Making Lemonade Out of Lemons: A Case Report and Literature Review of External Pressure as an Intervention With Pregnant and Parenting Substance-Using Women

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Slightly more than 5% of women in the United States use illicit drugs during pregnancy.[1] Estimates of the proportion of Child Protective Services cases that involve substance use range from 20% to 80%.[2] Pregnant and parenting women who misuse substances are frequently involved with child welfare services, and this either implicitly or explicitly entails use of external pressure or coercion to promote entrance to substance abuse treatment. In this context, *implicit pressure* refers to the threat of child welfare intervention or fear of loss of child custody that a pregnant or parenting woman may feel, whereas *explicit pressure* encompasses pressure in the form of warnings, requirements, or mandates (ie, legal coercion) from external sources. External pressure in the treatment of substance misuse is controversial, and even more so when considering this specific population of substance users. Between 50% and 75% of women entering substance use treatment programs have a history of trauma[3]; this mandates a thorough discussion of the most effective way to use external pressure to promote positive treatment outcomes while remaining sensitive to the unique context in which their substance use occurs, such that women are not retraumatized. Herein, we present a case report of a postpartum woman with substance misuse who faced implicit and explicit pressure to enter treatment in order to regain custody of her newborn child. We follow the case presentation with a review of the literature on the use of external pressure as it pertains to perinatal and parenting women.

Case Report

Ms A is a 25-year-old woman with a 12-year history of substance misuse, beginning with marijuana at the age of 13 years. By 18 years old, Ms A was using cocaine, ecstasy, and alcohol every weekend, and at 21 she started taking prescription pills, eventually shifting to heroin. Ms A made multiple attempts to attain abstinence from drugs, but it was not until February 2010 that she actively sought treatment and entered a methadone maintenance program. Despite this, she continued to use cocaine intravenously to offset the sedative effects of the medication. Later that year, Ms A found out she was pregnant at a gestational age of 11 weeks. (This was her second pregnancy and would be her first birth.) She was able to attain abstinence in the last 2 months of pregnancy, only to relapse to cocaine use immediately before delivery.

During pregnancy, Ms A's social worker notified her that if the baby were born with a cocaine-positive toxicology screen, she would be removed from Ms A's custody by child welfare services. Her social worker and her counselor at the methadone clinic urged her to enter treatment in order to decrease the chance of separation. She delayed doing so until her daughter was born cocaine-positive, at which point Ms A immediately contacted a residential treatment center, motivated by the hope that entering treatment would be "the fastest way to get [her] daughter back." Under the impression that she could stay in the hospital until her daughter's discharge to a temporary custody placement, Ms A was shocked when a Department of Children and Families (DCF) caseworker informed her she had 15 minutes to pack her bags, say goodbye to her daughter, and leave. Ms A informed caseworkers that the only place she had to go was her father's home and that he is a drug user. She pleaded that they allow her to stay to care for her daughter and remain clean, but instead they placed her in a cab and sent her away. Ms A used cocaine that day, stating that it was brought on by the distress of the DCF intervention and the hopeless feeling that "even if [she] stayed clean, [she] couldn't stay" with her daughter.

Ms A entered residential treatment shortly after and made an agreement with DCF that upon completion of 90 days of sobriety in the residential center she would regain custody of her daughter. The two would then spend the remainder of Ms A's 6-month stay in the center together. Ms A has complied with her treatment program, although at times she struggles to uphold a positive outlook. She described feeling that, to the counselors and caseworkers, she's "just a case number," simply "an addict," but that this is her child's and her life. Ms A stated that she found it easier to cooperate with caseworkers and counselors with whom she had a positive connection. When asked if she felt coerced to enter treatment, Ms A acknowledged feeling the external pressure imposed by the threat of permanently losing custody of her child, but also recognized feeling "self-forced" to address her substance misuse, as shown by scheduling her intake before DCF initially contacted her. Ms A confirmed she "actually kind of understood their side," but that this did not mean that her situation was handled appropriately. Ms A described the intervention as "an extremely traumatic experience," remarking that the "abrasive" manner in which it was conducted provoked her to "use heavily" after delivery.

Literature Review

Ms A's story illustrates the complex roles of maternal substance use, child custody, and motivation to obtain abstinence in the management of pregnant and parenting women who use substances. Many women have increased motivation to reduce unhealthy behaviors in pregnancy, and this may be an opportune time to intervene to reduce substance misuse.[4] Whether implicit or explicit, pressure for women to seek and comply with treatment is common in this situation.

To better understand how external pressure affects substance-using perinatal and postpartum women, we performed a systematic literature review of PubMed (1966–present), PsycINFO (1967–present), and CINAHL (1981–present), using the keywords *postpartum women, mothers, pregnant women, external pressure, coercion, substance abuse treatment, drug use, consumer attitudes, client attitudes, child welfare,* and *child protective*

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Clinical Points

- Pregnant and postpartum women are frequently exposed to external pressure to not use substances. The way in which pressure is applied in clinical situations can potentially influence the trajectory of the woman's addiction, as well as her motivation to seek treatment and get prenatal care.
- Providers should use external pressure to encourage pregnant and postpartum substance users to enter treatment in a collaborative and supportive manner. Confrontational strategies are less likely to be effective in addressing addiction, especially in this unique population.
- Some strategies include (1) acknowledging individual women's needs; (2) building positive, respectful relationships with patients; and (3) providing a range of resources that address their specialized barriers to treatment entry.

services and limiting our results to English-language writings. We conducted a manual review of relevant articles, including reports and literature relevant to published reports. We review substance use and treatment among pregnant and parenting substance users, and external pressure as it relates to their motivation to enter and succeed in treatment.

Substance use, child welfare involvement, and treatment entry barriers. Substance use in pregnancy is a substantial health concern.[5] Substance-using pregnant women are more likely to delay prenatal care and have inadequate prenatal care.[5,6] Prenatal drug exposure can result in prenatal death, premature birth, prenatal growth restriction, and infection.[7] Potential postnatal complications include growth restriction, behavioral problems, susceptibility to infections, and death.[7]

Substance-using parents are less likely to provide adequate care for their children, and their children are at a high risk of neglect.[8] Substance-using mothers have been noted to display less-appropriate parental involvement with their children and often lack basic knowledge of parenting behaviors.[9] The children who are exposed are at high risk to continue familial patterns of substance abuse[10] and are also more likely to have poorer physical, intellectual, social, and emotional outcomes.[11]

Efforts to reach out to substance-using populations are hampered by the fact that pregnant and parenting women are significantly less likely than men to enter and complete substance use treatment.[12,13] This may be a reflection of the relative deficiency in programs intended to treat this specific group,[14] as well as barriers to treatment entry that arise from the varying contexts of women's drug use.[12,13] Substance-using pregnant women report high rates of previous physical abuse, have more children in out-of-home placement, lack family support, and need more social services than nonusers.[12] Compared to male users, women are more likely to be unemployed, have high rates of mental health problems, and have histories of traumatic life events.[3,15]

Many studies cite lack of child care as a major barrier to treatment entry for pregnant and parenting substance-dependent women.[13,16–19] Scarcity of transportation, financial difficulties, and an overall dearth of gender-specific treatment services can also prevent women from seeking treatment.[17–19] Another noted barrier is the stigma of addiction during pregnancy and motherhood and the fear of punitive action from the state or health care providers.[19,20] Many mothers do not enter treatment because they fear they will lose custody of their children[20,21] or be incarcerated[20] and believe that they are bad mothers.[16] Shame and the fear of punitive intervention can result in lower self-esteem,[16] avoidance of seeking treatment,[22] and, as a result, lower rates of recovery.[20]

Improving treatment retention and completion rates. Pregnant and postpartum women who complete treatment have better outcomes with regard to later drug use, criminal activity, and employment,[14] as well as higher rates of reunification with their children, compared to those who do not complete treatment.[18] Therefore, providers must identify the most effective way not only to facilitate entry into substance abuse treatment, but also to encourage maintenance of care.

Components of programming associated with positive treatment outcomes for substance-using women who are pregnant or parenting include child care, prenatal care, women-only programs, supplemental services, mental health treatment services, and comprehensive programs that combine many of these components.[23] Moreover, women allowed to live with their children in therapeutic community treatment programs remain in treatment significantly longer and have higher measures of self-esteem than women whose children are placed with alternate caretakers.[24] Measures to increase self-esteem may be integral to achieving positive treatment and reunification outcomes, given that these women often have a history of trauma and experience guilt secondary to the stigma against maternal substance use. Evidence points to utilizing a motivational approach, rather than a confrontational one, to best increase self-efficacy and a change in drug-using behavior.[25]

These findings support the development of resources for women that promote increased access to treatment, as well as the aforementioned specialized services within a supportive environment emphasizing self-worth.[13,16,17,23] Just as pregnant and parenting women begin their substance use in unique circumstances, the means to end their use must also take place by recognizing these circumstances and addressing their specialized needs.

The many faces of external pressure. Legislation that leads to prosecution of pregnant and parenting women with substance use problems is a recurring theme in legislative history. California and New Jersey have attempted to prosecute women for homicide on the grounds of delivering a stillborn or injured newborn after using illegal substances.[26,27] Fifteen states consider substance abuse during pregnancy to be child abuse, and 3 consider it grounds for civil commitment.[28] Substance-using pregnant women have been charged with criminal mistreatment of a child,[29] child abuse,[30] and child neglect.[31] Supporters of these prosecutions argue that a pregnant woman has a moral duty to consider the interests of her future child,[32] and postpartum prosecutions are defended on the grounds that "newborn infants do not deserve to be burdened for life by the irresponsible behavior of . . . their mothers."[32] These attitudes fail to consider the reality that addiction is a medical illness.[33]

The most severe form of legal coercion is incarceration; however, incarceration may not be an effective way to curtail illicit drug use.[34] Incarcerated pregnant women are at a high risk for negative pregnancy outcomes.[35] Incarceration of a pregnant

substance user, or the threat of incarceration, can lessen her chance of receiving adequate prenatal care or substance abuse treatment; consequently, both the mother and her fetus suffer.[36] Prosecution of pregnant women could result in the prejudgment of pregnant users and loss of patient-physician confidentiality.[21] Furthermore, prosecution of women immediately after delivery is not therapeutic and achieves little beyond the punishment of women who used drugs during pregnancy.[32] Moreover, it can cause psychological damage to the infant by interfering with a critical bonding time.[37] Extremely punitive actions do not help the mother gain control of her life and can further discourage women from seeking treatment,[32] which argues for the use of other forms of legal and nonlegal pressure that may more effectively produce drug use cessation.[38]

Diversionary programs, such as drug treatment courts, are an alternative to incarceration in which treatment is not mandatory per se, but offered in exchange for a reduction in legal sanctions.[39] In a drug treatment court, a judge and collaborating substance abuse professionals construct a comprehensive treatment plan, which includes rehabilitation treatment, drug education, and drug therapy.[40] Drug courts have resulted in low rearrest rates and increased program retention rates in populations of substance users with a history of drug-aggravated, nonviolent crimes.[41] Supporters of alternatives to incarceration of pregnant and parenting substance users contend that society has an obligation to protect the children in substance-using households, but that the uncertainty of the precise effects of substances on a child makes it unethical to incarcerate women.[42] In addition, diversion-to-treatment programs can increase timeliness to treatment and improve the quality and delivery of services.[43]

Nonlegal sources of external pressure arise from formal noncriminal sources and informal sources. Formal noncriminal pressure is described as pressure to enter treatment from noncriminal organizations, such as employers and government agencies.[43] This type of pressure was illustrated in the presented case study. Informal pressure includes pressure from friends and family[43] and can be an effective source of pressure to enter treatment.[44]

The controversy of external pressure. Concern over the use of pressure with substance users has its origins in multiple arguments. Pressure in the form of mandates or incarceration is viewed as an infringement on autonomy,[45] a notion that becomes even more complex when discussing pregnant or parenting female substance users, since the well-being of the fetus or child is often taken into account. Furthermore, the population under question is extremely heterogeneous.[43] Substance users differ in their social, criminal, and drug history,[43] as well as in the extent of their internal motivation to seek treatment.[46] As discussed, pregnant and parenting women are a subset of substance users with particularly specialized needs that must be considered when using pressure to encourage treatment entry and completion.

Opponents of the use of external pressure argue that those forced into treatment are less motivated to change[47] and may be less likely to engage in treatment, which hinders their recovery process.[48] On the other hand, proponents contend that external pressure has an important role in motivating users to start treatment,[43] arguing that few addicts enter and stay in treatment without some outside pressure.[49] Motivation is a widely studied theme in the field of substance abuse treatment and is seen as key to promoting treatment engagement and positive treatment outcomes.[50] Motivation to enter treatment quite likely depends on the influence of external and internal reasons,[51] and pressure to do so can arise from a wide range of sources.

For instance, external pressure in the form of the threat of or actual removal of a child from parental custody can serve as a powerful motivator for a parent to enter and complete treatment.[45] The National Treatment Improvement Evaluation Study of 1,374 women entering substance abuse treatment reported that 42% of mothers with dependent children entered treatment in order to maintain or regain custody of the children.[52] Similarly, for Ms A, it was the certainty of child welfare intervention that ultimately galvanized her to seek treatment. In order to retain or regain custody of their children, completion of substance abuse treatment is often considered standard protocol for parents involved in child protective services.[53] In a study of 1,911 women whose children were placed in substitute care, mothers who completed treatment were significantly more likely to be reunified with their children (60.6%) compared to those who did not (35.5%).[54] The positive associations between treatment completion and reunification and abstinence emphasize the importance of quick maternal access to treatment after the child is removed from her care. This is especially important because the mother (like Ms A) may be more motivated to change her substance-using behavior if it enhances the chances of reunification with her child.[54]

Perceptions of external pressure. Generally, researchers have concluded that external pressure is effective in promoting treatment entry, retention, and positive outcomes,[43,49] particularly with women who are parenting or involved with the child welfare system.[2] Mandated patients have been shown to stay in treatment longer than those who are not mandated[55] and have greater rates of treatment completion compared to voluntary patients.[56]

A formal mandate to enter treatment, however, does not necessarily mean that an individual feels forced to do so, and, conversely, a substantial number of users who enter treatment without a mandate report feeling external pressure to do so.[57] Accordingly, providers must consider the full range of treatment entry pressures, as well as patients' perceptions of those pressures, to obtain a better understanding of treatment retention and outcomes. It may be that perceptions of pressure exert a greater impact on patients' reasons for entering and succeeding in treatment than their objective legal status.[43]

With pregnant and immediately postpartum women, this has particular relevance, as illustrated by Ms A's case. Although never legally mandated to attend treatment, she described herself as "self-forced" to do so, driven by the pressure of losing custody of her newborn daughter and her ensuing motivation to regain parental rights. Although Ms A acknowledged the resistance she felt toward the program and the investigation process, her intent to be reunified with her daughter allowed her to stay motivated to complete treatment.

Likewise, studies find that those who enter treatment under some form of implicit or explicit pressure (eg, loss of child custody) perceive greater pressure to be in treatment, but this does not necessarily lead to a difference in motivation to succeed in treatment.[57] These findings suggest that external pressure should be matched with efforts to augment a patient's internal motivation in the early stages of treatment.[39] As mentioned, one such method is motivational interviewing, which utilizes

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a client-centered, directive approach to enhance intrinsic motivation for behavioral change.[58] A meta-analysis of 30 clinical trials involving adaptations of motivational interviewing (AMIs) demonstrated moderate effect sizes for AMIs compared to no treatment for both drug and alcohol problems.[59] Using external pressure in a manner that increases internal motivation to change drug use behavior has become ever more relevant in society's increasing endorsement of treatment as an alternative to incarceration.[60]

Building positive relationships with substance-using mothers. Another approach to augment motivation is through the development of positive relationships. There is a significant correlation between positive child welfare worker–patient relationships and improvements in children's physical and emotional care,[61] as well as parental coping[61] and reunification.[62] Positive relationships with substance abuse treatment counselors are linked to higher rates of treatment retention and can increase the likelihood that mothers will attain abstinence and regain custody of their children.[63] Furthermore, positive involvement with child welfare services can encourage women to enter treatment at a younger age and thus interrupt drug use earlier.[64]

Studies have reported that the development of good working relationships relies on workers being respectful, nonjudgmental, positive, effectively communicative, and genuine.[62,65,66] Poor relationships occur when workers are perceived as disrespectful, judgmental, uncaring, and insincere.[65,66]

Ms A conveyed her understanding of the need for child welfare intervention and treatment to address substance use by pregnant and parenting women. Forming positive relationships from the start can improve women's self-esteem and sense of control over their lives and promote abstinence.[67] External pressure can thus be a means to develop substance users' motivation to enter treatment, granted that it occurs in a supportive atmosphere.[57]

Using firsthand accounts to examine the impact of external pressure. Little is known about whether pregnant and parenting women find external pressure meaningful to their recovery process, or whether they simply comply with mandated services to hasten exit from the child welfare system.[68] Additionally, few studies have viewed the experience of child welfare intervention and substance abuse treatment from the perspective of the mother,[69] so there is limited knowledge of how patients perceive and experience the programs designed for them.[70] Maternal views can provide a deeper insight into the factors that influence case outcomes,[68] as well as allow providers to better measure substance users' perceptions of pressure to enter treatment.[25]

One place to begin is by conducting in-depth interviews and focus groups, as done with Ms A. Just as researchers offer different definitions for what constitutes external pressure,[43] so do patients. Assessing individual perceptions of the types and meaning of "external pressure" and "coercion" can be instrumental in examining the role of pressure in a substance user's entry and continuation in treatment. Similar to our discussions with Ms A, recent work has focused on incorporating patient views on child welfare services and substance abuse treatment interactions.[19,68,70] Research has also begun to focus on patient views of external pressure in evaluating motivation and the effectiveness of external pressure in order to better align the measured experience of pressure with actual treatment entry and retention.[25,60] For example, one study found that the way in which parents perceive workers to use their authority influenced their reactions to an intervention. Although all parents perceived child protective services as more powerful than themselves, some viewed this dynamic as overly controlling, while others viewed it as supportive. Parents who viewed power as "tyrannical" tended to oppose workers or feign cooperation, whereas those who experienced power as helpful tended to form collaborative relationships with their caseworkers.[71] Because many women report initial experiences with child welfare services to be intrusive and embarrassing, it is important to address existing power differentials early on to greater increase the likelihood of building a cooperative relationship.[71]

Conclusions, implications, and future directions. When we last spoke with Ms A, she remained resolute to regain custody of her daughter "no matter what." She confirmed that although the pressure of losing permanent custody of her child did motivate her to enter treatment (essentially a positive outcome), there were elements of the intervention that undoubtedly could have been improved. Appropriate pressure from child welfare services prior to her daughter's birth could potentially have motivated her to seek treatment earlier, and appropriate respect at the time of her daughter's birth may have decreased her postpartum substance use. Furthermore, forming positive relationships with more of her counselors and caseworkers would have benefited her recovery process by building from the baseline understanding she had of the need for intervention, as well as her desire to stop using for the well-being of her child.

Interviews with recovering substance users like Ms A demonstrate that external pressure encompasses a wide range of meanings and is not always perceived in a wholly negative light. External pressure can play a beneficial role in promoting treatment entry and retention for substance-using pregnant and parenting women. Considering that the involvement of child welfare services can serve as the proverbial "wake-up call"[19] for substance-using mothers, it is essential that providers utilize external pressure in a way that promotes the formation of cooperative relationships with their patients and increases their motivation to enter treatment.

Involving parents in program planning, for example, can help improve their sense of competency.[72] Furthermore, since substance-using women often need a spectrum of resources to aid in their recovery,[73] child welfare services and substance abuse treatment providers should identify the range of personal and environmental issues in each woman's life.[74] Additional studies are needed on the perspectives of mothers involved in both the substance abuse treatment and child welfare systems, and efforts are needed to develop a regular means of soliciting and incorporating this input.[70] Further research is also needed to study the extent to which clients actually experience external pressure, and how it influences their motivation to enter treatment.

While acknowledging the role for external pressure in encouraging substance use treatment, providers must also take care to balance its use with the recognition that external pressure could cause women to avoid seeking health care or inhibit their honesty regarding substance use for fear of punitive action.[22] Providers must be realistic and transparent with their clients and acknowledge the particular difficulties that women experience.[73] Without recognizing individual needs and responses to external pressure, a severe approach could otherwise cause women to continue engaging in behaviors that put their present and future children at risk.[33] Also, because few

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studies have had follow-up periods beyond 6 months, future research should include plans to follow participants after they leave treatment to determine the long-term effects of mandated treatment on sustained abstinence,[43] as well as retained custody and improved parenting behaviors, all of which are reasonably expected benefits.

As mentioned, there are significant barriers to pregnant and parenting women entering substance use treatment, such as (1) the higher rates of psycho-social issues and trauma compared to male counterparts, (2) lack of child care, (3) insufficient gender-specific treatment, (4) fear of punitive action, and (5) stigma, which leads to shame and low self-esteem. To increase the effectiveness of using pressure to promote treatment entry by perinatal and postpartum substance users, specialized treatment programs that address these issues will be valuable.[73] Such programs can offer lengthy intervention[13] times and professionals who use interdisciplinary approaches so that drug use and its attending problems can be effectively combated.[37] If possible, mothers should be offered programs that allow children to reside with them and that provide parenting skills; this is supported by data showing that women who retained custody of their infant had longer treatment stays than those who did not retain custody.[2]

In conclusion, multiple important components should be taken into consideration when providers employ external pressure to encourage female substance users to enter treatment, including (1) acknowledging individual women's needs, (2) working to form positive and respectful relationships with clients, (3) focusing on prevention and cooperation rather than blame, and (4) minimizing punitive interventions. Addiction is regarded as a chronic illness; thus, remaining nonjudgmental in situations of relapse is important to improve self-esteem and facilitate recovery.[67] Child welfare and substance treatment systems that focus on cooperation, not blame and punishment, have the greatest success.[74] It is counterproductive to the goals of these systems to set the interests of a substance-using mother against those of her child and act punitively.[37,74] It is the appropriate use of external pressure, therefore, that can best result in positive outcomes in the treatment of substance-using pregnant and parenting women, as well as increase their readiness for treatment.[75]

References

1. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Results From the 2007 National Survey on Drug Use and Health: National Findings.* NSDUH Series H-34, DHHS Publication No. SMA 08-4343. Rockville, MD: Department of Health and Human Services; 2008.
2. Nishimoto RH, Roberts AC. Coercion and drug treatment for postpartum women. *Am J Drug Alcohol Abuse*. 2001;27(1):161–181.
3. Najavits LM, Weiss RD, Shaw SR. The link between substance abuse and posttraumatic stress disorder in women: a research review. *Am J Addict*. 1997;6(4):273–283.
4. Hankin J, McCaul ME, Heussner J. Pregnant, alcohol-abusing women. *Alcohol Clin Exp Res*. 2000;24(8):1276–1286.
5. Hohman MM, Shillington AM, Baxter HG. A comparison of pregnant women presenting for alcohol and other drug treatment by CPS status. *Child Abuse Negl*. 2003;27(3):303–317.
6. Kropp F, Winhusen T, Lewis D, et al. Increasing prenatal care and healthy behaviors in pregnant substance users. *J Psychoactive Drugs*. 2010;42(1):73–81.
7. Chasnoff IJ. Cocaine, pregnancy, and the growing child. *Curr Probl Pediatr*. 1992;22(7):302–321, discussion 322.
8. Takayama JI, Wolfe E, Coulter KP. Relationship between reason for placement and medical findings among children in foster care. *Pediatrics*. 1998;101(2):201–207.
9. Kettinger LA, Nair P, Schuler ME. Exposure to environmental risk factors and parenting attitudes among substance-abusing women. *Am J Drug Alcohol Abuse*. 2000;26(1):1–11.
10. Dunn MG, Tarter RE, Mezzich AC, et al. Origins and consequences of child neglect in substance abuse families. *Clin Psychol Rev*. 2002;22(7):1063–1090.
11. US Department of Health and Human Services. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection.* Washington, DC: US Government Printing Office; 1999.
12. Clark HW. Residential substance abuse treatment for pregnant and postpartum women and their children: treatment and policy implications. *Child Welfare*. 2001;80(2):179–198.
13. Finkelstein N. Treatment programming for alcohol and drug-dependent pregnant women. *Int J Addict*. 1993;28(13):1275–1309.
14. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Facilities offering special programs or groups for women. http://www.oas.samhsa.gov/2k6/womenTx/womenTX.htm. DASIS Report, Issue 35; 2006.
15. Denier CA, Thevos AK, Latham PK, et al. Psychosocial and psychopathology differences in hospitalized male and female cocaine abusers: a retrospective chart review. *Addict Behav*. 1991;16(6):489–496.
16. Colten ME. Attitudes, experiences and self-perceptions of heroin-addicted mothers. *J Soc Issues*. 1982;38(2):77–92.
17. Finkelstein N. Treatment issues for alcohol- and drug-dependent pregnant and parenting women. *Health Soc Work*. 1994;19(1):7–15.
18. Gregoire KA, Schultz DJ. Substance-abusing child welfare parents: treatment and child placement outcomes. *Child Welfare*. 2001;80(4):433–452.
19. Rockhill A, Green BL, Newton-Curtis L. Accessing substance abuse treatment: issues for parents involved with child welfare services. *Child Welfare*. 2008;87(3):63–93.
20. Jessup MA, Humphreys JC, Brindis CD, et al. Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *J Drug Issues*. 2003;33(2):285–304.
21. Gareau SJ. *Substance Abuse Treatment Avoidance, Length of Stay, and Criminal Justice Referral for Women of Reproductive Age in South Carolina Prior to and After the Whitner Decision (1993 to 2007)* [dissertation]. Columbia, SC: University of South Carolina; 2010.
22. Poland ML, Dombrowski MP, Ager JW, et al. Punishing pregnant drug users: enhancing the flight from care. *Drug Alcohol Depend*. 1993;31(3):199–203.
23. Ashley OS, Marsden ME, Brady TM. Effectiveness of substance abuse treatment programming for women: a review. *Am J Drug Alcohol Abuse*. 2003;29(1):19–53.
24. Wobie K, Eyler FD, Conlon M, et al. Women and children in residential treatment: outcomes for mothers and their infants. *J Drug Issues*. 1997;27:585–606.
25. Urbanoski KA. Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduct J*. 2010;7(13):13.
26. Center for Reproductive Law and Policy: New Jersey dismisses criminal charges brought against woman for conduct during pregnancy. *Reprod Freedom News*. 1997;6(1):6.
27. Reyes v. Superior Court. 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977).
28. Guttmacher Institute (US). State policies in brief: substance abuse during pregnancy. http://www.guttmacher.org/sections/index.php?page=spib. Accessed June 28, 2011.
29. Center for Reproductive Law and Policy: Washington appeals panel affirms dismissal of charges against woman for behavior during pregnancy. *Reprod Freedom News*. 1996;5(11):3.
30. Center for Reproductive Law and Policy: charges dropped against woman for allegedly drinking while pregnant. *Reprod Freedom News*. 1993;2(13):6.
31. Center for Reproductive Law and Policy: New York high court rules that positive drug test is not sufficient evidence of newborn's neglect. *Reprod Freedom News*. 1996;5(2):5.
32. DeVille KA, Kopelman LM. Moral and social issues regarding pregnant women who use and abuse drugs. *Obstet Gynecol Clin North Am*. 1998;25(1):237–254.
33. Madden RG. Civil commitment for substance abuse by pregnant women? a view from the front lines. *Politics Life Sci*. 1996;15(1):56–59.
34. Trace M. HIV and drugs in British prisons. *Druglink*. 1990;5(1):12–15.
35. Lorenzen D, Bracy K. MOMS Plus: a public health program for substance

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using pregnant inmates in an urban jail. *J Correct Health Care*. 2011;17(3):233–240.
36. Rubenstein L. Prosecuting maternal substance abusers: an unjustified and ineffective policy. *Yale Law Policy Rev*. 1991;9(1):130–160.
37. Garcia SA. Maternal drug abuse: laws and ethics as agents of just balances and therapeutic interventions. *Int J Addict*. 1993;28(13):1311–1339.
38. Roper ME. Reaching the babies through the mothers: the effects of prosecution on pregnant substance abusers. *Law Psychol Rev*. 1992;16:171–188.
39. Farabee D, Leukefeld CG. Recovery and the criminal justice system. In: Frank MT, Leukefeld CG, Platt JJ, eds. *Relapse and Recovery in Addiction*. London, England: Yale University Press; 2001:40–59.
40. Cooper CA, Bartlett SR, Shaw MA, et al. *Drug Courts: 1997 Overview of Operational Characteristics and Implementation Issues. American University Drug Court Clearinghouse and Technical Assistance Project*, vol 1. Washington, DC: Office of Justice Programs. US Department of Justice; 1997.
41. American University. *Looking at a Decade of Drug Courts. Prepared by the Drug Court Clearinghouse and Technical Assistance Project*. Washington, DC: Office of Justice Programs, US Department of Justice; 1999.
42. Mathieu D. Mandating treatment for pregnant substance abusers: a compromise. *Politics Life Sci*. 1995;14(2):199–208.
43. Klag S, O'Callaghan F, Creed P. The use of legal coercion in the treatment of substance abusers: an overview and critical analysis of thirty years of research. *Subst Use Misuse*. 2005;40(12):1777–1795.
44. Polcin DL, Weisner C. Factors associated with coercion in entering treatment for alcohol problems. *Drug Alcohol Depend*. 1999;54(1):63–68.
45. Nace EP, Birkmayer F, Sullivan MA, et al. Socially sanctioned coercion mechanisms for addiction treatment. *Am J Addict*. 2007;16(1):15–23.
46. Simpson DD, Joe GW, Broome KM, et al. Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). *Psychol Addict Behav*. 1997;11(4):279–293.
47. Cahill MA, Adinoff B, Hosig H, et al. Motivation for treatment preceding and following a substance abuse program. *Addict Behav*. 2003;28(1):67–79.
48. DiClemente CC, Bellino LE, Neavins TM. Motivation for change and alcoholism treatment. *Alcohol Res Health*. 1999;23(2):86–92.
49. Sullivan MA, Birkmayer F, Boyarsky BK, et al. Uses of coercion in addiction treatment: clinical aspects. *Am J Addict*. 2008;17(1):36–47.
50. Hiller ML, Knight DD. Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment. *Crim Justice Behav*. 2002;29(1):56–75.
51. Ryan RM, Plant RW, O'Malley S. Initial motivations for alcohol treatment: relations with patient characteristics, treatment involvement, and dropout. *Addict Behav*. 1995;20(3):279–297.
52. Gerstein DR, Johnson RA. Characteristics, services, and outcomes of treatment for women. *J Psychopathol Behav Assess*. 2000;22(4):325–338.
53. Stromwall LK, Larson NC, Nieri T, et al. Parents with co-occurring mental health and substance abuse conditions involved in Child Protection Services: clinical profile and treatment needs. *Child Welfare*. 2008;87(3):95–113.
54. Green BL, Rockhill A, Furrer CJ. Does substance abuse treatment make a difference for child welfare case outcomes? *Child Youth Serv Rev*. 2007b;29(4):460–473.
55. Collins JJ, Allison M. Legal coercion and retention in drug abuse treatment. *Hosp Community Psychiatry*. 1983;34(12):1145–1149.
56. Perron BE, Bright CL. The influence of legal coercion on dropout from substance abuse treatment: results from a national survey. *Drug Alcohol Depend*. 2008;92(1–3):123–131.
57. Stevens A, Berto D, Frick U, et al. The relationship between legal status, perceived pressure and motivation in treatment for drug dependence: results from a European study of Quasi-Compulsory Treatment. *Eur Addict Res*. 2006;12(4):197–209.
58. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. 2nd ed. New York, NY: The Guilford Press; 2002.
59. Burke BL, Arkowitz H, Menchola M. The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *J Consult Clin Psychol*. 2003;71(5):843–861.
60. Conner BT, Longshore D, Anglin MD. Modeling attitude towards drug treatment: the role of internal motivation, external pressure, and dramatic relief. *J Behav Health Serv Res*. 2009;36(2):150–158.
61. Lee CD, Ayón C. Is the client-worker relationship associated with better outcomes in mandated child abuse cases? *Res Soc Work Pract*. 2004;14(5):351–357.
62. Sun A. Helping substance-abusing mothers in the child welfare system: turning crisis into opportunity. *J Contemp Hum Serv*. 2000;81(2): 141–151.
63. Blakey J. *Struggle for Custody: the Salience of Trauma Among African American Women Navigating Substance Abuse Treatment and Child Protection* [dissertation]. Chicago, IL: University of Chicago; 2010.
64. Grella CE, Hser YI, Huang YC. Mothers in substance abuse treatment: differences in characteristics based on involvement with child welfare services. *Child Abuse Negl*. 2006;30(1):55–73.
65. Drake B. Relationship competencies in child welfare services. *Soc Work*. 1994;39(5):595–602.
66. Maiter S, Palmer S, Manji S. Strengthening social worker-client relationships in child protective services: addressing power imbalances and 'ruptured' relationships. *Qual Soc Work*. 2006;5(2):161–186.
67. Carten AJ. Mothers in recovery: rebuilding families in the aftermath of addiction. *Soc Work*. 1996;41(2):214–223.
68. Alpert L. Research review: parents' service experience—a missing element in research on foster care case outcomes. *Child Fam Soc Work*. 2005;10(4):361–366.
69. Smith N. Reunifying families affected by maternal substance abuse: consumer and service provider perspectives on the obstacles and the need for change. *J Soc Work Pract Addict*. 2002;2(1):33–53.
70. Gockel A, Russell M, Harris B. Recreating family: parents identify worker-client relationships as paramount in family preservation programs. *Child Welfare*. 2008;87(6):91–113.
71. Dumbrill GC. Parental experience of child protection intervention: a qualitative study. *Child Abuse Negl*. 2006;30(1):27–37.
72. Kapp S, Propp J. Client satisfaction methods: input from parents with children in foster care. *Child Adolesc Social Work J*. 2002;19(3): 227–245.
73. Gustavsson NS, Rycraft JR. The multiple service needs of drug dependent mothers. *Child Adolesc Soc Work J*. 1993;10(2):141–151.
74. Pelton LH. Concluding commentary: varied perspectives on child welfare. *Child Youth Serv Rev*. 2011;33(3):481–485.
75. Gregoire TK, Burke AC. The relationship of legal coercion to readiness to change among adults with alcohol and other drug problems. *J Subst Abuse Treat*. 2004;26(1):35–41.

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