Public Health and the Law

Drug Addiction and Pregnancy: Policy Crossroads

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Introduction

The medical and lay press have lately written extensively about drug use by pregnant women. Evidence suggests a significant increase in maternal drug use during pregnancy during this decade. In New York City, for example, the proportion of birth certificates indicating maternal illicit substance use tripled between 1981 and 1987.* Prevalence data indicate that, at least in certain hospitals, many women have used illicit drugs within hours of delivery. Anonymous urine toxicology surveys of women in labor and of neonates in several New York City inner-city hospitals revealed 11–20 percent positive for illicit drugs (mostly cocaine/crack).[1,**, ***] The medical consequences for mother and infant can be severe. In addition to the well-known roster of ills related to intravenous administration such as hepatitis B, endocarditis, abcesses, etc., illicit drugs have become increasingly associated with sexually transmitted diseases[2,3] and AIDS.[4] The sequelae for infants can include abstinence symptoms, low birthweight, developmental problems, and increased risk of infant death.[5,6]

Society has responded to this problem in three different ways: criminal prosecution of the mother; allegations of child neglect against the mother with interruption of maternal custody; and drug treatment. The purpose of this article is to explore each of these policy approaches in an effort to ascertain whether each furthers the goal of reducing drug use during pregnancy and improving maternal and infant health and well-being.

Child Neglect and Protection

Current Practice

Many urban hospitals are now routinely performing neonatal toxicology screens when maternal illicit drug use is suspected. Grounds for suspicion vary and can include clinical symptomatology in mother or newborn, or maternal characteristics such as public patient status; inadequate prenatal care or unregistered status at delivery; age under 20; or residence in neighborhoods where drug use is widespread.

State legislation and practice has not yet been nationally surveyed. New York is one state which deems parental chronic drug use that results in functional impairment to be prima facie evidence of child neglect.[7] Positive neonatal urine toxicology screens are being interpreted as evidence of maternal drug-related impairment and are therefore being reported to the child protective service agency. The child protective service agency is then obligated to conduct an investigation and make a determination regarding parental fitness. If the parent is deemed neglectful, then the agency staff devises a plan which can include supervision, protection, or foster care placement for the child. According to New York State's Child Welfare Reform Act, preventive or rehabilitative services are to be provided in such cases as "the state's first obligation is to help the family with services to prevent its break-up or to reunite it if the child has already left home."[8]

The reality is, however, that because of budgetary constraints, resources to assist these families are often not provided. Because of the increasing numbers of these cases, the investigations are sometimes perfunctory, sometimes prolonged, and often accompanied by disruption of maternal custody pending the case disposition. In New York City, for example, where case volume is high and there is a shortage of certified foster care homes, many babies board in hospitals or congregate care facilities (group facilities run by the city's Human Resources Administration where 6–24 infants are cared for together). In 1987, maternal substance abuse was the primary reason for boarder baby status in New York City, accounting for 40 percent of the 300 plus cases per day.[9] In 1988, maternal drug use and homelessness were the two primary reasons for boarder baby status in New York City; 300 plus babies/day boarded in hospital and another 130/day in congregate care.[10].

Legislation defining neonates with controlled substances in their systems as neglected has been passed in Illinois, Minnesota, and Florida, is midway through the legislative process in Delaware and Oregon, and has been defeated in Arizona.[11–16] Legislation requiring physicians to test and report pregnant women for illicit drug use has been passed in Minnesota and been defeated in Illinois.[17,18]

Historical Roots

From colonial days onwards, the children of the poor in the United States have often been removed from their parents

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**Bateman D: Harlem Hospital, personal communication, 1988.

***Parente J: Substance abuse during pregnancy. Presented: New York State Medical Society, April 1988, New York, New York.

whose poverty is considered de facto indication of neglect. Colonial law officials indentured or apprenticed the children of the indigent to "such religious families where both body and soul may be taken good care of."[19] Nineteenth century child welfare charitable agencies institutionalized these children in orphanages and reformatories and "placed them out" in foster homes in the country in order to protect children from "the perils of want and the contamination of example."[20] Consequently, in 1900 the majority of children in institutional and foster care were "half orphans", i.e., children of one living, destitute parent.

In the twentieth century, government assumed increasing responsibility for the maintenance of poor families, first with the establishment of Mothers' Pensions and later Aid to Families with Dependent Children (AFDC). In keeping with the same spirit that had infused the provision of colonial outdoor relief, conformity with moral standards of behavior was exacted from the recipients in exchange for relief. Maternal sexual activity outside of marriage, rather than alcohol or drug use, was a frequently cited reason for exclusion from AFDC or child removal.[21,22]

In the 1960s, following Kempe's identification of "the battered child syndrome," medicine claimed the terrain of child abuse as its own. Legal codification followed and now all states have mandatory reporting statutes for human service workers. Since the medical model is essentially a therapeutic one, a diagnosis of child neglect is intended to lead to the provision of rehabilitative services for the family in order to further the best interests of the child.[23]

Although the detection and treatment of child abuse and neglect cases has become a specialized field of expertise within pediatrics, many physicians have been ambivalent about mandatory reporting of suspected cases by health care providers. This ambivalence stems from skepticism that state intervention can succeed in assisting children of families.[24] It also reflects concern about violation of the standard of physician-patient confidentiality for both ethical and practical reasons. The accurate and complete patient history necessary for the provision of optimal medical care is less likely to be obtainable if confidentiality cannot be guaranteed.

This can be seen clearly in the case of drug use by a pregnant woman in those states where parental drug use is equated with neglect. Providing an accurate history to the obstetrician or neonatologist will lead to child neglect charges and threatened loss of custody of her baby. Anecdotal data suggest that fear of these responses is deterring such women from seeking prenatal care or from giving accurate drug histories when they do.

Criminal Prosecution

Attempts have been made to criminally prosecute women for illicit drug use during pregnancy, some of which have foundered on the question of non-recognition of fetal personhood by the law. Thus criminal child abuse charges were dropped in the Reyes and Stewart cases in California because the statute was not considered applicable to a fetus and a Rockford, Illinois Grand Jury refused to indict a woman for manslaughter regarding the death of her newborn which was attributed to her prenatal use of crack/cocaine. Others have attempted to circumvent the question of prenatal conduct or fetal status. For example, in Butte County, California the district attorney has announced his intention to regard a positive newborn urine toxicology screen as evidence of illicit drug *use* by the mother, a criminal offense under California's Health and Safety Code. Recently in Florida, a woman was convicted of delivery of a controlled substance to a minor, via the umbilical cord in the seconds after delivery before it was clamped. This was a felony drug charge with a possible 30-year sentence and the evidence again was a positive newborn urine toxicology screen. When a Washington, DC woman was convicted of check forgery to support her drug habit, the judge decided to incarcerate her rather than give the probationary sentence customary for first time offenders when he learned she was pregnant. It has been reported that parole infractions are more harshly punished for the pregnant.[25,26] This prosecutorial stance is fueled both by the current controversy over abortion, fetal status, and maternal obligation to the fetus; and by the longstanding debate as to whether drug addiction is a criminal or medical matter.

The Dilemma: Medical or Criminal Problem

The national debate as to whether drug addiction is a disease or willful criminal behavior has lasted for more than 65 years. Indeed current arguments are remarkably similar to those in vogue in 1914 at the time of passage of the Harrison Narcotics Act, in 1920 when the New York City Department of Health briefly dispensed "morphine maintenance" to addicts, and in the late 1960s when the methadone maintenance treatment program was established.[27,28]

Proponents of the disease model have sought to demonstrate physiologic changes and constructed a definition of the condition which includes anti-social behavior in pursuit of the drug as a manifestation. Opponents have considered anti-social and criminal behavior by drug users as evidence of their moral laxity, and have considered the limited effectiveness of various drug treatment modalities to demonstrate a willful and non-physiologic basis for drug use.

In the early part of the century the criminal model prevailed and physicians were prosecuted for prescribing drugs to addicts. Organized medicine initially colluded in condemning any treatment which placed opiates in the hands of addicts for self-administration, but reversed itself by the 1950s when the American Medical Association (AMA) urged decriminalization of addicted status and the development of comprehensive medical and social treatment.[29] Indeed, psychoactive substance dependency disorder occupies a place in the Diagnostic and Statistical Manual of Mental Disorders.[30]

The US Supreme Court recognized addiction to be a disease as early as 1925 in the Linder decision ". . .addicts . . .are diseased and proper subjects for such (medical) treatments."[31] In 1962 the Court held in *Robinson v. California* that criminal conviction for being addicted to the use of narcotics violated the 8th and 14th Amendments, and explicitly stated that drug addiction constituted a disease status:

". . .It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. . .in light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. . .the prosecution is aimed at penalizing an illness, rather than at providing medical care for it. We would forget the teachings of the Eighth Amendment if we allowed sickness to be made a crime and permitted sick people to be punished for being sick. . ."[32]

The vision of addiction as a medical or criminal matter is a critical one, not only for the obvious policy implications regarding resource allocation to sanction or therapy, but to the logical consistency of the criminal justice system itself. The imposition of criminal punishment presupposes the capacity of the defendant to voluntarily conform her conduct to the requirements of the law. If psychoactive substance dependency is acknowledged to be a compulsive medical disorder, then it would appear logical that criminal sanctions alone cannot deter this behavior.

Drug Treatment During Pregnancy

Discrimination against women

The general shortage of drug treatment slots is aggravated by the unwillingness of many drug programs to include pregnant women. A recent survey in New York City by the author revealed that 54 percent of treatment programs categorically excluded the pregnant. Effective availability was further limited by restrictions on method of payment or specific substance of abuse. Sixty-seven percent of the programs rejected pregnant Medicaid patients and only 13 percent accepted pregnant Medicaid patients addicted to crack.[33]

Two different phenomena may explain this stance toward pregnant women on the part of drug treatment programs. One component is a history of insensitivity to addicted *women* on the part of drug treatment programs.

In the early 1970s the National Institute on Drug Abuse (NIDA) began to sponsor research and program development which specifically addressed women addicts. The results of surveys of drug treatment programs and profiles of addicted women indicated that male program staff and participants were often hostile to women clients, employed a confrontational "therapeutic" style uncomfortable for women, and directed them into gender stereotyped tasks and training which offered minimal compensation or chance for success after completion of the program. Moreover, they did not address the environment of sexual exploitation and violence in which female addicts often lived; made no provision for care of the addicted women's children and thus effectively limited or precluded their participation in treatment; and did not incorporate contraceptive and prenatal medical services into the program.[34]

In 1979, after a half decade of encouraging treatment programs to recognize and provide for the specific needs of addicted women, NIDA surveyed those drug treatment programs which described themselves as specifically geared to female addicts. Only 25 such programs could be found nationally and more than half of the women treated in these reported that they did not receive gynecologic care and three-fourths did not receive contraceptive counseling.[35] A second component explaining the exclusion of pregnant women is medical uncertainty over optimal medical management during pregnancy, set against the current backdrop of fear of liability.

Medical Management and Uncertainty

Initially, the medical debate centered on the use of methadone for detoxification or maintenance for pregnant heroin addicts. In the early 1970s, the Food and Drug Administration (FDA) first recommended 21-day methadone detoxification during pregnancy and then withdrew the recommendation. Accounts appeared in the obstetric and pediatric literature of stillbirth and fetal compromise associated with maternal withdrawal from narcotics.[36] Obstetricians voiced concern about detoxification during pregnancy unless biochemical monitoring of fetal status could be assured.[37]

Clinicians then disagreed about optimal dosage for methadone maintenance. Several investigators reported correlations between maternal methadone dose and the severity of neonatal withdrawal symptoms and concluded that maternal methadone dose should be decreased to less than 20 mg/day as early in gestation as possible.[38,39] Other investigators, however, did not confirm a straightforward relationship between maternal dose and the severity of the neonatal abstinence syndrome. Some argued that the dose must be sufficiently high to prevent relapse and additional use of illicit drugs.[40–42] Kandall and colleagues reported a positive association between maternal methadone dose and neonatal birthweight and head circumference and speculated that higher dosages in the first trimester might promote fetal growth and still allow time for tapering the dose later in gestation in order to minimize neonatal abstinence symptoms.[43]

Methadone is considered superior to heroin for maintenance of addicts because of its longer half life and the width of the gap between tolerance and dependence dosages. There are data indicating that women enrolled in methadone maintenance treatment programs have improved pregnancy outcomes compared to heroin or methadone addicts not in treatment. Since data are inconsistent as to whether infants born to unsupervised heroin or methadone addicts fare worse, the improved pregnancy outcomes reported for participants in methadone treatment are thought to reflect lifestyle changes and improved access to services associated with program participation.[44]

"Crack" addiction however, is not amenable to therapy with methadone. Experimental trials with anticonvulsants and antidepressants will not include pregnant subjects because of possible untoward effects on the fetus. Treatment options for cocaine/crack addiction pregnancy have been restricted; studies of efficacy have been limited and have not specifically addressed pregnancy. The prevailing model employed for the treatment of cocaine/crack addition is a psychotherapeutic one; group support following the Alcoholics Anonymous model is a popular component.

Acupuncture has been employed for both detoxification and maintenance for various addictive conditions including crack in a small number of clinical settings in this country. Laboratory and clinical reports documenting an increase in endorphins in response to acupuncture indicate a possible biochemical basis for therapeutic response.[45] Investigations of clinical efficacy have been few and not rigorously designed, with two studies indicating moderate short-term improvement in alcohol- and heroin-using men compared to controls treated with traditional medications.[46,47]

Positive reports have come from programs that provide comprehensive medical and social services (drug treatment, obstetric, pediatric, gynecologic, job and educational training) for pregnant addicted women. These offer ongoing involvement after delivery, with an emphasis on child development and parenting skills.[48,49] Some federal funding is currently allotted to encourage the development of new treatment modalities, specifically responsive to cocaine/crack and amphetamine addictions.

The Physician's Role(s)

Medicine has become increasingly aware of difficulty in neatly delineating medical activity from the social and legal

consequences of diagnosis when the condition is a stigmatized or illegal one. The development of separate locked filing system for drug treatment records represents an earlier coping strategy. The debates about confidentiality and anonymity regarding HIV testing underscore this dilemma. Each of the public stances toward the pregnant addict implies a different role for the physician, with respective implications for the doctor-patient relationship.

The involvement of health care providers in reporting illicit drug use to either child protective services or the criminal justice system may deter addicted women from seeking care or from providing accurate histories. The non-recognition of "fetal abuse" precludes reporting the prenatal use of illicit drugs to child protective services. The expansion of child protective laws to include "fetal abuse" would be fraught with repercussions for the status of women. Recent efforts to constrain the behavior of pregnant women on behalf of "fetal rights" have not only included the prosecutions described earlier, but also restrictions on abortion, on employment opportunities, on the right to refuse medical interventions, and to make certain lifestyle choices.[50,51]

Protection of children after birth, however, is a different matter, although questions regarding maternal privacy rights and protection against search and seizure require exploration here too. These issues arise when determination of newborn status reveals maternal status (e.g., urine toxicology screening and HIV testing of neonates) and when urine toxicology testing of newborns is performed on the basis of maternal demographic characteristics, rather than clinical symptomatology.

When illicit drugs are detected prenatally, the prenatal care provider's obligations to the patient include encouraging and assisting her to obtain treatment for the addiction; informing her that the prenatal medical record will alert the nursery staff to perform a urine toxicology screen on the neonate, and the likely course of events if that screen is positive. Given the limited effectiveness and availability of treatment described here, this effort on the part of the individual practitioner becomes more meaningful if the medical establishment makes a research commitment to developing more effective modes of treatment; and together with the child protective establishment to forging firm links with the treatment world.

The criminal prosecutorial approach toward the pregnant woman involves the physician in a very different role. Physicians function as agents of law enforcement if they collect medical information for use in prosecutions upon request of law enforcement officials. In such a case, the physician must obtain informed consent from the patient which explicitly states that the results of medical tests are intended to be submitted as evidence in criminal charges against her. Otherwise, the physician, functioning as an agent of the state, becomes complicit in violating the patient's Fourth Amendment constitutional protection against improper search and seizure. The American Academy of Pediatrics has recently stated that it is unethical for physicians to perform drug screening for the primary purpose of detecting illegal use.[52]

The traditional role of the physician is that of provider of therapy. In the case of the pregnant addict, meaningful medical intervention necessitates coordination across specialties. The obstetrician/midwife, drug treatment experts, neonatologist, and social worker should function as a team so that the patient profits from a joint treatment plan and understands that the team members communicate regularly.

As described here, the efforts to criminalize addiction, to establish state constraint of pregnant women in the name of "fetal rights," debates over resource allocation to drug treatment, and to families in poverty are some of the varied political agendas which intersect around the person of the pregnant addict.

It behooves the physician to understand this so as to not unwittingly play a role in one of these other scripts, and to persevere in the traditional role of the physician — providing treatment and advocacy for the patient. The pregnant addict is a particularly needy and vulnerable patient and we have much to do to learn to provide effective therapeutic assistance.

Toward this end, health care providers can advocate locally and nationally that allocation of funds for the development of treatment for crack and polydrug addition during pregnancy become a priority. Rather than funneling the lion's share of resources toward law enforcement efforts that have not proven efficacious, as outlined by the Bush/Bennett plan, efforts and funding should be concentrated on rapid development and dissemination of effective treatment.[53] These treatment approaches should be subjected to rigorously designed clinical trials, and the promising modalities then made widely available. Whatever specific drug treatment modality is employed, it should be integrated within a comprehensive system of care. Drug treatment, obstetric and pediatric care should be coordinated, and services such as day care, job preparation and training to resist domestic violence must be incorporated if the women are to stand a meaningful chance at long-term recovery.

Coordination between the medical and treatment worlds and the child protective system is also essential. Addicted parents must be provided with drug treatment and parenting training; budgetary allocation, of course, is required to make this reality. These services must be available both to parents at risk of losing custody of children to foster care because of drug-related neglect charges, and to parents who have already lost custody and are aspiring to reunify the family. Again, ancillary services, such as day care, that make participation in treatment feasible, have to be included.

While these measures may be costly, they will be far less costly than hospital-based treatment of obstetric and neonatal complications of perinatal drug use, and hospital or foster-based custodial care of the children. The costs in social disruption are immeasurable if we construct a wedge between pregnant woman and fetus; between woman and doctor; and if we compound the in-utero drug exposure of these infants by a childhood of the emotional deprivation associated with institutional guardianship. We cannot afford it.

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