diarrhea, and suck-swallow incoordination, leading to caloric deprivation despite a voracious appetite; (3) respiratory signs, such as labored and rapid breathing and acid-base abnormalities; and (4) autonomic nervous system signs, such as sneezing, sweating, and fever.184 Treatment consists of nonspecific measures, such as providing increased fluid and calories, and specific treatment with either a substitute opiate (paregoric) or a central nervous system depressant (phenobarbital).185 Treatment of the abstinence, when necessary, usually requires about two to three weeks.186

Although opioids pass to the nursing infant in maternal milk, breast feeding is not discouraged since establishing and enhancing maternal-infant bonding is highly desirable. Breast feeding should not be encouraged, however, if a mother is HIV positive since there have been several documented cases of HIV transmission through breast milk or through blood from cracked maternal nipples.187 Although opiate abstinence usually becomes apparent shortly after birth, about 5-10% of methadone exposed newborns become symptomatic at about seven to fourteen days, making close follow-up very important.188 Some opiate exposed infants undergo a "subacute

179. Id. at 402-03.
180. Id. at 403-06. Abstinence syndrome means the constellation of signs and symptoms that are commonly called "withdrawal."
181. Id. at 403.
182. Id.
184. Kandall, supra note 172, at 403-04.
185. Kandall & Gartner, supra note 183, at 59-60.
186. Id.
188. Kandall & Gartner, supra note 183, at 58-60.
withdrawal," characterized by persistent irritability, fretfulness, and agitation, for as long as three to six months. Since infants with persistent crying may be difficult to console, their parents need counseling and medical support on discharge from the hospital. Failure to provide this support may result in child neglect, abuse, or even homicide attributed to parental frustration.

Another late complication of intrauterine opiate exposure is an increased risk of Sudden Infant Death Syndrome (SIDS). SIDS, which occurs at a rate of about 1.5 to 2 per 1000 live births in the general population, occurs significantly more often following intrauterine opiate exposure, even after accounting for other high risk variables, such as low birth weight, race (SIDS is more common among blacks), and maternal cigarette smoking.

Although heroin abuse has existed for many years, and methadone maintenance has been used widely since 1969, follow-up studies of opiate exposed infants are still quite fragmentary. Despite the many high risk concerns cited above, limited follow-up studies generally have not revealed consistent major neurobehavioral abnormalities, even in those infants who displayed withdrawal associated seizures or "subacute withdrawal." It should be evident, however, that an improved neurobehavioral outcome will likely result from an infant's interaction with emotionally stable parents in a secure home setting, one in which drug seeking behavior is eliminated and a child oriented focus promoted. These goals cannot be achieved if the mother continues heavy street drug use, but may well be realized when she is controlled on methadone and provided with support and parenting information.

(2) Cocaine

As with illegal opiates, maternal use of cocaine often leads to social fragmentation, poor nutrition, reduced prenatal care, and sexually transmitted diseases, all of which pose hazards for the developing fetus.

191. Id. at 235-39.
192. Tatiana M. Doberczak et al., One-Year Follow-up of Infants with Abstinence-Associated Seizures, 45 ARCHIVES NEUROLOGY 649, 651 (1988).
193. See, e.g., Wilson et al., supra note 189.
194. Zuckerman & Bresnahan, supra note 142, at 1387-95; SENATE COMMITTEE, supra note 170, at 4-5.
cluding an increase in early pregnancy loss, premature placental separation, preterm labor, an increased stillbirth rate, and reductions in birthweight and head circumference, all of which are consistent with cocaine's constrictive action on blood vessels. The teratogenic potential of cocaine is still unclear; some studies have noted increases in genitourinary, cardiac, and skull malformations in exposed offspring, while other studies have found no such association.

Cocaine exposed infants display a mild neurologic dysfunction, characterized by increased tone and reflexes, poor interactive behavior, lability of state, and poor organizational response to stimuli, that differs markedly from opiate abstinence. This dysfunction is transient, generally does not require treatment, and poses no immediate threat to life. A very small number of cocaine exposed infants, however, develop more dramatic sequelae such as seizures or cerebrovascular accidents (strokes). And unlike opiates, cocaine passed to babies in breast milk may produce an acute toxic syndrome of seizures and apnea; therefore, breast feeding is contraindicated even if the mother is HIV negative. Additionally, concern has been raised about an apparent increased incidence of SIDS in cocaine exposed infants. Because exposure to cocaine—especially smoke—may continue in the home, care must be taken not to blur the distinction between prenatal and postnatal cocaine exposure. It is unclear whether this increased incidence is properly attributable to prenatal exposure to cocaine (perhaps resulting from damage to the central nervous system) or postnatal exposure to smoke in the home.

Because the crack epidemic is a relatively recent phenomenon, little follow-up data exist regarding crack exposed infants. Many of the published observations on these infants have been anecdotal and unscientific. The lack of hard data has not, however, prevented the media from sensationalizing the issue by using the horrible term "crack babies" and, more recently, "crack kids." With very little evidence, the media has as-

198. Chasnoff et al., supra note 196, at 1742-44.
200. Kandall & Gaines, supra note 190, at 237.
201. See e.g., Sandra Blakeslee, Crack's Toll Among Babies: A Joyless View, Even of Toys,
serted that these infants are tiny, brain-injured, unteachable, unreclaimable, and even unadoptable. In addition, the media reports that these infants may be incapable of succeeding in school and condemned to joyless childhoods.

It is critical to acknowledge that these children are often exposed to a multiplicity of high risk factors, such as sexually transmitted diseases, lack of prenatal care, alcohol and nicotine exposure, and obstetric complications. These factors are frequently compounded by adverse postnatal events such as environmental deprivation, serial foster care placement, household violence, and toxic lead exposure. Identifying a mother’s cocaine use as the single most important variable in poor infant outcome at this time is both scientifically impossible and medically irresponsible. Since testing of infants’ urine is more common in children of color than white children, we are identifying drug exposure only in a narrow segment of American children, one that includes children we already know are medically “at risk” and socially fragile for many other reasons. We must abandon the term “crack babies,” which stereotypes infants having widely differing problems and potentials. We should instead focus on the more basic issue of poverty, which is the central unifying condition under which all other high risk factors are most reasonably grouped. Children born into poverty, and not just so-called “crack babies,” are truly our nation’s most “at risk” group.

IV. Societal Responses to the Drug Problem

Whether or not “America has a drug problem” is no longer at issue in today’s society. As the use of drugs increasingly is held responsible for rising crime rates, household violence, poor work productivity, logjams in our courts, expanding welfare rolls, overcrowding of our emergency rooms and trauma services, the spread of AIDS, and our high neonatal infant mortality rates, political pressure to “solve the drug problem” steadily increases. Judging from this nation’s 150 year history of ineffectual efforts at solving the problem, and our current state of societal disruption, success will not be easily achieved. Four general strategies for fighting the “war on drugs” have been offered. Stated broadly, they are:


202. See Blakeslee, supra note 201, at 1; Daley, supra note 201, at A1; Kantrowitz, supra note 201, at 62; Krauthammer, supra note 201, at 24.

203. See Daley, supra note 201, at A1; Kantrowitz, supra note 201, at 62.
The federal government has allocated the lion's share of its drug fighting budget to law enforcement in pursuance of its "zero tolerance" strategy. Analogously, state prosecutors and legislators have attempted to construct drug use during pregnancy as a specific crime. While this approach generally has foundered, the American Civil Liberties Union reports about fifty such prosecutions; many of the women prosecuted have been forced to spend time in jail. Some law enforcers have attempted to skirt the issue of prenatal conduct and fetal status through a variety of legal maneuvers and discretionary sentencing. Major medical and public health organizations have opposed the prosecutorial approach both on constitutional grounds and because of its likely adverse impact on perinatal health and the doctor-patient relationship. These adverse impacts stem from the private nature of a patient's disclosure to the physician. Failure to respect the doctor-patient relationship places the physician and mother in an adversarial posture, compromises


207. Chavkin, supra note 115, at 1560.

208. See generally Dawn Johnsen, Promoting Healthy Births Without Sacrificing Women's Liberty, 43 HASTINGS L.J. 569 (1992) (discussing various coercive governmental approaches and contrasting them with "facilitative" approaches).

209. See id.


212. Prosecutorial policies may be challenged as violating several constitutional protections, including the rights of privacy, liberty, due process, and equal protection. For a more thorough discussion of these issues, see Johnsen, supra note 208.

care, and may even deter a pregnant woman from seeking prenatal care out of fear of prosecution.

B. Child Protective Services (CPS)

The mandate of child protective service agencies is to protect the best interests of the child; thus they are to provide rehabilitative services for families who are at risk of neglecting or abusing their children.214 Because of limited resources, these agencies often interpret this mandate as requiring removal of the child from the home.215 As of October 1990, eight states (Florida, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, Oklahoma, and Utah) regarded maternal substance abuse during pregnancy as child abuse or neglect.216 A number of states also have made efforts to construct a “prenatal or fetal neglect and abuse” category and apply it to drug using women in parallel fashion to prosecutory efforts.217

Critics of this approach have noted that because the CPS mandate’s preventive and therapeutic aspects have been largely ignored, CPS intervention often does not “further the best interests of the child.”218 Instead, a CPS approach overwhelms an insufficiently supported and monitored foster care system219 and is already leading to the resurgence of congregate-care and orphanage-like facilities.220 In addition, legitimate concerns about parental drug impairment have been transformed into detention efforts aimed exclusively at parturient women.221 These efforts neglect the effect of drugs on nonpregnant mothers of older children and ignore altogether the effects on fathers. While the medical and public health establishments concur on the importance of child protection, the debate continues between those who advocate detection and removal, and those who emphasize the importance of primarily supportive resources and family preservation.

215. Id.
216. Substance Abuse and Pregnancy, supra note 211, tbl. 1.
217. Id. at 3.
C. Legalization

Advocates of legalization base their arguments on a number of specific points, which include the following: (1) efforts aimed at drug interdiction have been remarkably unsuccessful;\textsuperscript{222} (2) domestic law enforcement, despite increased arrests and prosecutions of drug traffickers, has not had a significant impact on the price or the availability of illegal drugs;\textsuperscript{223} (3) the massive sums of money spent on enforcement would be better spent on prevention and treatment programs;\textsuperscript{224} (4) our criminal justice system has been overwhelmed as a result of the criminalization of drugs;\textsuperscript{225} (5) the direct relationship between criminalization and crime is firmly established;\textsuperscript{226} (6) illicit drug use is closely linked to the spread of sexually transmitted diseases such as AIDS;\textsuperscript{227} (7) outright prohibition restricts medically useful applications of certain drugs;\textsuperscript{228} and (8) moral condemnation of drug use is transient and inconsistent, and it does not deal with nicotine and alcohol, two agents which injure and kill far more people than illegal drugs.\textsuperscript{229} These arguments appeal to a vocal minority. Nevertheless, logistical aspects of legalization, such as how to legalize crack safely, have not been delineated fully.

D. Treatment

Although drug treatment options for pregnant women recently have been expanded, the need for such services still far outdistances available treatment opportunities. In New York State in 1990, for example, it was estimated that only 42,000 treatment slots were available for an estimated 500,000 drug abusers, with pregnant drug abusers often turned away from treatment.\textsuperscript{230} And in a 1989 survey of drug treatment programs in New York City, fewer than half (46\%) accepted pregnant addicted women, 67\% would not accept Medicaid reimbursement, and 87\% denied treatment to pregnant crack addicted women on Medicaid.\textsuperscript{231}

\textsuperscript{222}. Nadelmann, \textit{supra} note 206, at 939-40.
\textsuperscript{223}. \textit{Id.} at 940.
\textsuperscript{224}. \textit{Id.} at 940-41, 943.
\textsuperscript{225}. \textit{Id.} at 940-41.
\textsuperscript{226}. \textit{Id.} at 941-42.
\textsuperscript{227}. \textit{Id.} at 942.
\textsuperscript{228}. \textit{Id.} at 942-43.
\textsuperscript{229}. \textit{Id.} at 943-44.
\textsuperscript{231}. Chavkin, \textit{supra} note 117, at 485.
Despite these disappointing statistics, efforts to improve and increase treatment for pregnant women actively continue. Comprehensive preventive and therapeutic programs that provide a wide range of specific and adaptable supports and resources for families with substance abuse problems are currently expanding. Among these are model projects funded by the federal Office for Substance Abuse Prevention's Division of Demonstrations and Evaluation. Each of the demonstration projects focuses on some aspect of substance abuse, pregnant and postpartum women, and their infants, and each project's objective is to "demonstrate" the workability of key ideas in real-life settings. Model programs based on these grants include The Cambridge and Somerville Program of Alcohol Rehabilitation, pioneered by Norma Finkelstein; The Women's Alcoholism Program in San Francisco, directed by Carmela Woll; Iris Smith's program in Georgia on addiction, pregnancy, and parenting; Center of Care in California, directed by Neal Halfon; the Eleanor Hutzel Hospital program in Detroit; and Pregnant Addicts-Addicted Mothers in New York City.

In a recent study at Beth Israel Medical Center in New York City, 150 addicted women and 50 experts in many areas of drug dependency, through structured interviews, sketched out what they felt would constitute an effective drug treatment program. The following features were considered essential for success:

A continuum of addiction services (e.g., residential, outpatient, and home-based);
Multiple counseling modalities (e.g., individual, group, and family);
Counseling on other issues (e.g., history of sexual abuse and domestic violence);
Services for children (e.g., day care, play therapy, child developmental monitoring, and parenting training);
Concrete services (e.g., housing, food, and transportation);
Program orientation (e.g., long-term, community-based, and individualized care);
Comprehensive health care (e.g., prenatal, family planning, and HIV prevention);
Services related to women's educational needs (e.g., job training and high school equivalency);
Appropriate staffing (e.g., female staff, nonconfrontational, and culturally/racially sensitive);

232. BESCHNER & THOMPSON, supra note 120, at 12-20.
233. We report these examples of model programs from our personal knowledge. To the best of our knowledge, no list or catalogue of such programs exists.
An advocacy role (e.g., contact with child protective services, welfare);
Aftercare (e.g., twelve-step, transitional housing, individual counseling after the completion of the intensive treatment program, as the recovering woman attempts reintegration into sober life).235

In identifying the specific needs of women, the experts accentuated the differences between chemically dependent women and men, and concurred on the importance of providing gender sensitive treatment. Imperatives for programs include efforts to assist women in maintaining relationships with their children, in strengthening relationships with their partners and families, and in developing extended support networks. This vision of women “in relationship” represents a departure from previous treatment ideology, which has either offered a narrow view of women in the context of pregnancy, or has focused almost exclusively on male addiction issues.236

The study's findings highlight the desirability of an approach that combines treatment for drug addiction, medical and therapeutic services for mother and child, education and job training, assistance with concrete needs such as day care and housing, and long term after-care focused on relapse prevention and management. While the approach is not new—it has formed the basis for the model programs established in New York, Philadelphia, Chicago, Detroit, Boston, and elsewhere over the past twenty years—it still is not widespread.

We must recognize that substance abuse cannot be separated from the social, emotional, and economic conditions that define women's lives. These conditions shape both the illness and the recovery. In order to substantially reduce the incidence of alcoholism and drug abuse in women of childbearing age, it is critical to advocate dramatic improvements within the social structures providing financial support, housing, health care, employment, child care, children's services, family supports, and legal rights. The complex needs of drug dependent women require nothing less than this comprehensive approach if success is to be obtained.

235. Id.
236. U.S. GAO, DRUG-EXPOSED INFANTS, supra note 146, at 37.