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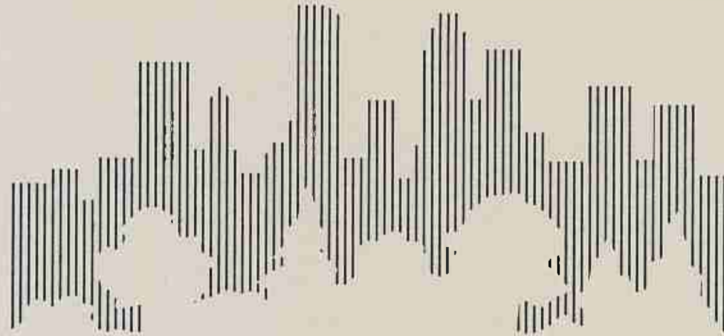

MASTERS IN SOCIAL WORK THESIS

MSW
Thesis

Thesis
Clauso

Susan Ann Clauson

Cocaine and Maternal Addiction

1993

COCAINE AND MATERNAL ADDICTION

A THESIS
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF AUGSBURG COLLEGE
BY

Augsburg College
George Sverdrup Library
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SUSAN ANN CLAUSON

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF
MASTER OF SOCIAL WORK

JUNE 1993

MASTER OF SOCIAL WORK
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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

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has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

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This has been a long marathon. I would like to thank the colleagues, faculty, and friends who ran along beside me sharing their energy. I also want to thank those who stood along the sides of my path and cheered me on when I became tired enough that quitting (or at least taking a very long rest) seemed like a plausible option.

It is my pleasure to thank my thesis advisor, Dr. Anthony Bibus. Your enthusiasm, creativity, and discipline have been an inspiration to me. You have taught me to reach into new places within myself to find strength and learning, encouraging me to develop my own sense of inquiry.

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I would like to thank my mother, Marguerite Tiefenthal, who is in Who's Who because she knows what's what. You are my mentor and my role model. Your contribution to the field of Social Work will always be an inspiration to me.

I would like to thank my husband, Charles, who picked up all the late night shifts at Hennepin County Medical Center. Your support has been appreciated.

I would like to acknowledge all women who are struggling to get cocaine out of their lives and those who are winning the war; especially the women of Haymarket House in Chicago, who were kind enough to openly and honestly share their stories with me in the hopes of helping others.

Most of all, I would like to thank my precious and special daughter, Meaghan, who through the eyes of a five-year-old, helped me to keep a sense of humor and perspective throughout this process. I would like to thank you for quietly entertaining yourself while I worked on my thesis. This includes the time you touched up the marks on your (non-white) bedroom walls with a bottle of white-out and the day you put lipstick on the dog. Next time, however; please ask me

before you give yourself another haircut with the scissors. Thank you for your patience of a student as mother. You are the apple of my eye.

La lutte elle-même vers les sommets suffit à remplir un coeur d'homme. Il faut imaginer Sisyphe heureux.
The struggle to the top is in itself enough to fulfil the human heart. Sisyphus should be regarded as happy.

Albert Camus

ABSTRACT OF THESIS

Cocaine and Maternal Addiction

Susan Ann Clauson

26 March, 1993

ABSTRACT OF THESIS

Cocaine use during pregnancy is a problem that has been increasing steadily over recent years. For this thesis, eleven women who gave a history of cocaine abuse during their pregnancy and were currently receiving services at Haymarket House's Maternal Addiction Center (MAC) in Chicago, a drug addiction treatment center for pregnant women, were interviewed. This study found that although the women interviewed knew the potential dangers of cocaine use to their unborn child, they were uncertain whether or not they would be able to abstain from cocaine use after the birth of their child. This speaks to the highly addictive properties of cocaine.

DEDICATION

I dedicate this thesis to the memory of my son, Matthew. You are the reason I am in Social Work today.

It is a risk to attempt new beginnings.
Yet the greater risk is for you to risk nothing,
For there will be no further possibilities
of learning and changing,
of traveling upon the journey of life.
You were strong to hold on.
You will be stronger to go forward to new beginnings.

Earl Grollman, **Time Remembered**

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While on a walk one day, I was surprised to see a man hoeing his garden while sitting in a chair. "What laziness!" I thought. But suddenly I saw, leaning against his chair, a pair of crutches. The man was at work despite his handicap. The lesson I learned about snap judgments that day has stayed with me for the years now: the crosses people bear are seldom in plain sight.

Annette Ashe, **Guideposts**

SECTION ONE

SECTION ONE

Overview

Cocaine use has increased among women of childbearing age. According to a National Household Survey on Drug Abuse (National Institute of Drug Abuse, [NIDA], 1985), approximately 1.96 million women aged 18 years and over used cocaine in 1985, a 59 percent increase from 1982 when 1.23 million women were estimated to be users (Handler, Kistin, Davis, and Ferre, 1991). Current statistical estimates are that 400,000 babies born annually are addicted, but because many hospitals neglect to routinely screen infants for drugs at birth, as many as two-thirds of the infants born with cocaine in their system go undetected (McCuen, 1991). The rate of cocaine-exposed births ranges from one percent to 27 percent nationwide (Pieper, 1991).

Cocaine and maternal addiction present relatively new concerns. Information regarding the effects of cocaine on the developing fetus and newborn infants when taken during pregnancy is sparse (Chasnoff, Griffith, MacGregor, Dirkes, & Burns, 1989). My thesis explores some of the issues concerning maternal addiction by studying a treatment intervention program in Chicago and examining how effective it is toward helping pregnant women overcome their addiction to cocaine, as well as why it works for some women, while not working for others.

History of Cocaine

Cocaine's use as a stimulant goes back nearly 5,000 years. Cocaine comes from the coca leaf of the coca shrub. The locations where these plants are most predominantly found are: in Columbia, on the Indonesian island of Java, on the lower slopes of the Andes Mountains in Bolivia and Peru, or in the jungles of the Amazon River Basin. The cocaine shrub was introduced into

Europe in the 1500's. In the late 1800's, the Incan Indians found that chewing the coca leaf helped them control their appetite, avoid altitude sickness, and feel better in general (The Haight-Ashbury Cocaine Film, 1985).

In Germany in 1860, Dr. Albert Niemann found that the active ingredient in the coca leaf was cocaine hydrochloride. Sigmund Freud popularized cocaine in both the United States and in Europe when he proclaimed cocaine to be a magical substance that was wonderfully fulfilling and stimulating. In his cocaine papers, On the General Effect of Cocaine, March 1885, and Craving for and Fear of Cocaine, July, 1887, he claimed cocaine was a good remedy for stomach ailments and asthma. Freud prescribed cocaine to help a colleague overcome a morphine addiction; however, the colleague became psychotic (Washton & Boundy, 1989).

Use and Abuse of Cocaine

Cocaine has been used and sold in the United States both legally and illegally. As far back as the late 1800's, cocaine has been used medicinally. It was used to cure everything from headaches to depression. Medically, cocaine is a local anesthetic which is used to numb tissues in the body by blocking nerve conduction (Washton & Boundy, 1989). It is the only natural topical anesthetic available today. Cocaine is used in emergency rooms to stop severe nosebleeds. It is also used as an anesthetic when intubating patients and for some types of eye surgery.

In the 1920's and 1930's in the United States, cocaine was widely used as a party drug for the wealthy. The dangerously addictive properties of cocaine were not yet appreciated by these recreational users. The problems associated with cocaine use did not become apparent until the 1970's. A method called freebasing, in which cocaine was smoked, rather than snorted, was popular.

Also by the 70's, the price of cocaine dropped, making it easier to obtain on the street. Cocaine abuse became a major public health issue in the 80's (Manschrek, 1988). In the 1970's, only four or five tons of cocaine were smuggled into the United States. The amount of cocaine smuggled into the States increased to 100 tons by 1985. By 1989, cocaine-related emergency room visits were up 200 percent from 1988 (House, 1990). By 1991, according to a National Household Survey by NIDA, more than 4.5 million, or 7.7 percent of nearly 59.2 million United States women in their childbearing years between 15 and 44, had used an illicit drug in the past month (NIDA, 1991).

Pharmacology of Cocaine

Cocaine hydrochloride is the chemical name for cocaine, which is legally considered a narcotic. One molecule of cocaine consists of 17 carbon atoms, one nitrogen atom, eight hydrogen atoms, and four oxygen atoms that crystallize into a snowflake pattern.

The cocaine that is available in the United States is in a white crystalline powder form. Substances such as talcum powder, laxatives, sugar, flour and soda may be added to increase the bulk of the cocaine that is sold illegally. This is adulterated cocaine. Crack is a light brown rock that is a nearly pure form of cocaine. It is crushed and smoked, producing a rapid high that is initially intense. Because this euphoric high is replaced by severe depression, addiction can manifest itself in as little as two weeks.

Routes of Administration

Cocaine is used intranasally, intravenously, or smoked. As a finely chopped powder, cocaine can be inhaled through the nose. Intranasal cocaine use is also sometimes referred to as snorting or tooting. As a salt, cocaine is

water soluble and can readily cross the mucous membranes in the nose. Cocaine is placed on a hard surface, such as a mirror, and chopped into powdery lines to be inhaled. The rush is not as intense as with other methods and it often causes the mucous membranes of the nose to break down. Frequently intranasal use can cause nosebleeds. With chronic and continued use, it can cause a hole to develop in the septum of the nose. When used intranasally, the effects of taking the drug can be felt within ten minutes, with the duration lasting up to an hour.

Cocaine can also be injected intravenously. A gram of cocaine hydrochloride can be drawn up in a syringe after being mixed with water. The rush from intravenous use is immediate and can last from ten to 30 minutes (Gold, 1984). This method has lost much of its popularity recently because of the threat of Acquired Immunodeficiency Syndrome (AIDS), a disease caused by the Human Immunodeficiency Virus (HIV) from contaminated needles. The effects from using cocaine intravenously happen within as little as 15 seconds. The duration is five to 10 minutes.

The most popular method of using cocaine is freebasing. Vapors are produced by heating the cocaine hydrochloride salt, which releases a powerful, free cocaine base. Crack is an inexpensive form of cocaine that is made by mixing water and baking soda into cocaine hydrochloride. It is a highly addictive form of cocaine freebase that when freed of adulterants is 80 to 90 percent pure. Unlike the salt, the alkaloid form can be heated and smoked. Crack earned its name from the crackling sound it makes when it is being smoked (The Minnesota Police Journal, 1991). It also "cracks" into chunks when dried, which are called readyrock. Seldom used alone, crack is smoked in a water pipe and produces effects that have the intensity of cocaine that is taken intravenously (Spitz & Rosecan, 1987). The effects last anywhere

from five to ten minutes, starting in as little as ten seconds. Repeated usage becomes common because of the intense effect and short duration. Polydrug abusers often mix cocaine with alcohol, marijuana, tranquilizers or phencyclidine (PCP) (Kronstadt, 1989).

Perhaps the most dangerous form of cocaine ingestion is smoking cocaine pasta or paste, which is the first refinement of the coca leaf. This practice is still widespread in South America. The danger of smoking cocaine paste lies in the kerosene and gasoline residues that are left over from the refinement process. Ingestion of these materials can cause serious respiratory difficulties. Coca paste is more concentrated than cocaine hydrochloride and yields intoxications similar to those reported with intravenous drug use (Washton & Gold, 1987). With paste, the effects of the drug occur within is ten seconds, with the duration lasting five to ten minutes.

Cocaine use can no longer necessarily be detected with the usual ways of the past. An example of this is the use of an aluminum pop can. By placing ether in the bottom of the can, foil with pinholes over the top, cocaine on top of the foil, and a hole with a straw in the side, the cocaine can then be smoked through the straw. Others have found that by removing the filter from a cigarette and replacing it with cocaine, the cigarette can be smoked undetected in a social setting because cocaine is odorless. The cigarettes are called "lady" or "lovely".

Cocaine's Effects on the Body

Once in the body, cocaine acts as a central nervous system (CNS) stimulant; therefore, an accelerated heart rate, rise in blood pressure and lowered digestive activity are experienced. Cocaine blocks neurotransmitters causing a euphoric feeling followed by a crash. Cocaine can result in sudden

death by causing the heart to go into ventricular fibrillation, or rapid contractions of part of the heart muscle, resulting in an irregular heartbeat. The risk of death from being high is equal to the risk of death from a myocardial infarction (heart attack). Cocaine's effects are so unpredictable in the human body that someone who is in excellent health and smokes the purest form of cocaine only once can die immediately as was evidenced by the death of basketball star, Len Bias. Cocaine's effects are also devastating to the brain, causing cerebral vascular accidents (CVA) hours or even days after the cocaine has been taken (Williams, 1990).

Cocaine use follows a pattern that starts when an addict binges. The binge is followed by a crash. Following the high from cocaine, the addict will often use alcohol or heroin to counteract the effect of the high from the cocaine. Cocaine use combined with heroin use is called a highball. Although cocaine is seldom used alone, it usually is not the second drug of choice. The crash that addicts experience is called euthymia, which is a period where the addict falsely feels good. It is also called the honeymoon phase because it is during this time that the user deludes her/himself into believing s/he will not use again. The addict may even develop an aversion to cocaine. The final phase of withdrawal is characterized by anergia, or the loss of energy, and anhedonia, or the loss of ability to feel pleasure. This is followed by a long period of obsessive craving. During the craving period, the addict is especially vulnerable to relapsing.

Maternal Cocaine Use During Pregnancy

Cocaine use during pregnancy has serious implications. When cocaine is used during the first trimester of pregnancy, miscarriage or spontaneous abortion can result. When it is used during the third trimester of pregnancy,

the risk of premature delivery increases. In one study, nearly a third of the babies were born between the 20th and 38th week of pregnancy compared to only a three percent incidence of premature babies for the 40 non-drug using women in the study (Kansas Alcohol and Drug Abuse Services, 1990). Abruptio placentae occurs when the placenta separates prematurely and can cause bleeding that can result in death for both the mother and the baby (March of Dimes Birth Defects Foundation, 1991). Low birth weight and Sudden Infant Death Syndrome (SIDS) have also been documented with cocaine and maternal addiction. The risk of SIDS is ten times higher for babies who have been exposed to cocaine in utero. The effects of using cocaine last longer in the fetus than they do in the mother because the incompletely developed liver in the fetus is unable to excrete the cocaine (Chasnoff, 1987).

Effects on Babies Exposed to Cocaine in Utero

Babies who are exposed to cocaine in utero are at increased risk for spontaneous abortion, abruptio placentae, intrauterine growth retardation and in utero cerebrovascular accidents (Schnieder, Griffith & Chasnoff, 1989). They are prone to hydrocephalus (water on the brain) and poor brain growth in general. They may have kidney problems and experience respiratory distress. They have an increased risk of having genito-urinary problems. Gestational age, birth weight, length and occipitofrontal head circumference (OFC) have been significantly lower in babies exposed to cocaine in utero. They also have lower APGAR scores (Doering, Davidson, LaFauce, & Williams, 1989). APGAR scores were developed by Dr. Virginia Apgar to allow for quick assessment of an infant's condition at birth. The following five areas are assessed: heart rate, respiratory effort, muscle tone, reflex irritability, and color.

Maternal medical, demographic and behavioral factors have been associated with low birthweight, including low socioeconomic status, low levels of education, childbearing at a young or an old age, poor nutrition during pregnancy and poor prenatal care including lack of a medical, gynecological, or obstetrical history. A life style that is detrimental to healthy living may include smoking, use of alcohol, use of street drugs, and inadequate prenatal care (Lia-Hoagberg, Knoll, Swaney, Carlson, & Mullett, 1988). Women may have little or no control over economic factors that make quality care impossible. As will be seen later in this thesis, the women from the Maternal Addiction Center whom I interviewed experienced many of these factors. Figure 1 on the following page depicts possible effects of prenatal exposure.

Figure 1.

POSSIBLE EFFECTS OF COCAINE USE:
(Adapted from: Harpring (1991), p. 21)

In the Fetus (Before birth):

Miscarriage
Premature labor
Abruptio placentae
Cerebral stroke
Stillbirth

In the Infant (0 to 1 year old):

Low birthweight
Small head circumference
Impaired motor development
Seizures and strokes
Abnormally formed internal organs
Rapid respiratory and heart rate
Irritability
Frequent startles
Hypertonicity
Unresponsiveness
Tremulousness
Difficulty in being comforted
Irregular sleeping patterns
Poor feeding patterns
Abnormal sucking and swallowing
Disorientation
Frequent gaze aversion
Atypical motor development
Poor interactive capacities
Alterations in bonding and attachment
Increased risk in child abuse and neglect
Increased risk of Sudden Infant Death Syndrome (SIDS)
Increased risk of Acquired Immunodefiency Syndrome (AIDS) and syphilis from the mother

In the Child (1 to Adolescence):

Impaired play skills
Small head circumference
Impaired ability to concentrate
Impaired social skills
Difficulty coping with an unstructured environment
Impulsivity and hyperactivity
Heightened response to internal and external stimuli
Tremors
Irritability
Speech and language delays
Poor task organization and processing difficulties
Problems related to separation and attachment
Motor development delays

Cocaine use causes irregular menstrual cycles, and consequently, many women do not realize they are pregnant until they are several months along (Chasnoff, 1987). This has serious implications for the fetus. Since the brain is only half-developed, it is extremely vulnerable to the effects of cocaine (Dr. Robert Ten Bensel, personal communication, October 2, 1992).

Another problem for babies who have been exposed to cocaine in utero is possible exposure to AIDS. Prenatally, fetuses that are exposed to drugs and alcohol may also be exposed to syphilis, hepatitis, malnutrition and stress. Because their mothers often have not received prenatal care, these problems may go unrecognized until it is too late.

In summary, cocaine exposure can have serious effects on both short and long-term development of the child who is exposed to it in utero. An important aspect of prevention is understanding and being able to offer services to women who are at greatest risks for cocaine use during pregnancy. The more services that are available to a mother who is using drugs, the better are her chances of receiving help with her addiction. The use of cocaine by pregnant women is a relatively new concern, requiring further studies of treatment programs. My thesis adds qualitative information regarding the use of a specific treatment intervention program for eleven women I interviewed in Chicago. Previous studies will be reviewed in detail in the next section.

SECTION TWO

SECTION TWO

Review of the Literature

The focus of this literature review is to summarize some of the research studies that have been done so far on cocaine and maternal addiction. An exhaustive on-line, data-base search was done at the Augsburg College library. The literature this review focused on included causes and effects of maternal addiction, as well as types of drug treatment intervention centers.

Cocaine use during pregnancy was suspected to cause neurological difficulties in infants as far back as 1985. In one of the earliest studies of cocaine and maternal addiction, Dr. Ira Chasnoff and his colleagues studied twenty-three women who used cocaine during their pregnancy and were involved in a treatment program in Chicago. They were divided into one of two groups: those who used cocaine only, and those who used cocaine plus a narcotic (Chasnoff, Burns, Schnoll & Burns, 1985). The two groups were then compared to a group of women who were involved in a methadone treatment program during delivery and a control group of women who had not used drugs. All four groups were approximately the same maternal age, socioeconomic status, number of pregnancies and chemical (cigarette, marijuana, and alcohol) use.

In this study, four women who used cocaine went into labor early because of abruptio placentae. The Brazelton Neonatal Behavioral Assessment Scale showed that cocaine-exposed infants had poor organizational responses to stimuli. The study's authors felt that cocaine influenced the outcome of the pregnancy as well as the neurological status of the newborn. More long-term studies are needed according to the authors, who stated: "A full assessment will require larger number of pregnancies and longer follow-up" (p. 666). Chasnoff claimed that the implications were present for long-term

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developmental difficulties, citing the importance of early intervention and prevention in the lives of pregnant women who were using cocaine.

In another study in 1989, Dr. Chasnoff and his colleagues did a study in which they divided women who were using cocaine into two groups. The first group consisted of women (n=23) who used cocaine only during the first trimester of pregnancy. The second group consisted of women (n=52) who used cocaine during their entire pregnancy. A control group of women who had no history of drug use was selected from women who were currently receiving obstetrical care at the same hospital (n=40). ANOVA (Analysis of variance) was used to analyze data on all three groups. The study confirmed Chasnoff's earlier research which found that exposure to cocaine during the prenatal period led to significant impairment in neurological outcome. The authors of this study also believed that implications were present for long-term developmental difficulties for infants exposed to cocaine in utero.

In yet a third wave, seven years later, Dr. Chasnoff and his colleagues (Chasnoff, Griffith, Freier & Murray, 1992), published another report of a study that observed three groups of infants: n=106 infants exposed to cocaine, alcohol and marijuana; n=45 infants exposed to marijuana and alcohol, but not to cocaine, and a group of infants who were not exposed to drugs during pregnancy. In this study, Chasnoff stated, "The present study demonstrates that intrauterine drug exposure may place infants at risk for developmental outcome and that head growth after birth may be an important biological marker in predicting long-term development in children exposed in utero to cocaine and other drugs" (p. 284). Again, Chasnoff stated that studies regarding cocaine and maternal addiction were sparse, but felt the topic was gaining increasing attention. In this study, all three groups of children were

similar in mean maternal age and weight gain during pregnancy. 85 percent of the women in each group were in a lower socioeconomic class.

Although Chasnoff is credited with being one of the pioneers of research in studying cocaine and maternal addiction, there are studies by other researchers that support the belief that cocaine use during pregnancy can have serious implications for both long and short-term development of the embryo/fetus. Neuspiel and Hamel (1991) evaluated a study of 715 pregnant women who were residents of Pinellas County, Florida. The study was conducted by the National Association for Perinatal Addiction and Research and Education (NAPARE), in conjunction with Operation PAR, a drug treatment program in St. Petersburg, Florida from January 1, 1989 to June 30, 1989. These women were enrolled in prenatal care at public health clinics (n=380) or at 12 of 20 private practice clinics (n=335). Toxicology screening was done on all of the women in the study. Florida requires that hospitals notify local health departments when an infant tests positive for drugs at birth.

This study claimed to have found no significant findings between public and private offices (13.1 percent of the women who received private care and 16.3 percent of the women who received their care in a public clinic tested positive for drug use), but did find that black women used cocaine more frequently (7.5 percent for black women, 1.8 percent for white women), while white women used more marijuana (14.4 percent for white women versus 6 percent for black women). In the six months that this study was done, of the 133 women who were reported for substance abuse, 48 were white and 85 were black. White women were 1.09 times as likely to have used drugs, black women were 9.58 times more likely to be reported for drug use during pregnancy (McCuen, 1991). Neuspiel and Hamel felt that most studies published contain

methodological flaws and therefore lack credibility. Some of the limitations they noted were also noted by Chasnoff and included: verification of cocaine use, need for more subjects, and need for subjects who have had less exposure to multiple drugs. The differences in class and socioeconomic status between the different cultures could also be addressed. The authors felt that there is a lack of studies beyond infancy.

Bateman and Heagarty (1989) stated that although many studies have proven tobacco's harmful effects on the environment, there were no studies available that examined the effects of cocaine vapors. In a study of infants (n=4) who were exposed to freebase cocaine ('crack') inhalation by their caretakers, the authors found that cocaine showed in the urine of infants. They said there are numerous studies published that address the effects of cocaine on infants when exposed to it in utero. They also cited Chasnoff's study in which infants were exposed to cocaine through breast milk (p. 26). In this study, the infants experienced tremulousness and irritability, but Bateman claimed the information is not definitive because the children were not being breast-fed at the time the symptoms occurred. In their own study, Bateman and Heagarty found that the four children who had inhaled cocaine vapors required hospitalization for symptoms that included seizures.

There is a need for longitudinal studies of children who were exposed to cocaine and are now older. One study done by Young, Wallace and Garcia (1992) evaluated the developmental status of children who are three to five years old and were exposed prenatally to drugs. The authors of this article found that the two most frequent areas of delay were fine motor skills and expressive language abilities (p. 1). The authors believe there cannot be a uniform treatment plan that would allow for individual risks, vulnerabilities, and supportive factors needed by these children (p. 12). They cite the value of

a program that would build on each child's potential and capacity to function.

Because drug-exposed children are not a homogenous group exhibiting identical symptoms, a professional team should be formed to work with anyone who is involved with a child who has been exposed to cocaine in utero and the child's family. Ideally, the mother and father of the child should be included in the team as soon as the child is identified of being at risk at birth. The mothers and fathers of these children need to be included in the multidisciplinary team as the children enter school (Janisch, 1991). This team should include the child welfare worker and the public health worker, in addition to the school social worker.

Substance-exposed infants may experience difficulty functioning in a classroom that can make it difficult for them keep up with their classmates. Following simple directions, playing with toys and socially interacting with others may present a myriad of problems for children who were exposed to drugs in utero. Teachers who are not trained to work with special needs children and who already have overcrowded classrooms, will need to learn what will be the most effective way to help these children. Smaller class sizes may allow teachers to devote more time to helping these children adjust.

Physicians also need to be aware of research involving cocaine and maternal addiction and what implications it will bring to them in their practices. Some researchers believe that toxicological screening should be a routine part of each prenatal visit; however, the costs and logistics make this recommendation prohibitive (Jessup, 1990). Physicians who work in areas where cocaine use is prevalent will need to assess infants who are brought in for seizures, including the possibility of cocaine inhalation. Physicians who work in suburban hospitals should also be able to assess the child at birth.

Many articles that looked at the legal aspect of cocaine and maternal addiction cited both legal and ethical dilemmas. Besharov states that adoption should be an option for children whose mothers are unable, or unwilling, to abstain from drug use (p. 11). This would involve a termination of parental rights (TPR), an often costly and time-consuming procedure. He states mothers frequently give birth to more than one child who tests positive for cocaine, yet are repeatedly unable to break their drug habit. Besharov believes that each day decisive, protective action is not taken means suffering and death for these children: "Substance abuse has become the 'dominant characteristic' in the child abuse caseloads of 22 states and the District of Columbia".

The studies I reviewed in this literature search are very relevant to social work. The information in the articles reviewed presents new concerns for people who come into contact with infants and children who have been exposed to cocaine. The authors felt that cocaine use during pregnancy and around children is dangerous and that only through continued research of this topic will the full magnitude of cocaine's harmful effects be understood. The authors of the articles reviewed agreed that there is too little information available at this time. Although many studies focused on the effects of cocaine on infants and children, few articles researched the effectiveness of treatment intervention programs. Long-term evaluation of these programs could indicate what changes are needed to help pregnant women who are using cocaine.

SECTION THREE

SECTION THREE

Methodology

The research model I used was what Glaser and Strauss (1967) refer to as the "discovery of grounded theory": "In field work, general relations are often discovered in vivo; that is the field worker literally sees them occur. When generation of theory is the aim, one is constantly alert to emergent perspectives that will change and develop his theory" (p. 40). This was an exploratory and descriptive study that used both qualitative and quantitative information. Because it is descriptive in nature, the interviews themselves were used to generate a specific hypothesis. My initial hypothesis stated that although the women interviewed knew the potential dangers of cocaine use to their unborn child, due to the highly addictive properties of cocaine, they were unable to act on this sense of danger. This hypothesis has been modified according to what I learned from these interviews. These modifications will be addressed in the discussion section of this thesis.

Research questions asked in this study included:

1. Do the women realize the potential harm to their child from using cocaine while they are pregnant?
2. If they do recognize the potential harm to their children from using cocaine while they are pregnant:
    a. what strengths do they have that allow them to seek help initially from a treatment center?
    b. what variables prohibit them from seeking help initially from a treatment center?
3. What aspects of the treatment program, in their perception:
    a. were helpful to them in overcoming their addiction?

b. prohibited them from receiving intervention of any kind?

4. How can these aspects be incorporated or eliminated in future treatment programs to address the needs of pregnant women who are attempting to overcome their struggle with addiction?

Key words used in this study need to be defined. They were:

1. *cocaine*: a short-acting, central nervous system (CNS) stimulant extracted from the coca bush in South America; available in the U.S. in pure white crystalline powder form; snorted intranasally, injected, or smoked (freebased); also known as cocaine hydrochloride.
2. *crack:* the rock form of cocaine that is smoked (freebased); it causes a fast-acting dramatic high that is replaced by severe depression, causing addiction in as little as two weeks of use.
3. *freebasing*: freeing the basic alkaloid, or the cocaine base, from its hydrochloride salt form; can then be heated and smoked
4. *cerebral vascular accident*: a stroke
5. *abruptio placentae:* when the placenta separates prematurely from the uterine wall, may be life-threatening for both the mother and the infant.
6. *Sudden Infant Death Syndrome (SIDS):* the sudden death of an infant who appears to be healthy; possibly caused by a breathing problem.
7. *occipitofrontal head circumference (OFC)*: the measurement

of baby's head from the occiput (base of the skull) to the frontal (front) portion of the skull.

8. *low birth weight:* a baby who weighs less than 5.5 pounds at birth; the mortality risk to these infants is increased 40 times in the first year of life.

The variables in this study were measured at nominal and ratio levels. The variables were categorized into seven sections:

1. Personal History
2. Family History
3. Drug History
4. Relapse History
5. Pregnancy History
6. Previous Children's History
7. Plans for the Future

Personal history included: age, marital status, race, Chicago resident or not, educational level, and gestational age of the baby when the mother entered the treatment program. *Family history* included: age of parents, parent's occupation, highest level of education obtained by parents, number of siblings, highest level of education obtained by siblings, and whether they are currently employed or in school. *Drug history* included: current cigarette smoker or not (nicotine is considered the gateway drug), years smoked if smoker, packs per day smoked if smoker, alcohol consumed or not, quantity of alcohol consumed, age when first started drinking, drug of choice, frequency used, and number of attempts to abstain. *Relapse history* included: number of times abstinence was attempted, support systems available when trying to abstain, whether or not Haymarket House was helpful to them or not, and if it was, what aspect of the program has been the most beneficial to them.

Pregnancy history included: how many months along when first learned of pregnancy, baby exposed to cocaine in utero for how many months, whether or not pregnancy was planned, prenatal care received before entering treatment program or not, how far along in the pregnancy before receiving care, marital status, if involved, partner's feelings about pregnancy, aware of potential dangers of cocaine use during pregnancy or not, whether they felt it was safe to use cocaine while breast feeding or not, and number of friends, if any, who delivered babies who tested positive for cocaine exposure at birth but appeared not to had any effects from the exposure. *Previous children's history* included: number of previous children, ages of the children, whether or not any of these children tested positive for cocaine at birth, noted health problems of children if they did test positive at birth, and what kind of care had been arranged for these children while their mother participated in Haymarket House's program. *Plans for the future* questions included: immediate plans mother has for after the birth of the baby, will she plan to seek new friendships if friends are using, family support available or not, financial and housing plans, plans to continue with treatment, and changes they have made in their lifestyles.

These variables were operationalized by means of an interview guide that allowed the acquisition of data for analysis and interpretation. The respondents in my study were 11 women who used cocaine during pregnancy and were enrolled in Haymarket House's Maternal Addiction Center (MAC), a treatment program in Chicago (see Appendix A), from August 3 through 7, 1992. The MAC is a program that is supported by the Illinois Department of Alcohol and Drug Abuse, the Department of Children and Family Services (DCFS), and the Chicago Clergy Association. The MAC opened in March of 1990 with 22 beds. A pregnant woman may be accepted at any time during her

gestation. The majority of the population at the MAC is African American. 90 percent of the clients are referred to treatment by a social service agency. Of those referrals, many come from DCFS, parole or probation officers. Some are task-monitored in lieu of prison.

Upon arriving at the MAC, the women must undergo a complete physical within 48 hours. They are also referred for prenatal care. The women go through an orientation at the MAC. All clients are routinely screened with urinalysis (UA) upon arriving and UAs are done at regular intervals thereafter. The women begin classes and counseling sessions that focus on parenting skills, nutritional guidance, and AA meetings until their delivery. Approximately 80 women wait for three to four weeks before getting into the program. The staff at the MAC consists of six counselors who are licensed in substance abuse training, six addiction specialists, and five nurses who are available 24 hours a day. The MAC has a service agreement with Cook County Hospital, an institution equipped to deal with high-risk pregnancies. Medical referrals and prenatal visits are scheduled as needed.

The use of cocaine during pregnancy was assessed by using an Interview Guide (see copy of Interview Guide in Appendix E) that was developed specifically for this study. Informed consent was obtained from women as approved by the Augsburg College Committee on the Use of Human Subjects (see Appendix B). The researcher was "blind" to biological, psychological, social, and drug histories prior to conducting the interview. Confidentiality of responses was assured. The participants were informed their responses would not affect their relationship with the MAC. The 11 pregnant women interviewed volunteered to be participants in the interviewing process. The compliance rate was 100 percent for a total of 11 questionnaires obtained. Each interview lasted approximately 90 minutes.

The approach to qualitative analysis used in this thesis is what Glaser and Strauss refer to as "analytic induction" (p. 103). This approach was valuable for generating a theory that helped to explain certain behaviors of drug addiction. All available data were coded and analyzed to identify recurring patterns and themes. The results of the interviews influenced and brought about a change in the initial hypothesis.

SECTION FOUR

SECTION FOUR

Results of Interviews

In field studies, theoretical sampling involves reviewing articles and documents, as well as interviewing and observing responses at the same time. All information is important and relevant. The best method for obtaining data is to sit back and listen while the interviewee shares their past (Glaser, & Strauss, 1967). Numerous observations were made while the women of Haymarket House's MAC talked about their struggle with cocaine.

Personal History

All 100 percent (11) of the women interviewed were voluntary participants. Their ages ranged from 26 years old to 38 years old, with the mean being 32 years of age. 82 percent (nine) of the participants were single and 91 percent (10 women) were African American and 9 percent (one woman) Caucasian. 91 percent (10 women) interviewed were Chicago residents. 45 percent (five women) were high school drop outs, 27 percent (three women) had two years of college. The gestational ages of the fetuses when the mother entered the MAC ranged from 1.5 months to eight months, with the mode being five months (three mothers).

Family History

The women interviewed were asked for information regarding their fathers, mothers, and siblings. Their father's ages ranged from 40 to 63. The ages of the mothers ranged from 40 to 73. Occupations held by the women's fathers included: police department clerk, CTA bus driver, foreman, construction worker, cab driver, watchman for the city, furniture mover, and a thoroughbred racer. Their mother's occupations ranged from: keypunch

operator, data processor, file clerk, security guard, housekeeper, Avon salesperson, clerk for police department, and a mail clerk. Highest level of education of the fathers ranged from 6th grade to 12th grade, with the median being 8th grade. Three of the interviewees stated their fathers were deceased; one woman's father was a deceased alcoholic. One of the women interviewed stated she was raised by her relatives because her mother was a heroin addict. Two of the interviewees were unable to give any information regarding their fathers. Highest level of education obtained by the mothers of the women interviewed ranged from three mothers who had two years of college to one mother who's highest level of education was sixth grade. Two respondents stated their mothers were deceased.

The number of siblings the women had ranged from one to seven siblings. Four of the women had three siblings. Sibling's ages ranged from 16 years of age to 51 years of age. The highest level of education obtained by the siblings was college level (three siblings). The highest level of education obtained by the other siblings (28 siblings) was high school. 19 siblings were currently working, two siblings were in school, and seven sibling's career or academic status was unknown.

Drug History

When asked about cigarette smoking history, 91 percent of the women interviewed (10 women) currently smoked cigarettes and of this 91 percent, the range of the length of time they had been smokers varied from two to 22 years with the mode being 15 years (three participants). Also, of the 91 percent who were smokers, the average consumption of nicotine was 12 cigarettes a day per woman.

Alcohol was consumed by 82 percent of those interviewed (9 women). The quantity of alcohol per day reportedly ranged from one can of beer per week to one six-pack combined with a half-gallon of wine and a pint of gin per day. Some participants combined beer and hard liquor and/or wine daily and others consumed as much as a case of beer per day reported by one individual who combined the beer with gin. The average age when the women interviewed began to drink was 15 years old. The ages when they took their first drink varied from 12 to 20 years.

All of the women interviewed said cocaine was their drug of choice. The preferred route of administration was freebasing. 50 percent of the women (five) used readyrock and 50 percent of the women (five) used crack. One woman said she uses both readyrock and crack. 64 percent (seven women) reported daily cocaine use. The women spent $40 to $400 a day to purchase cocaine. The women interviewed stated various means of supporting their drug habit which included work, prostitution, forging checks, stealing from family, using ADC money and owning a smoke (drug) house.

Relapse History

All of the women had made prior attempts to abstain from using cocaine. Two women had made five different attempts to quit. When asked what kind of support system the respondents felt they had as they tried to overcome their addiction, 64 percent (seven) women stated their families were highly supportive of their efforts. One woman said her mother was supportive, however her father was not, and one said her source of support was her friends.

When asked if they felt Haymarket House was helpful to them, 91 percent (10 women) stated they felt it was. Their reasons why included: liking

the structured discipline of program helpful, the program helped them address behavior problems, group camaraderie, sharing of stories with other women who have been there, and feeling less isolated. One woman said she did not feel Haymarket House's program was helpful to her this year; however, she stated it was helpful to her last year with a previous pregnancy.

Pregnancy History

All women learned of their pregnancy by the third month; seven knew of their pregnancy in the first month. The women's reactions to learning of their pregnancy varied. Some women reportedly continued to use cocaine for a total of six months while one began using at three months and continued use into the eighth month. 82 percent (9 women) said their pregnancy was not planned, while 18 percent (two women) said it was. 64 percent of those interviewed (seven women) stated they received prenatal care before coming to the MAC. Gestational age when the women first received prenatal care ranged from two to eight months, with the mean being three-and-a-half months and the mode being three months. Figure 2 on the following page illustrates these values.

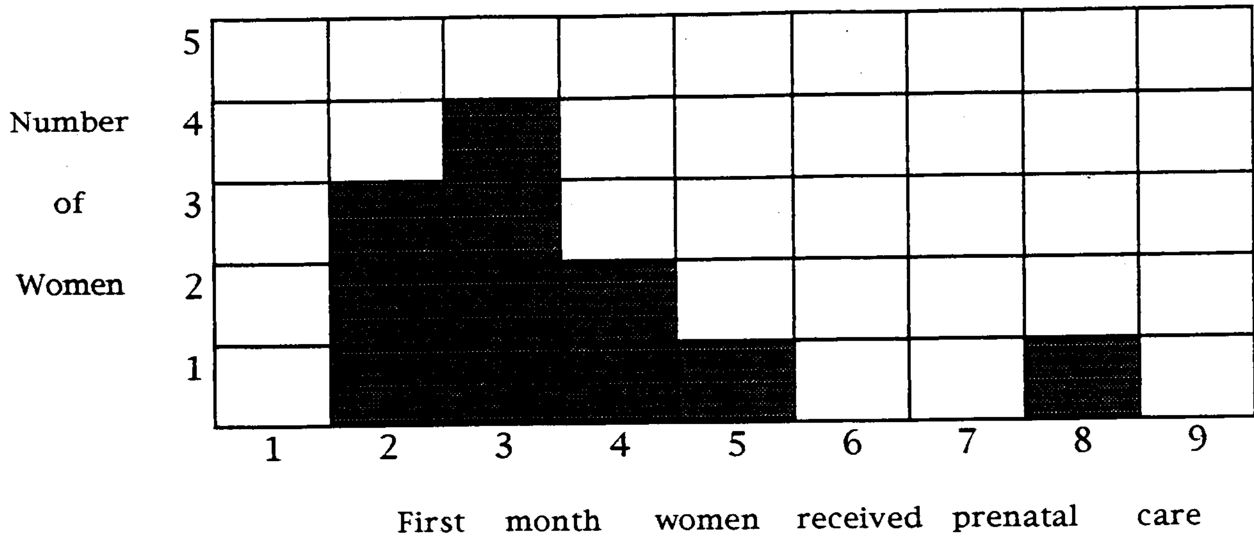


Figure 2. Gestational age when women first received prenatal care. (n = 11).

Although 64 percent (seven) of the women stated they received prenatal care before coming to the MAC, most of the pregnant women began receiving prenatal care in their third month of pregnancy. One relapsed on cocaine upon learning of her pregnancy and continued to use until the eighth month of pregnancy at which point she entered the MAC. None of the women interviewed were married. All of the women were single, separated, or divorced. 64 percent (seven) women said their partners felt positive about the pregnancy. 18 percent (two) women said their partners were not happy with the pregnancy, while one woman said she does not have any contact with the father of her baby.

All of the women interviewed stated they believed that both cocaine and alcohol could be harmful to their unborn child, but several felt it was alright to begin reusing cocaine following delivery. One woman reported a previous delivery was cocaine-positive and the baby exhibited no health problems.

Another woman said it would be alright to resume cocaine use after delivery because she had given the infant a "chance to come out clean". 100 percent of the women (11 women) were multigravid (had more than one child). All of the women interviewed said they did not feel it was safe to breast feed the baby while using cocaine. 73 percent (eight) women said they had friends who used cocaine during their pregnancy and had babies who were apparently healthy.

Previous Children's History

One mother had six children at home, another had seven, however, three mothers each had one, two, and three older children. The mothers reported all of their children were free of health problems although 54 percent (six) of the children had been identified as cocaine-exposed babies at birth. 100 percent of the mothers (11 women) interviewed stated their children had no health problems. When asked who was taking care of their other children while they were in the MAC program, one woman said DCFS has five of her children, while she still maintains custody of one of her children. Other respondents said their other children are being cared for by their father, mother, aunt, or other relative.

Plans for the Future

The respondent's plans for their future varied greatly. Two interviewees stated that after their baby is born, they plan to go either to their mother's house or to a friend's house to raise their children. Another woman stated she planned to return home and begin participation in a parenting class. 27 percent (three) interviewees stated they also planned to return home. One woman said she will return home after she places her baby for adoption.

When the respondents were asked if they planned to see the same people they saw while they were using drugs, 64 percent (seven) women stated they plan to avoid friends who use cocaine when they are through with their treatment. Three women said they feel they can not stop their friends from using cocaine; however, their friends will be forbidden to use drugs when they come over to visit. 82 percent (nine) of the women said they felt their family was basically supportive of their attempts to successfully complete the treatment program.

When questioned about their future financial plans, one woman said she plans to continue on welfare. She said she is unable to read well and would like to continue her education. One respondent said she would like to find a job when her baby is two months old, while another mother said she will wait until the baby is one year old to attempt to find employment. Another respondent said she plans to continue her education through a program called Project Safe.

Four of the women planned to enroll in Maryville, Haymarket House's postpartum program of the Maternal Addiction Center (See Appendix A). This program is for chemically-dependent women with newborn babies and is funded through the State of Illinois through: the Department of Alcoholism and Substance Abuse, the Department of Children and Family Services (DCFS), and the Chicago Clergy Association. The Maryville program is designed to allow the mothers who have participated in the Maternal Addiction Center's program to continue their recovery process. Graduating from the MAC program is not a prerequisite to being in the Maryville program.

Participation in this program is not necessarily voluntary. Some women in the program have lost custody of their children by DCFS and through the Maryville program are able to work toward reunification with

their children by participating in the parenting classes and the chemical dependency treatment groups. Maryville, located several miles from Haymarket House, is near DCFS thus allowing babies who are in their custody to have visits with their mothers while the mothers are in the Maryville program.

The fifth floor of Maryville has housing for 34 postpartum women who are enrolled in the primary chemical dependency program of Haymarket House's Maternal Addiction Center. Length of stay is approximately 60 to 90 days. The sixth floor of Maryville has living accommodations for 16 postpartum graduates of Haymarket House's program for women from other chemical dependency programs in Chicago and their babies. They may be joined by their children who are up to six years of age as their mothers go through the recovery process. Length of stay on this floor is up to six months. Through community resources, the women are helped to find employment, housing, and educational opportunities.

When the women were asked if they planned to voluntarily continue in a treatment program, all 11 respondents said they have definite plans to continue with their treatment. One woman said, "I will be in treatment the rest of my life."

When asked what changes they felt they had made in their lifestyle since being involved with the Maternal Addiction Center, one woman responded the biggest change she made is in her attitude. Another woman recollected one of the Twelve Steps of Cocaine and Alcoholics Anonymous, saying she has accepted things that she can not change and is planning now for her future. One woman said her way of thinking has changed, saying: "Life is more positive now." Another woman said her love for her children keeps her focused on her goal of being reunited with them. One woman said

she has toned her style of dressing and make-up down. Another respondent said, "I let myself know that I was a drug addict and was powerless over it. I realized I couldn't beat it alone." Other comments included: "I am now willing to ask for help", "I am better able to control my temper", and "My life was unmanageable, but now I look at it with an open mind."

Finally, the women who were interviewed were asked to add anything that was not covered in the interview that they thought may help other pregnant women overcome their addiction. One woman's advice to other women was, "Don't try it. Don't even start. The first one is the one that gets you started. Stick with positive people only and avoid any potential traps." Another woman said, "Don't feel like there's no one to help you. Don't keep beating yourself up. You have to want to change. Look to the Higher Power for help. It won't be easy." One woman said, "Start praying on your knees to give you strength to back away from alcohol and drugs. You had a chance at life, your baby should have a chance also. Treatment does work."

One woman said the lowest point in her life was when she was too ashamed to go to her mother's or her boyfriend's house because of her drug use. She said she ended up going to a shelter and stayed there for two months. One woman said she would like to tell women not to do cocaine and she said, "If they read, they know better." Another woman said she highly recommended treatment. She said she believes; however, that inpatient treatment works, while outpatient treatment does not work. She said she was basing this observation on her own personal experience. One respondent said either inpatient or outpatient treatment was fine, but simply attending meetings like Cocaine Anonymous was not enough. She said she believed an outpatient program would have to be quite intensive to be effective. She said what helped her the most was when she realized what effect her drug use was having on

both her baby and others who were important to her. She also said she realized that using cocaine was not how she wanted to spend the rest of her life.

One respondent said that she felt it was only fair to allow the baby to have a chance. She said, "Let the baby come out clean. Then you can go back to smoking." She said she harbors resentment toward her mother, who is watching her children while she's in treatment. She said she believes her mother wanted her children because of the money she receives from the state for taking care of them. She said in Illinois, Aid to Dependent Children (ACD) is $200/month. One woman said, "Give the baby a chance. Someone has to continue this generation. The kids aren't given a chance with DCFS." She said she believes foster care is too crowded.

The 11 women who were interviewed talked openly about their addiction. Although some of the women interviewed seem reserved initially, they all appeared eager to share their experience and advice with other women, and stated that they believed that by doing so, they would give someone else a sense of hope and direction.

Additional Comments from Respondents

During the interviewing, it appeared that the less time the women had been in the MAC program, the more likely they were to project blame for their addiction and circumstances onto others. A few of the women still seemed to be in the denial stage of their illness.

Some of the women interviewed said they felt it was alright to smoke cocaine, but all of the women interviewed felt it was dangerous to smoke cocaine while pregnant. They listed numerous reasons why they felt it was not safe. Some of the comments were: "the baby could be hyperactive, the

baby could be physically and mentally handicapped, the baby may not live, a miscarriage is possible, the baby may be brain-damaged, and there is a chance the child would have poor development later in life." One woman said, "The baby comes out shaking and wants a hit just like you do."

Even though the women could identify reasons why they should not use cocaine during pregnancy, some of the women interviewed had used cocaine with past pregnancies and did not notice any adverse affects on the baby. A few women also said they had friends who used cocaine during their pregnancies whose babies appeared to be free of any health problems. The women who shared these stories seemed to have a false sense of security from their prior experiences. They seemed to believe that babies born to women who used alcohol frequently, while pregnant, suffered effects that were far more dangerous and apparent than cocaine was.

Other women stated how cocaine had affected their lives. One woman said when she was high on cocaine, "You're sorry about nothing. When someone is talking to you, you just want them to stop so you can go to sleep." Another interviewee said, "Coke makes you feel a certain way, as if you're possessed by a demon. Immoral things are OK to do." One interviewee said she had a friend who traded her baby for cocaine.

For one of the women in the Maternal Addiction Center, the first step toward her recovery was to admit that she was powerless over cocaine. She said she enjoyed a positive rapport with her counselors that she found helpful She told me her best friend introduced her to cocaine and shortly after this friend delivered a baby who tested positive for cocaine at birth, the baby was "taken away". This woman said one of the hardest times for her is on Wednesdays because, "Most of the girls go to Cook County Hospital for their prenatal check-up on Wednesday. All girls go for their appointments at 8 AM.

When they are done with their check-up, they don't call the Haymarket House van to come back and pick them up." The wait can be so lengthy at Cook County Hospital that they are not accompanied by a staff member. One of the women interviewed said after her check-up, she called her boyfriend to come and meet her. They then proceeded to get high on cocaine. She returned to Haymarket House at 9 PM.

In an article in which he reviewed Cook County Hospital, Moore states: "You have to go to Cook County Hospital expecting it to take the full day." He continued by saying, "Morning clinic starts at 9:00 AM, but with the clinic serving an average of 10 to 20 new clients every week [a patient] may not see the doctor until noon." (Moore, 1992). Haymarket House has changed their policy so that a physician's signature is required with the time the woman was seen; however, the woman may still wait at the hospital for hours, unsupervised. This idle time is especially dangerous to women who are vulnerable to relapsing.

Systems failure was again evidenced when one of the interviewees stated she had two babies who tested cocaine-positive at birth. When asked what role DCFS played in her life, she said, "DCFS came to me in the hospital and told me they would be coming out to my house to see if the baby was being cared for properly. They came out and saw that the baby had plenty of supplies and closed the case."

In Illinois, women who are cocaine addicts are eligible for Supplemental Security Income (SSI) and are considered disabled. Because of this they are able to avoid the lengthy wait to get housing assistance. This seemed to cause some ambivalence with the women who were not on SSI who were in the program.

Many of the women I interviewed had a past history of physical or sexual abuse. These women expressed concern for their own children and in many cases their children were the motivating factor driving the women to seek treatment for themselves. Ironically, it is the lack of services for their children that keeps many women out of the treatment programs that are available.

One woman said that because of her cocaine use, "I completely missed out on my daughter's life." She continued by saying, "I started using coke when my daughter was two. It's never to late to get help. It's not you that needs help, it's the baby. You can use coke after the baby's born, but give the baby a chance." This was her second time through the treatment program. Only one woman interviewed said she planned to give her child up for adoption.

One woman said, "I got married in 1988 but I got divorced on July 24, 1992, the day I walked in ADD's (Alcohol and Drug Dependence Detox Unit) door. That's the day my husband signed the papers and now he's out of my life forever. When I tell this to my AA group, people think I'm talking about my marriage to a man, but I'm talking about my marriage to cocaine." She added, "Cocaine is a disease. We're just like people who have AIDS only we're dying faster." This woman said she finally sought treatment when her two-year-old walked over to the dining-room table and picked up her pipe, proceeding to mimic her smoking to perfection.

SECTION FIVE

SECTION FIVE

Discussion

As stated earlier, in grounded theory, the researcher refines a hypothesis as the study develops. My initial hypothesis stated that although the women I interviewed knew the potential dangers of cocaine use to their unborn child, due to the highly addictive properties of cocaine, they were unable to act on this sense of danger. The findings from this study tend to support my original hypothesis; however, as this study developed, other influencing factors surfaced as well. Further exploration and study added possible explanations for the women's apparent inability to act on the sense of danger that using cocaine during pregnancy brought to them. The women interviewed gave various reasons for the difficulty they experienced in attempting sobriety that included: too few treatment centers available, long waiting lists to get into treatment programs when they are available, lack of daycare, and lack of adequate insurance coverage.

Although the women interviewed for this study were abstaining from cocaine use at this point in time, some of them were thinking of reusing cocaine after their baby was born, which speaks to the highly addictive properties of cocaine. Abstinence was a difficult and constant struggle for some of the women in the treatment program.

Maternal addiction and cocaine present a multitude of potential problems which other studies are beginning to address. Researchers have found that cocaine use during pregnancy causes complications such as premature birth, abruptio placentae, low birth weight, increased incidences of SIDS, and reduced head circumference. These studies are significant because the pharmacological properties of cocaine have been found to be responsible for these problems when used during pregnancy.

Cocaine and maternal addiction have presented society with a host of concerns that have often become controversial challenges. Arguments have been made for criminal sanctions against mothers who use cocaine during their pregnancy. It is easy to look at maternal drug use punitively, especially when one sees a newborn child suffering from drug withdrawal. No one wants the hand that rocks the cradle to be a shaky one, as the old adage goes. It is very difficult to ask anyone to try to understand how some mothers could choose cocaine over their infants as they appear to be doing.

In Minneapolis, on October 19, 1989, a judge sentenced a mother of four children to more than two years in prison for attempting to inject herself with cocaine while giving birth at a local Minneapolis hospital. This is not an isolated incident. Other people feel that when an infant tests cocaine-positive at birth, the mother should be incarcerated and a TPR (Termination of Parental Rights) should be done on that child and any other children she may have. Some believe the woman should not be given a second, or third, or fourth chance, especially in lieu of the fact that the mother's previous children may have also tested cocaine-positive at birth.

The costs of cocaine-exposed children to society have raised more than one eyebrow. In a presentation at the Humphrey Institute on February 2, 1993, Sheila Ards addressed concerns regarding the costs of substance-exposed children to society. These costs include medical challenges such as low birthweight, birth defects, respiratory difficulties, SIDS, and AIDS. The cost of foster care alone is astronomical. Reasons that these children may end up in foster care include:

1. the mother may leave the baby in the hospital and fail to return,
2. due to mandated reporting laws that are now required of all

hospitals, the hospital where the baby was born may refuse to allow the infant to return home with the mother when she is discharged,

3. the baby may be too ill to be discharged.

Foster care is also an expensive option for society to consider. The basic rate of foster care in Hennepin County is dependent upon:

Age of child:	Amount paid to foster parent(s):
0 - 11	$275/per month
12 -14	$329/per month
15 -18	$363/per month

A Difficulty of Care (DOC) rate is a scale that aids in assessing the amount of extra money the foster parent(s) should be granted due to special needs of the foster child. This rate can go from an additional $50/per month up to $627/per month added to the base rates listed above, dependent on the level of special care the child needs (Terri Powell, personal communication, February 28, 1993). A private agency may command higher rates than the county. When considering the multitude of special needs of a child who is withdrawing from cocaine, foster care can become a costly proposition. Even more costly is the threat to permanency.

There is also the cost of special education to consider as these children enter the school system. Ards summarized these costs accordingly:

1. medical costs: *$16 billion*
2. foster care *$774 million to $1 billion*
3. special education *$41 billion*

These are annual costs to society. One could also claim that if substance abuse creates a vicious positive feedback loop for the family, these children may

themselves eventually be involved with the juvenile justice system, another costly proposition for society. These are strong and valid arguments for punitive action toward the mother, which would also seem to address the question of who is watching out for the rights of the child. However, punitive action is costly.

Women who use cocaine need to support their drug habit. This is frequently done by prostitution, stealing, or property crimes, which are the crimes the women usually get arrested for. During the intake assessment, if the woman is believed to be able to benefit from treatment, she will qualify for external sanctions that include home detention with electronic monitoring, or a work program. Sometimes, women who are deemed eligible for treatment are held in prison for up to a month because the treatment program's waiting list is full. Although a judge may order a woman into treatment, it is rare that a treatment program, if full, will be ordered to accept a woman. If a woman is accused of multiple crimes and not found by the judge to be a good candidate for a treatment program, she will be held in straight detention at a cost of $96.75 per day. (William Nelson, personal communication, February 23, 1993). The maximum amount of time she can be held is 365 days, at a total cost of $35,313 for that one-year period.

Sentencing for possession of cocaine has increased substantially (Marguerite Bittner, personal communication, February 23, 1993). Several years ago, crack used to carry a four-year sentence, while cocaine carried a two-year sentence. This discrepancy was declared unconstitutional in August of 1991 and they both now carry a four-year sentence. Whether the woman is tried for a felony conviction or not depends on the amount of cocaine she had in her possession at the time of the arrest, and on whether she was dealing cocaine or using it. As little as three grams can result in a four-year sentence.

In The Minnesota Correctional Facility of Shakopee, 29 women were committed for drug sentences in 1992. The drug most frequently used is cocaine. Although the women are sentenced to serve four years for possession or use, they are only actually required to serve two-thirds of this time. To go to a state institution, one year and one day of time is required to be served. The cost per day is $107, totaling $36,192 for 366 days. To incarcerate 29 women for a one-year period, society is spending half a million dollars. These women, who will be able to continue to find and use cocaine while in prison, may be released without receiving rehabilitation. Jail, which is often a threatening, high-risk environment, is a non-therapeutic approach that may not work.

Al Houston, a treatment manager at Turning Point is familiar with the penal system. He came to Minneapolis from New York City, where he used cocaine for 25 years and spent 10 years in jail. There was no treatment program available to him while he was incarcerated, and cocaine was always easily obtained. When he was in jail, he said, "My addiction lied dormant until I got out, like a bear hibernating in the winter". As soon as he was released from jail, he began using again on a regular basis. He became involved in a treatment program in Minneapolis and began to turn his life around. He said, "Cocaine becomes like a god". The effect cocaine has on women who use it is particularly devastating because many women who use cocaine also become involved with prostitution (Al Houston, personal communication, February 22, 1993).

To prevent the costs of both substitute care of the children and institutional punishment of the mother, treatment programs need to be made universally available to all women. Dr. Wendy Chavkin said pregnancy has been described as a "window of opportunity" for treating addiction because a major motivator to the women for initiating treatment, as well as decreasing or

abstaining from cocaine use during pregnancy, is their child (Chavkin, 1991). Women need to be in a treatment program where abstinence is the only solution; where a drug-free philosophy exists. The chances of recovery increase greatly if the woman is able to get cocaine out of her immediate life.

I believe that as social workers, we need to address the issue of cocaine and maternal addiction from a societal, rather than individual perspective. We need to stop blaming the victim. Cocaine addicts have a physiological disease in which relapsing is, unfortunately, a frequent occurrence that can overwhelm all but the most dedicated women who are attempting sobriety.

SECTION SIX

SECTION SIX

Limitations and Values of the Study

Because the women in this study were voluntarily selected from a specific treatment intervention program, this biased selection process was a threat to both internal and external validity. For this reason, it was not possible to use probability theory to generalize to the larger population. Another limitation was that my findings were only as accurate as the honesty of the women's responses. This is a difficult limit to assess, because the researcher can only trust that the answers given by the respondents are an accurate and honest reflection to the questions being asked. I felt the women were honest and open; however, one respondent, who did not open her eyes during the interview session, admitted to using the session to be excused from her Cocaine Anonymous group meeting that was being held at the same time. Whether the Cocaine Anonymous meeting may have been painful, threatening or even boring to her, the interview session apparently seemed to be a better option.

I am aware that my questionnaire may have been unintentionally culturally biased. My own cultural identity may have inadvertently influenced my interpretation of what I observed. When analyzing responses to open-ended questions, it is possible that my own biases may have manifested themselves in the coding process. With closed-ended questions, the categories may not have been as exhaustive and mutually exclusive as possible.

The questions also may run the risk of being interpreted differently by the respondent than they were interpreted by the researcher. With this study, there was the danger of what Rubin and Babbie (1989) described as social desirability bias where respondents, when asked for information, will respond

through a filter of what they believe will make them look good (p. 132). The information they reveal may or may not be completely factual. Especially with a sensitive issue such as cocaine and maternal addiction, the respondents may have been experiencing a myriad of reactions that influenced their responses to the questions.

Questions that could have been added may have addressed issues that evaluated why some of the women relapsed. The treatment program itself could have been studied and evaluated, with questions that addressed the quality of the supervision the women received during treatment. Questions could address the models and theories used by the treatment center to see if the program adequately met the needs of the women. Another question may have addressed whether changes needed to be made in the educational aspect of the treatment program. Other treatment programs could be evaluated and compared.

Further research may include evaluating the client's attitude toward their future use of cocaine. Another valuable study would be to continue to study the women as they mainstream back into society with their new baby. It would be interesting to see if the women felt the treatment program was helpful to their recovery and whether or not they were able to find the emotional and financial support they needed to overcome their addiction to cocaine. A future study may evaluate whether women who are addicted to cocaine and pregnant and are not getting their basic needs met are realistically able to overcome the highly addictive properties of cocaine. A longitudinal study may be useful for following the child's academic progress to assess short and long-term effects of cocaine exposure as the child develops in school.

A major limit of any cocaine study is that cocaine is rarely used alone. Polydrug use is common, with heroin and alcohol often being used to bring the cocaine addict down after a high. Because of this, it is difficult to prove many of the theories about the effects of cocaine.

The value of this study is that it contributes to a field where additional research is desperately needed. Cocaine and maternal addiction is raising ethical, medical and legal issues that were not recognized as major problems for society until recently. The women interviewed at Haymarket House shared unique stories and information that could not be found in a textbook. Some of the women said that talking about their addiction was therapeutic for them.

By sharing their stories, several of the women interviewed said they hoped they would be able to help another pregnant woman who was attempting to overcome her addiction. One woman said she would like to tell women who think they can use once and then quit that they are wrong. "Using once is all it takes", she said. Some of the women felt that by sharing their past, they realized the power cocaine had in their lives and that it was a sign they were moving out of the denial stage of their illness.

Finally, other facets of the effects of cocaine and maternal addiction on society need to be further examined. These includes researching and evaluating the penal system, the educational system, the medical system and child protective services. Longitudinal studies are needed to monitor how cocaine use affects the extended family, especially grandparents who often end up watching these children.

Also, there are very few studies that evaluate the harm of cocaine's secondary vapors to children. Since signs of this exposure have been found in the urine of infants who have been exposed to it, this potential harm will present another concern that will need to be evaluated.

The fathers of the babies seem to be in the shadows of many research studies and often are not mentioned at all. Although all of the women interviewed for this study were single, separated, or divorced, 10 of the women still had contact with the father of their baby. The roles these fathers play in the lives of their children need to be examined and the father's contributions, when present, need to be acknowledged.

Social services need to be offered that identify the women's strengths, assets, and current resources, especially for women of color and women who have limited finances, education, and abilities. This is also true for women who are struggling to overcome the addictive properties of cocaine while they are dealing with other stressful issues and may be lacking any type of support system. By evaluating treatment programs, especially through the eyes of the women who are receiving treatment, effective treatment programs can be offered.

SECTION SEVEN

SECTION SEVEN

Summary

Guidelines for Practice

Women who use cocaine may be frightened, irritable, paranoid, and physically exhausted. Even when pregnant, they may not be receptive to suggestions from a helping professional. Rather than making a judgmental decision, it is important for the intervener to remember that:

1. the individual is the victim of a progressive and fatal disease,
2. denial, as with alcoholics, is characteristic,
3. the addict will sacrifice almost anything, including their children sometimes, to keep using.

Keeping the above thoughts in mind, the helping professional should:

1. try to address the person's addiction on a day-to-day basis, rather than attempting long-range goals,
2. avoid punishing, bribing, preaching, or threatening the addict,
3. try to be understanding and show concern, but be firm that the woman needs professional intervention,
4. refer the woman to a treatment center that specializes in cocaine addiction. (Adapted from Karen Edens of The Edens Group).

When evaluating the effectiveness of a treatment program, it is necessary to include the following questions:

1. What strengths do the women have individually and collectively to draw on?
2. What can be done to help the women avoid a relapse? How could the program be more effective to prevent this

from happening?

3. How do the clients feel about returning to their community at the completion of their treatment program? Do they feel they are ready to make the necessary changes in friendships and/or families?
4. How realistic are the program's goals for the women
   ---to find affordable housing?
   ---to be able to rejoin the community?
   ---to be able to support their children financially and emotionally?
5. Are the women being set up to fail? If not, why are some of the women back for a second and third time?
6, What was the quality of supervision received during treatment?
7. What models and theories were included in the treatment program? Were they adequate to meet the needs of the women? What could have been changed or done differently?
8. What changes could be made educationally (in parenting groups, CA, AA?)

This list is by no means exhaustive; however, these questions address integral components that make up a successful program according to this study.

In treatment, one week is necessary to get the cocaine out of the woman's system, or to detoxify her. It will be another four weeks to three months until her body is able to readjust itself back to a normally functioning state, and for the brain to reestablish its normal chemistry. Women, especially if they are pregnant, need to receive proper nutrition, rest, and support. If

they find themselves in highly stressful situations, they will be vulnerable to relapsing. Secondly, the women need to receive help returning back into society. The woman and her counselor need to be aware of environmentally-cued cravings that remind her of cocaine. These cues may include seeing a snowfall, a mirror, a pipe, being on a street corner where she used to receive cocaine, or even certain smells. She will need help finding employment, as well as making new friends with people who do not use cocaine or other drugs. For some women, it may be necessary to confront and even leave a drug-using partner, or to redefine their idea of a family. Finally, the woman needs to replace her cocaine habit's artificial high with a high that does not come from cocaine.

For this reason, a program offering a minimum of 12 weeks total is preferable to allow the client to return to society while still receiving group support. Since cocaine is a physiological addiction that results in a euphoric high, the high is similar to what gamblers experience following a substantial win. Like gamblers, cocaine addicts are always chasing that initial high only to find they are not able to recapture it. Compulsive tendencies cause cocaine addicts to continually seek this high.

Twin City Treatment Programs

In the past, Child Protective Services would automatically remove infants from their mothers if the infant tested positive for cocaine at birth. This practice did not always work and in some cases, the mother would actually leave her child in the hospital and not return. In May of 1990, Minneapolis (Hennepin County) and St. Paul (Ramsey County) received a grant to find a better way to address this issue and help the women get into a treatment program, preferably prenatally. In Minneapolis, this is called Project Child.

In St. Paul, it is called Maternal Child Project. Since May of 1990, Project Child has made over 700 referrals to treatment programs (Billie McCoy, personal communication, March 1, 1993). The programs they utilize are:

1. **Park Avenue Center** (2525 Park Avenue, Minneapolis):

   Eligibility: Men and women who have chemical dependency problems,

   Method of Payment: Insurance, consolidated funds, private pay,

   Chemical Heath Services: AM and PM outpatient treatment, separate women's treatment program on Wednesday and Saturday, aftercare, and individual counseling,

   Adjunctive services: Relationship groups.

   **Note: The women may not have their children with them in this program.*

2. **Eden Day Program** (1025 Portland Avenue, Minneapolis):

   Eligibility: All women, 18 and over,

   Hours: Monday - Friday, 9:00 AM - 5:00 PM,

   Method of Payment: Insurance, consolidated funds, some private pay,

   Chemical Health Services: Outpatient primary treatment, family/concerned persons, women's group on Thursday evenings, aftercare, and cocaine program,

   Adjunctive services: Housing for women and their children, independent living, coordinate services for child care, acupuncture, and a children's program.

3. **Turning Point** (1105 16th Avenue, North, Minneapolis):

   Eligibility: Men and women, 18 and over,

Hours: Monday - Friday, 8:00 AM - 5:00 PM, 24-hour coverage,

Method of Payment: Insurance, consolidated funds, private pay,

Chemical Health Services: extended care program providing individual, family, and group counseling, aftercare, outpatient treatment, family/concerned persons, women's groups, CD program: live-in services for pregnant and non-pregnant women with up to 2 children, ages 0 - 5, apartment living with outpatient treatment program.

Adjunctive Services: AA, counseling for: self-awareness, employment, development and job referrals. Prenatal care, relapse prevention, reunification counseling for children whose children are in foster homes, parenting skills program, child development program, psychological services.

**Note: This program is especially geared for African American clients.*

Conclusions and Recommendations

There is a need for more outpatient treatment programs, especially programs that utilize creative approaches with many options available to help the client. These options may include: acupuncture, hours that accommodate the client (for example, a program that is open at 1 AM on Fridays and Saturdays), a good nutritional program for pregnant women, a place that allows for adequate rest and healing in a low-stress environment, a program

that is affordable to those women who do not have insurance coverage, a program that allows the women to be with their children, as well as significant others and family, and a program that gives continual support even when relapse occurs.

Counselors need to be trained to listen to the women's stories as to why sobriety is so important that the woman has finally decided to get into a treatment program, help the women understand, in the women's terms, what to expect as they begin their recovery process. The women need to be aware that depression, anxiety, a sense of hopelessness, and paranoia are all to be expected, so they can deal with it as it happens. The women need to be encouraged to list possible pitfalls that may trigger a relapse if they are not recognized and dealt with. Role-play in groups could help the women practice facing the environmental cues that may signal a potential relapse. Initial intake assessments need to be modified. Although Rule 25 assessments are geared to all drugs, cocaine-specific questions need to be added to this assessment.

Finally, I believe that counselors who are specially trained for cocaine addiction and are non-judgmental are needed to empower the women as they support and educate them. The women's cultures need to be understood and respected. The use of medicine needs further evaluation because the biochemical changes in the reward and pleasure center of the brain are almost identical to major depression. Tricyclic antidepressants have been found helpful in treatment. Cocaine abuse is a debilitating and potentially fatal disease. I believe courage is an integral part of recovery. If the women are able to admit that their struggle with cocaine will be a lifelong process, and if they are willing to take the steps necessary to get cocaine out of their lives, they will have a better chance for recovery.

APPENDIX A

COMMENTARY

Chicago Sun-Times, Monday, December 31, 1990

Haymarket gives hope to many

It was on New Year's Eve fifteen years ago that Haymarket House opened as a haven for the homeless and addicted. Its milestone anniversary tonight draws well-deserved attention to one of Chicago's most effective private-public partnerships.

The center, at 120 N. Sangamon on the Near West Side, has served 25,000 people as the state's first social-setting detoxification facility. It was the inspiration of its founder, Monsignor Ignatius McDermott, known as the priest of Skid Row.

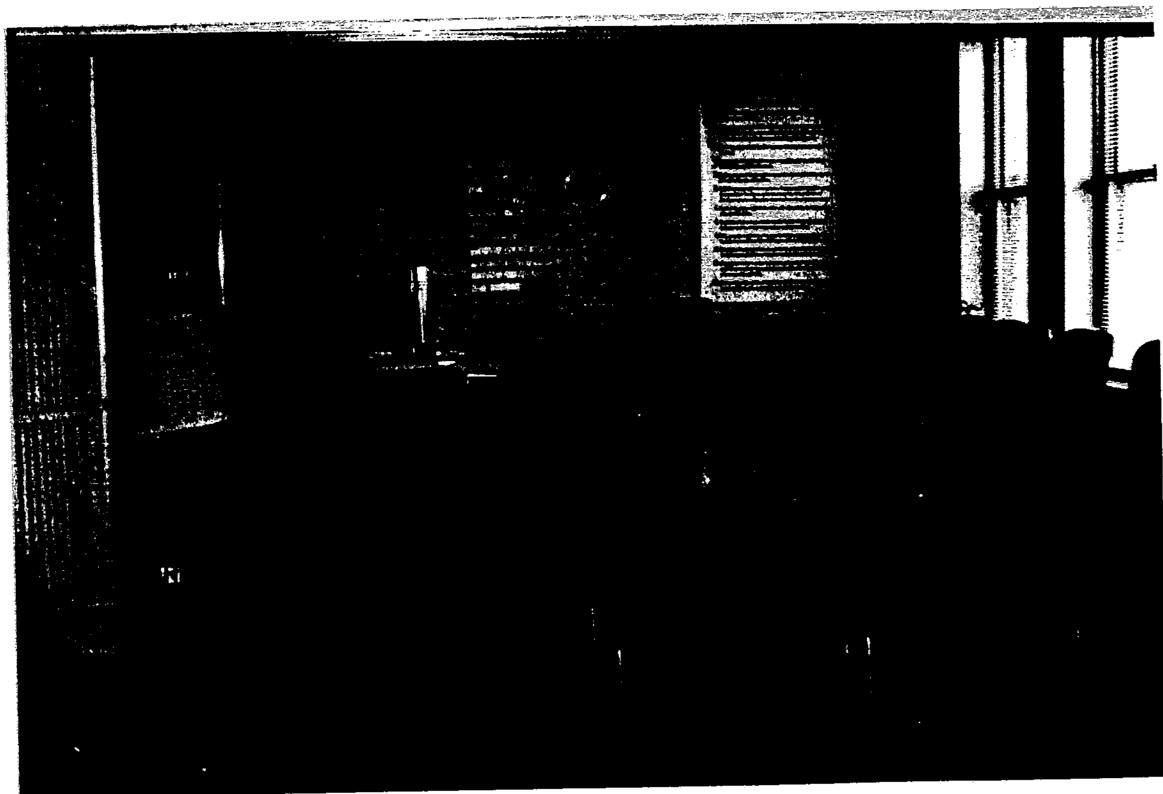
With most of its funding from the Illinois Department of Alcohol and Substance Abuse, the foundation-operated Haymarket has succeeded admirably as a detox and self-help complex. It has a section devoted to pregnancy counseling, a residential program for intensive counseling of male addicts, a sanctuary for men recovering from addiction and other specialized functions.

As Haymarket House starts its 16th year tomorrow, it plans soon to begin a postpartum program, giving a sheltered environment for treating new mothers from its maternal addiction center.

The venture, to be operated by Haymarket and the old Cuneo Hospital's Maryville program for children, will be quartered at the former hospital on the North Side, with additional funding by the state Department of Children and Family Services.

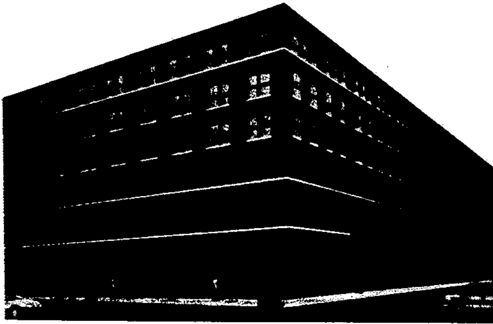
Haymarket House shines as a beacon of hope for so many of the needy. May it continue to grow and expand into the next century.

HAYMARKET HOUSE
120 North Sangamon Street
Chicago, Illinois



HAYMARKET HOUSE

CEE'S MANOR



Haymarket House and several of its programs occupy the newly renovated building shown here. A second, six-story brick structure shown just beyond is being renovated for future needs.

Haymarket House, along with Cee's Manor, and several programs are administered by the Chicago Clergy Association for the Homeless Person.

Its mission is...

- To serve the homeless, the chemically dependent, the substance abuser, the disadvantaged and the unfortunate.
- To provide shelter, sustenance, encouragement and support for these populations, their families and their significant others.
- To provide a continuum of care for the chemically dependent person and the substance abuser, including detoxification, education, treatment, rehabilitation and support.
- To provide a place and social structure for persons, groups or agencies who do similar work or work that aids or enhances the basic mission.

The Chicago Clergy Association was founded by Msgr. Ignatius McDermott.

HAYMARKET HOUSE

Detox, residential and outpatient substance abuse services for adult men and women

CEE'S MANOR

A sanctuary for male substance abusers

120 North Sangamon
Chicago, Illinois 60607

Phone: 312-226-7984
Fax: 312-226-8048

Established 1975

Haymarket House/Maryville Program

(MAC)

Women's Residential Programs

Detox Programs for Women

Project SAFE at Haymarket House

Project SAFE is a specialized, intensive outpatient program for women referred by the Department of Children and Family Services and designed to meet their needs relating to alcohol and drug dependency.

The 12-week program provides an outreach component to assist in the initial stages of their recovery.

Child care services are developed through this program.

Sangamon House:

O'Hare Outreach Program

Detox Programs

Men's Residential Programs

Intensive Outpatient

Cee's Manor at Haymarket House

Cee's Manor is a residential sanctuary for adult male substance abusers.

Located at 120 N. Sangamon, in Chicago, and operated as another of the Chicago Clergy Association programs, Cee's Manor offers open-ended stay to chronic abusers, requiring them to have had prior formal treatment and to pay their room and board.

The environment offers not only a quality of life that many residents feel is worth striving to maintain but structured daily living, recreational activities and self-help group meetings that enable them to continue their sobriety.

Residents are assisted with vocational training and, when appropriate, in finding

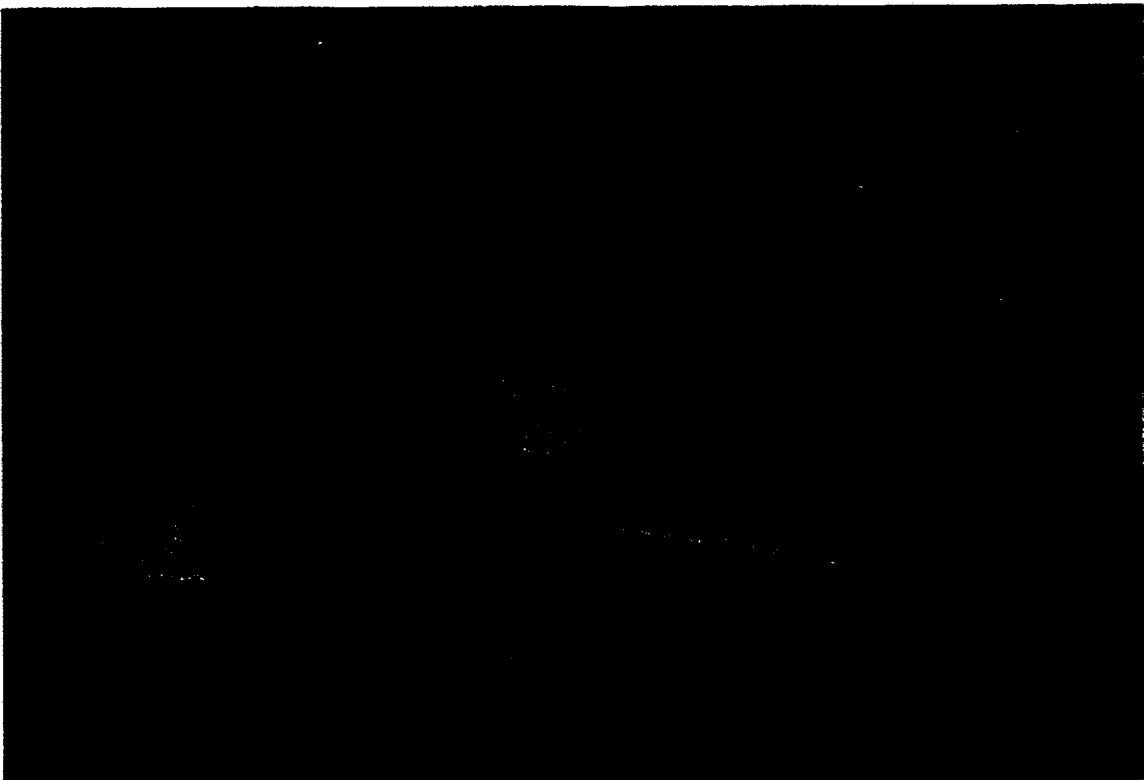
OPERATED BY CHICAGO CLERGY ASSOCIATION

HAYMARKET HOUSE
120 N. SANGAMON ST.
CHICAGO, ILLINOIS 60607

(312) 226-7984
FAX 226-8048

BETTIE FOLEY MS CAC
MATERNAL ADDICTION CENTER
PRENATAL PROGRAM DIRECTOR

MARYVILLE
750 West Montrose Avenue
Chicago, Illinois



APPENDIX B

INDEPENDENT STUDY 598 CONSENT FORM

You are invited to be in a research study of women who are currently residing in the Maternal Addiction Center of Haymarket House. You were selected as a possible participant because you have used cocaine or other drugs during your pregnancy. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

Background Information:
The purpose of this study is to interview women who have used drugs during their pregnancy in an effort to understand why women use cocaine during their pregnancies.

Procedures:
If you agree to be in this study, we ask you to do the following things. You will be asked to participate in an interview that will last approximately one hour. You are asked to be open and honest in your answers. There are no perceived risks to you from participating in this study.
This information will remain strictly confidential and only your first name will be used.

Confidentiality:
The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be kept in a locked file; only the researchers will have access to the records.

Voluntary Nature of the Study:
Your decision whether or not to participate will not affect your current or future relations with Haymarket Center. If you participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:
The researcher conducting this study is Susan A. Clauson. You may ask questions you have now. If you have questions later, you may contact Susan through the Department of Social Work at Augsburg College. The phone number is: (612)-330-1189.

You will be given a copy of the form to keep for your records.

Statement of Consent

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature____Date______________

Signature of Investigator________________________________Date______________

APPENDIX C

HAYMARKET HOUSE AND CEE'S MANOR
DISCLOSURE OF CONFIDENTIAL INFORMATION
AGREEMENT FORM

I, ______________________________ I.D. # ________________________

a registered client receiving treatment for alcoholism/substance abuse hereby grant permission to ________________________________,

to ☐ interview me,

☐ take my picture,

☐ record my voice for purposes of ________________________

____

The reasons for needing this confidential information about my presence here or for information about me has been explained to me and I understand the need for this information. I believe it is in my best interest to disclose this information. I grant this permission on a one time basis for this purpose only.

______________________________ ______________________
Signature of Client Date

______________________________ ______________________
Signature of Witness Date

H.H. #1047
Rev 03/90

APPENDIX D

Augsburg College

731 21ST AVENUE SOUTH
MINNEAPOLIS, MN 55454
612/330-1000

March 22, 1993

To: Susan Clauson
From: Nancy Steblay N. Steblay
Chairperson, Institutional Review Board
Re: Approval of proposal

For the record:

Susan Clauson submitted an application for approval to the Augsburg Institutional Review Board on July 17, 1992. The project is entitled "Interviews conducted with cocaine mothers at Chicago's Haymarket House." Ms. Clauson's proposal was accurately completed, and the appropriate documentation from Haymarket House was attached. Although the proposal technically should have been routed through the full IRB, at that point in time there was not yet an IRB operating on campus. (Our first meeting was held in September, 1993.) Therefore, in consultation with two of the IRB members, Erickson and Pike, I approved the application for Ms. Clauson's project.

The approval number for Ms. Clauson's project is 92 -1.

APPENDIX E

INTERVIEW GUIDE

At the beginning of the interview session, the respondent will be told that at the end of the session, the researcher will be giving them the opportunity to add anything that was neglected during the interview, but that they feel may be helpful to others.

Respondents will be reminded that their participation is strictly voluntary and they may choose to refrain from answering certain questions and that if they choose to terminate the session at any time, it will not affect their relationship with Haymarket House. They will also be assured that the information they give will be kept confidential and only their first names will be recorded.

Personal History

1. First name:
2. Date of birth:
3. Marital status:
4. Race:
5. Chicago resident?
6. Live with?
7. Baby's due date?
8. Age of baby when mother entered Haymarket House?
9. How did you learn about Haymarket House?
    a. voluntary self-referral
    b. referral through other:
    c. court-ordered
10. What is your expected length of stay at Haymarket House?
11. What is your highest level of education?

Family History

1. Age of your father/mother:
2. Father's/mother's occupation:
3. Highest level of education obtained by father/mother?
4. Number of siblings:
5. Their ages:
6. Highest level of education they obtained?
7. If they are not in school, are they working?

Drug History

1. Do you smoke cigarettes?
2. For how long?
3. How many packs per day?
4. Before Haymarket House, did you drink?
5. What kind of ETOH?
6. How often?
7. Before Haymarket House, what kind of drug did you use?

8. If you used cocaine, did you use it:
    a. intranasally
    b. IV
    c. freebased
    d. other:
9. What form of cocaine did you use (crank, crack)
10. How often did you use cocaine?
11. How old were you when you first tried drugs?
12. Was there any significant factor that precipitated initial drug use?
13. How did you pay for the drugs?
14. When you used drugs, were you influenced by:
    a. peer pressure
    b. tension or stress release
    c. desire to get high
    d. relief of pressure
    e. depression
    f. other:

Relapse History

1. Did you ever try to quit drugs?
2. What support systems did you have?
3. Do you believe Haymarket House is helpful to you?
4. What aspect of Haymarket House is the most beneficial to you?

Pregnancy History

1. How far along were you when you found out that you were pregnant?
2. When did you stop using cocaine?
3. Was this pregnancy planned?
4. Did you receive prenatal care before coming to Haymarket House?
5. What point were you at in your pregnancy when you first received prenatal care?
6. Are you married? Single? Separated? Divorced?
7. If you are involved with your partner, what are his/her feelings about your pregnancy?
8. Do you believe it is OK to use cocaine while you are pregnant?
9. What possible effects to you see resulting from cocaine use while you are pregnant?
10. Do you believe it is safe to use cocaine while you are breast feeding?
11. Do you have friends who have tried cocaine during their pregnancy and delivered healthy babies?

Previous Children History

1. How many children do you have at home?
2. What are their ages?
3. Did any of your children test positive for cocaine at birth?
4. Do any of your children have noted health problems?
5. Who is taking care of your children while you are at Haymarket House?

Plans for the Future

1. Where do you plan to go immediately after the baby is born?
2. Do you plan to keep your same friends if they used cocaine?
3. Is your family supportive?
4. What are your financial plans?
5. What are your plans for housing?
6. Will you continue with your treatment?
7. What changes have you made in your lifestyle?

What information/suggestions would you like to add that we haven't talked about that you believe may help others?

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