Pregnancy, Drugs, and Harm Reduction

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INTRODUCTION

Shortly after the National Institute on Drug Abuse (NIDA) was established in 1974, physicians and scientists expressed concern about the effects of drug use during pregnancy. In 1974 Public Law 94-371 mandated that drug abuse and dependence *among women* be given special consideration for treatment and prevention (Kandall 1996). Subsequently, NIDA funded many research and demonstration projects that focused on the etiology, consequences, and treatment needs of women who use drugs. Although interest in women's issues and Federal funding for research continued through the 1980s and into the 1990s, recent prevalence data indicate that the expected reduction in drug use among women has not occurred (National Institute on Drug Abuse 1996; Substance Abuse and Mental Health Services Administration 1994). Women's use of illicit (and licit) drugs has increased, along with drug use during pregnancy.

The increasing size and scope of the problem of women's substance abuse has been exacerbated, if not caused, by two national trends. First, poverty, homelessness, substandard education, and lack of health care have increased since 1980 (Phillips 1991). As members of America's ever-growing underclass, drug users have seen their lives become more chaotic, risky, dangerous, and violent (Currie 1993). Second, for addicted women without financial resources, access to drug treatment has become increasingly problematic. A decline in Federal funding for drug treatment programs for women has occurred since 1976 (Gerstein and Harwood 1990), with the exception of research and demonstration studies on drug abuse among pregnant women funded by NIDA and the Substance Abuse and Mental Health Services Administration between 1989 and 1994. Although the Office of National Drug Control Policy advocates a shift in funding from enforcement to prevention and treatment (Brown 1995), thus far drug users have experienced little change in access to treatment (Wenger and Rosenbaum 1994). Ironically, if money and availability *were* increased, it seems unlikely that even the

best form of drug abuse treatment could reverse the deleterious effects of the social and political policies of the 1980s and 1990s. Lacking a chance at the American Dream and a stake in conventional life, drug abusers will continue to relieve their suffering through the use of pain-killing and euphoria-producing substances (Rosenbaum 1989; Waldorf et al. 1991).

In 1991, when the Pregnancy and Drug Use Study discussed in this chapter began, the authors believed that the life circumstances of drug users, including women and especially pregnant women, were dismal and that policy recommendations advocating total abstinence or treatment as a cure for addiction had not been effective. Despite the efforts of the "War on Drugs," drug abuse seemed here to stay, and its consequences, such as acquired immunodeficiency syndrome (AIDS), were more dire than ever. Given a social and economic system that almost by definition fostered the alienation, hopelessness, and boredom that perpetuated drug abuse, the authors also believed that a new framework was needed that was more pragmatic and less idealistic, more reality-based and less moralistic, and more focused on what *could* be done rather than what *should* be done.

The concept of harm reduction is simple and straightforward and does not constitute a radical change in drug policy. Harm reduction was first implemented in Europe and Australia primarily to deal with the AIDS crisis. In the United States, professionals have been using the harm reduction concept for about 30 years in the form of methadone treatment (Rosenbaum 1995). Those who subscribe to a harm reduction perspective deplore, yet accept, the inevitability of drug use. They advocate working with users to minimize the harms brought about by abuse, even if the drug use cannot be stopped completely (Nadelmann et al. 1994).

PREGNANCY AND HARM REDUCTION

In the Pregnancy and Drug Use Study, the authors and their colleagues (Sheigla Murphy, Margaret Kearney, Kimberly Theidon, and Jeanette Irwin) interviewed 120 women in the San Francisco Bay area who used heroin, cocaine, or methamphetamine; were pregnant or immediately postpartum; and were not in treatment. The grounded theory method (Strauss and Corbin 1990) was used to collect and analyze data. Many of these women were practicing harm reduction in some form. In the following paragraphs, some of these women and their efforts

are described. This discussion begins with a subject's definition of harm reduction and proceeds with discussions of perceived levels of harm, women's fears, and methods of harm reduction. The conclusions contain a modest set of policy recommendations.

Sherry provided a definition of harm reduction during pregnancy. At the time of her interview, she was a lively 24-year-old African-American crack smoker in her seventh month of pregnancy. Sherry chatted easily about her attempts to lessen the harmful effects of her crack use and articulated harm reduction strategies several times during the interview. In the following passage, she explained her stance on the subject: "I know I'm an addict and I do like to get high, but I don't want to die, you know what I'm saying? . . . So I, in my mind—this is my own philosophy—if you're gonna do it, you need to know when you're getting close to the edge and try to back up a little bit."

Perceived Levels of Harm

Perceived harms and the ways individual women attempted to reduce them varied and related directly to the intensity of harm they felt their drug of choice introduced into their lives. Women who perceived their drug use as harmful were mostly, but not exclusively, crack smokers.

The high perception of harm expressed by these women may be correlated with the intense media attention given in the late 1980s and 1990s to crack use during pregnancy. Heroin and methamphetamine failed to get as much attention as crack, and this media bias may have helped create the view in the study population that crack was a more harmful drug to use during pregnancy. For this reason, this chapter focuses on women whose drug of choice was crack.

Fears Motivating Harm Reduction

Women feared crack would cause fetal damage, and this concern was evident in their accounts. Some feared crack use would cause serious behavioral problems; others worried that their infants would be deformed; still others feared their babies would be intellectually damaged. Although their specific fears differed, all crack-using women believed their drug use would definitely cause damage to their children.

For example, Rhonda was a 30-year-old African-American woman who had smoked $100 worth of crack daily in the beginning stages of

pregnancy. When she was 2 months pregnant, she went to a doctor, discovered her pregnancy, and looked back in horror at the amount of crack she had smoked. She immediately quit using crack, but the fear of the possible physiological harms haunted her. In her third month of pregnancy, Rhonda decided to have an abortion. The following passage describes some of the factors in her abortion decision:

> The baby was doomed from the start. I don't care what those doctors say when they say, "Oh, you're pregnant and you can stop using drugs and your body will be okay." Mmmmmm, that's a lie. 'Cause my baby suffered after that and it was my fault, my own fault. I ain't blaming it on nothing. I'm not saying because the doctors didn't notice it or nothing. It was me.

Methods of Harm Reduction

Although abortion was one harm reduction method, many women did not choose that option for personal or religious reasons. Therefore, it became imperative to reduce drug-related harms through (1) reducing or quitting use, (2) substituting other drugs or attempting to counteract the effects of drugs, (3) making a lifestyle change, and (4) seeking prenatal care.

Reducing or Quitting Use. Unfortunately, women were not often successful at permanently abstaining from drugs. Experiencing alternating periods of drug use and abstinence from drugs was the norm for this group. Women usually had used crack during their pregnancies in a binge-and-purge style, with binges characterized by periods of smoking one crack "rock" after another, a process called smoking "back to back," which lasted for several days during which sleeping and eating often were inhibited. Women referred to this drug-using routine as "going on 24/7," a euphemism for smoking 24 hours a day, 7 days a week. Although 24/7 was a common term, women admitted that in reality they had never gone without sleep for a whole week. A crack-using binge rarely lasted longer than 3 or 4 days. Women often experienced interspersed periods of abstinence, which could last from a couple of hours to several months, between binges.

Because returning to drug use after periods of abstention was common, women attempted to balance times when they were free of drugs

with other times when they relapsed so that the time they were drug-free would be maximized during pregnancy. Although all forms of drug abuse treatment were considered good methods to become drug-free, overall drug treatment was not considered a sure path to that goal. Many women combined drug treatment programs with their own methods of staying away from drugs. Courtney, a 30-year-old African-American crack smoker in her fifth month of pregnancy, described this process: "But it's like when the baby comes, it's like I know I cannot mess with anything. From when I go next week to the [outpatient drug treatment program], I'm gonna do my best not to mess with anything until I deliver this baby."

Like Courtney, other women used various points in the pregnancy as markers and goals. For Courtney, the time between the interview and her screening appointment with the drug treatment center was when she would try to abstain on her own. After that she would rely on the program for support in abstaining.

Other women chose to reduce their use without drug treatment. Lindly was a 21-year-old African-American crack smoker in her first month of pregnancy. She decided to forgo drug treatment and reduce her level of drug use on her own. She told the authors: "I don't stay in the same space like I used to. I leave, I go shopping, I do something to occupy my time. Eventually, I feel I'll get it out of my system."

Substituting or Counteracting. One method of harm reduction was to combine the drug of choice with other drugs or substitute drugs perceived as less harmful for the more harmful ones. Sherry, the 24-year-old crack smoker mentioned above, told how difficult it was to stay away from drugs during her pregnancy. When she wanted to smoke crack, she smoked marijuana instead: "Yeah, I couldn't do anything. I just smoked pot a little bit. You know, I smoked pot. He [her husband] knew I did have a drug problem, okay, so what he would do if he seen me getting edgy or what he'd say, 'Go in my closet, dear. I got some weed in there. Why don't you smoke some of that?' "

Because women's attempts to reduce or quit drug use or substitute other drugs were not always successful, many employed other methods to counteract drug harm during pregnancy, including ingesting prenatal vitamins, niacin, pickle juice, and vinegar.

Lifestyle Changes. Other harm reduction techniques included making changes in the drug-using lifestyle. Most women acknowledged that poor eating habits accompanied heavy immersion in "the life." For crack

smokers, loss of appetite was particularly pronounced and perceived as a dire problem during pregnancy. Eating regularly, even forcing oneself to eat on a regular basis, became a common practice. For example, Amanda struggled constantly with her loss of appetite. The following excerpt explains her views on eating as harm reduction:

> I had to eat it. I had to put something in my baby's system so the drug won't affect him or hit him as hard, because I can't see that. I cannot see knowing you have a weakness and sitting up there smoking and knowing you have a life in you, too, at the same time and not feeding your child, because basically what that boils down to . . . [is] "Yeah I know I'm hurting my child." But if you know that your weakness is there . . . you're going to try to help your child at the same time. You're gonna feed it. Even though you're doing something wrong, even though you're doing something that is not basically right and you have no control over the drug or the weaknesses that you have, you have control over whether you feed your child while he's inside you.

Other lifestyle changes included forcing oneself to sleep, moving away from friends or family members who were using drugs, or moving out of neighborhoods where drug use was rampant.

Harm reduction was not static. Women mixed and matched several different techniques at different times during their pregnancies. For example, Sherry tried numerous times to reduce her crack use, but continually failed because her husband and most of the people living in her building, one of the largest projects in San Francisco, were crack smokers. Before her pregnancy, people often used her apartment to smoke in private or to sell crack. They often "kicked her down" a rock or two as payment for the use of her apartment. After she discovered she was pregnant, Sherry felt this routine was compromising her chances for a healthy pregnancy. Eventually, she and her husband abandoned their apartment in the projects and moved in with her husband's relatives in a city 80 miles away where she successfully stopped smoking crack by substituting marijuana for crack whenever she felt the urge to use.

Prenatal Care. Health care, and more specifically prenatal care, was perceived as one of the best ways to improve one's health during pregnancy. Women who believed their drug use posed grave threats to fetal

well-being had unique relationships to health care. Overall, they were more likely to disclose their drug-using status to health care providers as a way of enlisting providers' cooperation in maximizing their health. Women looked at providers' medical expertise and the various technological advances of traditional health care as powerful harm reduction resources.

Amanda, mentioned above, told her doctor about her crack use as a way of alerting her doctor to the tenuousness of her pregnancy. In addition to technological advances, she felt her provider could give her valuable information she could use to improve her health. In the following passage, she describes her relationship to her provider: "When I go to my prenatal care appointment, I'll tell the doctor, 'I ——ed up. I smoked. Is my baby okay? I don't want nothing to happen to him. Please don't let nothing happen to my baby . . .' I'm learning and wanting to know all these things so it'll help me further help my baby."

Unfortunately, women's attempts to improve their health through traditional health care were problematic. Crack users often found that after disclosing their drug-using status, they were judged harshly by health care providers. Jessie, for example, had just given birth to her first crack-exposed child when she was interviewed. The uncomfortable memories of her hospital experiences were fresh in her mind. During Jessie's first two pregnancies, she had not smoked crack or missed a single prenatal appointment, and at the births, the nurses and doctors were supportive. However, during her most recent pregnancy, she smoked crack almost continually and managed to keep only two prenatal appointments. When she gave birth, the nurses and doctors treated her like "a dirty little crack addict." Looking back at her own experiences and those of others, she explained why women in her position fail to get prenatal care:

> I know a lot of mothers say that they don't get prenatal care 'cause they feel like as soon as they walk through the door, they will be judged, "Oh, you're a crack-head. Why the —— did you get pregnant anyway?" So they don't get prenatal care . . . They have those commercials about addicts that don't get prenatal care because they just don't give a ——. They do give a ——, but they are thinking about how they gonna be looked

> at when they walk in the hospital door, like they not good enough to be pregnant.

Like Jessie, women who received harsh judgments during or immediately after pregnancy were reluctant to continue to endure further ridicule. Therefore, women in this group had to navigate a precarious path between their efforts to reduce drug-related harms and their efforts to avoid persecution. Although few women avoided health care altogether, many admitted they did not get as much health care as they would have liked.

CONCLUSIONS

The data presented above indicate that pregnant drug users often practice harm reduction in some form or another. Given their own efforts, the following suggestions for intervention might help:

1. Women should have better information so that their harm reduction efforts are more effective.
2. Those who intervene should stop judging these women and, instead, facilitate their efforts.
3. Women should have access to health care (1) without risk of losing their children to child protective services, (2) without humiliation, and (3) without having to be totally abstinent.
4. Finally, professionals in research and treatment must learn to settle for less because insisting on total abstinence may exacerbate the problem.

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