Cocaine Abuse in Maternal-Child Health Care

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DR BRIAN JACK *(Assistant Professor of Family Medicine)*: Today we will discuss an increasingly common problem, cocaine abuse and maternal and child health care. We will consider some of the medical, ethical, and legal issues surrounding testing and treating patients who use illegal substances. Our audience includes members of the Corkery Commission, which is a legislative commission studying the impact of substance abuse within the state of Rhode Island.

Substance abuse is a major problem in the United States. Current studies show that many women of childbearing age use cocaine, and the number of pregnant women using illegal drugs continues to grow despite warnings about effects on the fetus and possible long-term problems for the child after birth.[1] A study of women presenting in active labor to all eight maternity hospitals in Rhode Island during 17 consecutive days in October and November 1989 in which urine screening tests were anonymously collected revealed a statewide prevalence rate of 7.5%. Of this group of patients with positive screening results, 40% were positive for marijuana, 34.3% were positive for cocaine, and 22.9% were positive for opiates. Women with public insurance were over four times more likely to be using illicit drugs than women with private insurance.[2]

This Grand Rounds will discuss primarily the use of cocaine in the perinatal period. Use of cocaine during pregnancy has been shown to be related to an increase in spontaneous abortion, premature delivery, abruptio placentae, fetal growth retardation, and congenital anomalies.[3–8] Newborn infants exposed to cocaine during pregnancy may show signs of central nervous system dysfunction.[9–11]

Residents who care for these high-risk patients will present a series of cases. Rather than discussing all aspects of the issues, our goals for this conference are (1) to raise consciousness about cocaine abuse by women in their reproductive years, (2) to begin a multidisciplinary dialogue that will facilitate bridge-building between disciplines, and (3) to emphasize that this problem has created difficult clinical problems with which we wrestle every day. Some of these clinical problems are highlighted below and are illustrated by brief case presentations.

DOES DRUG SCREENING DURING PRENATAL CARE DISCOURAGE FURTHER PRENATAL CARE?

Case 1

DR SUSAN CLEMENS *(Second-Year Resident in Family Practice)*: B.B. was seen only once for prenatal care at 31 weeks' gestation. At this visit a urine test was positive for cocaine. Follow-up care was arranged, which included consultation with the Visiting Nurse Association (VNA). When the nurse went to the home, she was told that the patient had moved. The Family Care Center physician called the patient's father, who said that he would insist that the patient come in for care. Despite these interventions, the patient did not return for prenatal care. The patient reported to the Labor and Delivery floor in labor and gave birth to a healthy infant. Screening tests of the mother's and infant's urine at delivery were positive for cocaine. The Department of Children and Their Families (DCF) was involved, an ex parte order (custody of the child) was obtained, and the infant is now in foster care.

Case 2

In past years we saw one to two patients per month who presented with no prenatal care. During the month of November there were seven patients who presented to Labor and Delivery at Memorial Hospital with no prenatal care, and six of these patients had urine drug testing that was positive for cocaine. One patient, C.V., on her admission to the hospital in labor, reported that she had used cocaine 3 months previously. Urine tests of the infant and mother were positive for cocaine at the time of

Submitted, revised, July 31, 1990.

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delivery. When asked why the patient did not seek prenatal care, she said that she was "afraid of doctors" and that "they may take your baby away."

Case 3

At her prenatal intake interview, L.S. admitted to a history of substance abuse. At that time a test of the mother's urine (for which she gave consent) was positive for cocaine. She did not return for any further prenatal care. She delivered a healthy infant. Testing on the mother and the infant at delivery revealed cocaine use. DCF was notified, and an ex parte order was obtained. This patient said to the social worker, "The word is on the street that if you do cocaine when you are pregnant, you will be arrested."

REFERRAL TO SUBSTANCE ABUSE TREATMENT AGENCIES MAY NOT BE EFFECTIVE

Case 4

DR LAURA KNOBEL *(Third-Year Resident in Family Practice)*: M.M. had a long history of substance abuse. Testing for cocaine, done with her consent during prenatal visits, was positive on two occasions. The patient continued to refuse treatment or intervention and insisted that she was attending regular Narcotics Anonymous (NA) meetings. When asked about the positive test results, she insisted that she had stopped, but "fell off the wagon." This patient gave birth to a healthy infant. At delivery the patient's urine again tested positive for cocaine, as did that of the infant. DCF was involved, an ex parte order was obtained, and the infant was discharged in the custody of the grandmother.

Case 5

M.P. is currently pregnant and has had two urine tests that revealed traces of cocaine. The patient accepted referral to a substance abuse treatment agency. The initial appointment, however, was not for 2 weeks. The patient missed the intake appointment at the outpatient substance abuse treatment facility to which she was referred and has missed subsequent prenatal care appointments.

DR JACK: Let me ask a question of the panel. If you were pregnant and addicted to cocaine and the word on the street is that if you go to the doctor your urine will be tested, and if it is positive, they will take your baby away from you, would you go for prenatal care?

DR KEVIN MURPHY *(Director of Clinical Services, Junction Human Service)*: I don't think I would. What we have to do is change the word on the street. I work at a drug and alcohol ambulatory treatment facility, and in our programs we go out of our way to make sure we have no affiliation with the police, and we try to convey that to our clients. The fact that they will not be arrested is important.

DR JACK: But your baby is taken away.

DR MURPHY: That procedure is not followed at treatment centers; that may be done in hospitals.

STEVEN BROWN *(Executive Director, Rhode Island American Civil Liberties Union)*: But DCF involvement is a direct result of performing urine testing to detect cocaine. I think because women are worried about having their babies taken away, they are going to delay prenatal care as long as possible. Obviously they go to the hospital for delivery because they have to, but not necessarily because they have gotten over these fears. I think this problem is very serious.

RALPH DETRI *(Executive Director, Family Center)*: It becomes a public health measure when we use sanctions that will keep women from seeking medical attention or appropriate social services for themselves or for the baby. I also work at an ambulatory substance abuse treatment facility, and if I were addicted to drugs, I would not attend prenatal care under the current circumstances.

DR EDWARD BEISER *(Associate Dean of Medicine, Humanities and Social Science, Brown University)*: Do you all say the same thing about child abuse? Child abuse is reportable. The residents in this hospital as well as those in other hospitals have anguished over reporting child abuse. What I hear, and I would be delighted to be corrected by house officers, is that the obligation to report child abuse sometimes makes doing so easier, cleaner. Physicians are relieved to be able to say to the parents, "I am very sorry, but I must report this as child abuse." Does that requirement keep children away from pediatricians when they break legs? Or get burned? I suggest it as a possibility.

KENNETH FANDETTI *(Assistant Director of Child Protective Services, Department of Children and Their Families)*: I think testing a women's urine for cocaine does inhibit women from seeking prenatal care because there is a threat that the mother will lose legal custody of the infant. Some reassurances need to be made to women with a history of substance abuse who seek treatment that they will not be reported and the baby will not be taken away. Some programs in other places have agreements with the local child protective service agency that even though urine testing for cocaine is positive during pregnancy, if treatment is undertaken, the mother will not be reported when the baby is born.

MR BROWN: Does DCF in Rhode Island have a policy of seeking an ex parte order if the testing is positive for cocaine once the child is born?

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MR FANDETTI: Yes, if the testing for cocaine is positive at the time of the delivery. DCF carefully considers all calls to the Child Abuse Hotline by concerned individuals alleging that a pregnant woman is using drugs. If there are specific allegations of abuse or neglect of children in the home, an investigation is conducted. If there are no specific allegations or if there are other children in the home, then the information is registered as an "early warning." If we have received such a warning, then there is a good cause to test both the mother and her baby for the presence of drugs immediately after the birth.[12]

If there is evidence of cocaine use by testing the urine on the mother or the infant at the time of delivery, the drug use is reportable based on the child abuse and neglect laws. The law states that "babies born with drugs in their systems, as evidenced by a positive toxicology screen at birth or observable withdrawal symptoms, babies born to mothers who admit to using drugs during pregnancy or who have been observed ingesting drugs, and babies born with fetal alcohol syndrome must be reported to the Child Abuse Hotline."[12] An investigation will be conducted if there is a specific allegation of abuse or neglect of the newborn once the baby has been born.

To ensure that these babies and their families receive necessary intervention, substance abuse treatment, and social services, the DCF investigator consults with DCF counsel as to the advisability of requesting an order of detention, ex parte. When the matter comes before the court, DCF will recommend that the mother (and father, if appropriate) receive drug treatment.[12] If the child is at imminent risk and requires placement out of the home, then an ex parte petition will be sought in court. Otherwise, if the infant is not at imminent risk, a straight petition will be brought before the court charging abuse and neglect, but the child will be left in the home. The reason the court is involved, however, is to engage that family in treatment services, and removal of the infant is not the plan of first choice.

DR MURPHY: Is testing for cocaine done routinely? Among the cases presented, I noticed that sometimes consent is obtained, other times consent is not obtained. What is the policy regarding consent?

DR JACK: One reason we are here is that there is no policy. We have guidelines for cocaine testing within the residency. If a woman presents with a medical complication such as preterm labor or abruptio placentae, consent is not routinely obtained. If a woman presents for routine prenatal care, and substance abuse is suspected, then consent is obtained. Our approach is similar to that taken with patients who use alcohol in that if a patient presents to the Emergency Department in coma and an alcohol level is performed to evaluate the medical condition of the patient, then this information cannot be used legally against them. To obtain an alcohol level that could be used in court, consent is needed. I am not sure it is the same with cocaine, but that is how we are proceeding.

DR SAVERIO SAVA *(Family Physician, Pawtucket Health Center)*: I am concerned about women in a community health center who are from low socioeconomic groups but are not substance abusers. The system is set up so that these women are treated negatively. If a woman does not have insurance and cannot go to a private physician, then she must go to a health center. We are targeting, and appropriately so, these high-risk women; unfortunately, every woman who goes to a health center in some ways gets treated with suspicion. They are told their urine will be tested, and there will be substantive investigation if the screening is positive. I am sure that most women who attend a private physician's office do not get questioned about substance abuse.

DR JACK: There is certainly no doubt that it is easier if you do not ask the question initially.

DR FRED HAWWA *(Clinical Assistant Professor, Department of Obstetrics and Gynecology)*: As an obstetrician in private practice, I suggest that private practice is very different from a clinic or health center practice. If I suspect drug use, the most I can do is to refer the woman to a social worker. I cannot order a urine drug test on this woman because of the obvious threat of a lawsuit. In the clinic, physicians are protected by the hospital and by the hospital lawyers. Private practice is completely different. I could offer testing, but if the woman refuses, that is the end of it.

DR BEISER: You do not need that information to deliver the baby safely?

DR HAWWA: If a patient comes in with an abruption or in preterm labor, then I would obtain permission before ordering the test and would alert the pediatrician. I cannot ignore the results of the testing once it is done. I would have to alert DCF, and perhaps the baby will be taken away from the mother. I cannot simply use this information for medical purposes, no matter how much we like to think that we could.

DR JACK: In the first case, the VNA nurse was asked to visit the patient in her home after the urine test for cocaine was positive. Presumably, VNA referrals are to perform patient education and medical services such as change of dressings and blood pressure checks. Is it an appropriate use of VNA services to "check-up" on a patient who used drugs? Is that a DCF function? Is that a police function? What is the appropriate response?

MR DETRI: Well, from my own perspective, the appropriate response has to come from the recognition that substance abuse is a medical problem; consequently, a number of medical and social services need to be networked. Agencies involved in patient care must address substance abuse.

DR BEISER: Why did the physician call the patient's father? Do you have a right to call the father of a 23-year-old patient to get her into treatment?

DR JACK: Every attempt was made to get this patient to attend her prenatal care visits. We want to go out into the community to engage these women in care rather than being responsible only for those that come in for care. The family was called in an attempt to mobilize them. Perhaps, we could become allies to help the patient receive care.

DR RAY RION *(Third-Year Resident in Family Practice)*: We also see the father. The father is also a patient here.

MARTHA LAWTON *(Maternal-Child Health Social Worker)*: He was also the contact person named by the patient.

DR MURPHY: It is important to enlist as many people as possible. When an individual is identified as having a primary drug or alcohol problem, he or she is covered under federal confidentiality laws. We need to be sensitive to who tells whom what, when, and with whose permission. The experience of providers in substance abuse treatment facilities is that we do not need an individual to be self-motivated to begin treatment. A treatment approach has been developed wherein you elicit the cooperation of family members and other professionals. We enlist as many people as possible in an attempt to get these patients into treatment.

The Driving While Intoxicated (DWI) program has social sanctions that say, "Look, if you are caught while driving drunk, you have to go into treatment." An individual's rights are violated when his or her license is removed, but there is good reason, and society condones this action. I think similar reasoning applies when we test a pregnant woman for drug use.

I would like to see the up-front access to treatment improved. Then the hammer should come down if they do not come for treatment or if later they give birth to a baby that tests positive. The message to patients should be that if you request care up front, you can go into treatment, you will be tracked, and if you give birth to a drug-free baby, you can go home with the baby and receive further follow-up and support services. The word on the street needs to be that it is safe to request treatment early, because if you do not, the consequences will be severe.

MR BROWN: I think the problem with routinely testing for cocaine is not the procedure itself, nor its use as a clinical tool. There are disturbing consequences, however, to using the screening procedure as more than a clinical tool to assist the physician. DCF may take the child away if there is evidence of cocaine use when the baby is delivered. Is it in the best interest of that child to be taken away? I question whether the best interests of the child are being served by a kneejerk reaction to deal with the problem instead of viewing it, as others have said, from a medical viewpoint. You should test for cocaine as you perform other medical tests, that is, to assist the treatment of the patient, not to provide sanctions or other punitive measures.

DR BEISER: Is urine cocaine testing being done for legitimate medical reasons, or for legal evidence against the parents to obtain an ex parte order? Is that information clinically necessary to know how to treat the mother or the baby? Is it a social placement issue or a treatment issue?

DR KNOBEL: I use it to treat the mother. Identification of substance abuse as a problem can steer the mother in the direction of help. Many times patients will deny cocaine use, but when a test for cocaine returns positive, they will say, "Why, yes, I was using it." In this way I can use the positive screening result to initiate treatment.

DR BEISER: Other than promoting substance abuse treatment, is the information useful clinically, for example, to decide the type of anesthesia to use or the best mode of delivery?

DR KNOBEL: Cocaine puts women at risk for preterm labor, so if the patient has a history of drug use and she presents in preterm labor, this information will be helpful.

DR LARRY CULPEPPER *(Associate Professor, Department of Family Medicine)*: We have had a patient present with elevated blood pressure readings. If that patient has not used cocaine, then she is likely to go more quickly to cesarean section for severe preeclampsia than she would if she had recently used cocaine.

DR BEISER: I would like to describe a case that may be useful as a contrast. A father apparently had an alcohol problem. His wife worked hard to get him into a hospital treatment center, not specifically a detoxification setting. In the course of his treatment, he reported abuse of his teenaged child. The physicians anguished about whether they were required to report that child abuse, and ultimately it was reported. The father, of course, never came back for his alcohol treatment, and the spouse took the attitude that "you doctors have destroyed my husband's only hope for detox of alcohol by reporting child abuse." I think of that case as I listen to some of these.

MR DETRI: That clinical scenario, by the way, is not unusual. It is not unusual to make a diagnosis of chemical dependency in an individual, and then discover additional abuse in the family. The clinical problems are compounded.

DR CLEMENS: We are talking a lot about the mother's rights while she is pregnant. What are the infant's rights?

DR HOWARD MORNINGSTAR *(First-year Resident in Family Practice)*: We wrestle with these very complicated problems all the time. I think that screening for cocaine during pregnancy is proper, since delivering cocaine into the bloodstream of a newborn is a form of child

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abuse. The proper use of urine testing for cocaine is as a screening test for child abuse. It is similar to when a physician evaluates a child with multiple bruises, and an x-ray examination is routinely ordered. You can use the urine drug testing to look for child abuse in a similar way. I am going to let the experts decide what the correct use of this information is once I have found the child abuse. From a clinical perspective, if I suspect child abuse, then I am obligated to order the appropriate tests on the child, with or without parental consent, to determine whether child abuse has occurred.

DR JACK: In some jurisdictions, the courts have defined the duty of medical professionals to warn prospective victims when their patients confide their intention to harm third persons. For example, in *Tarasoff v Regents of the University of California*,[13] the court held that a therapist who knew of his patient's intention to kill Tatiana Tarasoff had a duty to exercise reasonable care to protect Tatiana because of the "special relationship" that exists between therapists and their patients. With regard to the conflict between the obligation to preserve confidentiality in the patient-therapist relationship and the duty to protect third persons from threatened harm, the court stated that there is a duty to warn when necessary to avoid danger to individuals or to the community.

Also, physicians are asked to break confidentiality when they are required to report such conditions as hepatitis, venereal diseases, and gunshot wounds, among others. The law in Rhode Island, however, does not classify prenatal substance abuse as child abuse unless there is evidence of substance abuse at the time of or after the birth of the child.

MR FANDETTI: Until the child is born, we cannot become involved. That ruling is not universal across the country. There are some states and counties that will not react if a child is born with evidence of recent maternal cocaine use. They will only act after some adverse event has occurred.

DR SCOTT EARLY *(Family Physician, Central Falls Health Center)*: There are other places where women have been incarcerated during their pregnancy.

MR FANDETTI: That is correct. I do not advocate that response because, if anything, I see it driving women underground, where they will not seek treatment.

MR BROWN: In a case pending in a Florida District Court of Appeal, a woman was found guilty of delivering cocaine to her fetus during pregnancy.[14] I think the consequences of declaring child abuse when drugs pass through the umbilical cord to the fetus are extremely dangerous, with tremendous ramifications for women's reproductive freedom. Defining maternal cocaine use as child abuse interjects criminal law into this very personal matter that should be addressed privately by the physician and patient.

The first time a woman was charged with medical neglect of a fetus was the Pamela Rae Stewart case. In this important case, which was dismissed in a California municipal court, three reasons were given by the prosecution for charging her with a crime. The first was that she ingested drugs that prompted labor and delivery of a stillborn child. Second, she had sexual intercourse with her husband, which the physician had recommended against because of the high-risk status of her pregnancy. Third, she did not go to the hospital immediately upon starting to hemorrhage. This case gives precedent to law enforcement authorities being able to investigate an array of other matters during pregnancy such as advice about exercise, tobacco, alcohol, etc. Some people have called the ramifications of this hearing the creation of "pregnancy police."

MR DETRI: Many of us in the substance abuse field are obviously very concerned about civil liberties and due process. We also need some leverage to induce patients into treatment. The nature of addiction is denial. Often, some kind of adverse consequence may help a patient get into treatment. Frequently if you explain to addicts that they are going to die from their condition, they will still choose the drug. But if you tell them they are going to go to jail, they occasionally choose treatment as an alternative.

DR JACK: Taking someone's baby away is the most powerful thing you can do to anybody. And to still use drugs despite that threat emphasizes the severity of drug addiction. We are going to present several more cases and then continue the discussion.

DO WE VIOLATE PERSONAL LIBERTIES IF WE SCREEN ROUTINELY FOR COCAINE DURING PRENATAL CARE?

Case 6

DR MONIQUE MORISSEAU *(Second-Year Resident in Family Practice)*: V.V. presented to Labor and Delivery and was precipitously delivered of a healthy infant soon after admission. The patient reported several prenatal visits at another hospital clinic, and as is routine, the clinic was contacted to obtain medical information and prenatal laboratory tests. Over the telephone the clinic personnel related that the patient had previously presented with preterm labor, and at that time urine testing revealed cocaine. The patient made no further visits. Urine tests done at the time of delivery were positive for both mother and infant. After being informed of these results, the patient became hysterical, required sedation, was seen by a psychiatrist, and was placed on suicide precautions. The

patient's husband vehemently denied his wife's substance abuse, threatened legal action, and contacted a lawyer while his wife was still in the hospital. The husband continually urged his wife not to discuss her substance abuse with medical professionals. In private, the patient admitted to a significant substance abuse problem. DCF was contacted, an ex parte order was obtained, and the infant is in foster care.

WHAT IS REASONABLE FOLLOW-UP OF WOMEN WITH POSITIVE SCREENING TESTS DURING PRENATAL CARE WHO REFUSE TREATMENT?

Case 7

DR MARK POLISAR *(Second-Year Resident in Family Practice)*: One year ago, K.T. presented at 34 weeks' gestation in preterm labor with no prior prenatal care and at that time had a urine test positive for cocaine. The patient refused treatment, and 1 week later presented with an intrauterine fetal death. The medical examiner officially declared the fetal death secondary to cocaine abuse. One month later, the patient was admitted to the hospital with pneumonia. She admitted to intravenous cocaine use. The patient is now pregnant again and denies drug use since her previous admission. Urine testing was positive for cocaine. An inpatient bed was arranged at a private substance abuse treatment facility with funding through the Rhode Island Division of Substance Abuse. The patient continued to refuse treatment.

Case 8

During the early stages of prenatal care L.D. was found to have evidence of cocaine in her urine on five occasions. The patient also admitted that her boyfriend was using and selling cocaine. Four early warnings were called in to DCF, but no action was taken until the fifth early warning was registered. At that time, DCF explained that if there was any further evidence of cocaine use, the ex parte process would take place when the baby was born. The patient refused treatment because no child care was available for her other children. Drug testing was negative during the remainder of prenatal care and at delivery. The patient was delivered of a healthy infant and went home with multiple social services involved. DCF obtained a "straight petition" (granting legal custody of the infant, but allowing the infant to remain with the mother) and mandated treatment.

Case 9

L.H. was a known substance user. During her pregnancy she admitted to cocaine use and accepted treatment. Treatment was arranged through the Junction Human Services in Providence, and the patient was admitted to Edgehill (an inpatient substance abuse treatment center) after a 10-day wait. The patient was admitted for 30 days, and following discharge had frequent urine tests for cocaine in the Family Care Center, all of which were negative. She continued outpatient treatment and NA meetings. The patient gave birth to a healthy infant, and mother and infant are now followed in the Family Care Center and continue to do well.

DR JACK: There are windows of opportunity for treatment of cocaine use because of the typical binging pattern. Often patients are not motivated until they get close to delivery. It often is difficult to get these patients into treatment immediately. In fact, nowhere in the state can you get the patient into treatment on the day that she says, "Yes, I'll go." There is always a week or two delay, and by then the patient often will have changed her mind.

MR DETRI: You are absolutely right. There is tremendous overcrowding of substance abuse treatment services in Rhode Island and many other places. We need more slots in outpatient and inpatient settings. One possible solution would involve having an outreach worker visit that patient immediately to try to get at the window of opportunity. The scenario in case 5, which mentioned my center, is very typical. That patient seemed ready at a particular time, but had to wait 2 weeks for evaluation. Often by then the woman is in a state of denial or has relapsed so much that she does not know what she is doing. One solution is aggressive outreach to these women.

MR BROWN: In case 8, the woman is specifically denied access to treatment because there was no child care available for her children. Substance abuse treatment is often not optimal, especially for poor women. There are probably many cases in which the woman may want treatment, but it simply is not accessible for one reason or another. It is important to arrange flexible care that is sensitive to the individual needs of women. Otherwise, society punishes them by charging them with a crime or by taking their children away.

MR DETRI: On an outpatient basis there is a sense of inequity in access to treatment between people who are and who are not insured. For the inpatient setting, lack of insurance becomes a tremendous barrier to care. We experience it at our agency as well.

DR JACK: The patient in case 7 continued to refuse treatment despite a previous fetal demise secondary to cocaine use. Is the woman with her second pregnancy different? When we first heard that this woman was preg-

ant again, we all said, "Oh no, not her." Then the urine ests for cocaine started coming back positive again. She ontinues to refuse treatment. We see her frequently, we all her on the telephone almost daily, and she still refuses reatment.

DR MURPHY: Was she offered outpatient treatment? t's very disruptive to go away for 30 days.

DR JACK: She was. This patient refused all treatment nodalities.

DR MURPHY: Perhaps trying to tease out why she is efusing will help. What is going on in her head? Will she go for an assessment? Is transportation a problem?

DR JACK: She will come to the Family Care Center. She was here for all sorts of things last week. Would you come to see her and perform an assessment in the clinical setting?

DR MURPHY: Yes, if someone asked us to come out, we would. Such a procedure is not typical because we are at 140% of our designated caseload, but if it is clinically indicated in a particular circumstance, we will.

DR CULPEPPER: Is this a case of mental illness that one could commit for? We know that abusing women, in a binge cycle of cocaine, can become paranoid, and during this stage of intoxification there are increased risks of homicides, suicide attempts, and car accidents. If we substituted alcohol for cocaine in this case, there is no question this woman would be involuntarily transferred to a detoxification center. She would be back out on the street in 4 or 5 days, but at least in terms of the acute episode, she would have no alternative. What is the difference with cocaine? Why do we not commit patients who use cocaine?

DR MURPHY: We try to address cocaine addicts in the same manner as we do alcohol addicts. There are fewer beds for drug use treatment than for alcohol detoxification. There is a lack of access to substance abuse treatment programs. There will be some federal money available, and one proposed way to use it is to create 10 or 12 residential beds for pregnant women.

MR DETRI: From the clinical perspective I do not believe there is a difference between treatment of alcoholism and the treatment of cocaine addiction. If a patient's life is in danger, then proper guidelines have to be taken to protect the person's life. When I admit a patient to the hospital against her will, I make it clear that I am doing so out of concern for the patient, and that I am going to take her back into outpatient treatment when she is discharged. I do not think taking these steps will necessarily damage the patient-therapist relationship if it is handled properly. In terms of clinical management I do not think there should be a difference between the treatment of alcoholism and substance abuse, but as Dr. Murphy said, the big issue is available beds.

DR JACK: How do we decide between outpatient

treatment and inpatient treatment? Should we contact inpatient units directly, or should we contact you in the outpatient evaluation units so that you can make the disposition?

DR MURPHY: Generally we recommend that you contact us directly. If after taking a good psychosocial history, we feel that a patient has a chronic substance abuse problem characterized by a number of relapses, we ask them to sign a contract. The contract indicates that the patient will participate in a number of self-help groups such as NA, they will attend a 4-week chemical dependency education group, and they will meet with a therapist on a weekly basis. It also allows us to obtain random tests for cocaine. The odds that the patient will succeed on an outpatient basis are not good if the patient has a chronic relapsing history. The attrition and relapse rates are high, but we try to integrate as much structure as we can within our care system. A patient who is not able to fulfill the contract has a substance abuse problem that needs to be treated in an inpatient setting.

DR BEISER: Am I correct in thinking that the treatment decisions have nothing to do with pregnant women? The way you presented the patient, Dr. Culpepper, has nothing to do with pregnancy. Indeed, it could have been a man as well as a women. Should the fact that the addicted woman is pregnant be used as leverage to get her into treatment? If a woman needed a mortgage, you could get "leverage on the mortgage"? If her husband was a politician, you could "get leverage"? At some point it becomes extortion, right?

MR BROWN: Poor, pregnant women who have a substance abuse problem hesitate to come forward. When you provide "help" by removing the infant from the mother, the ultimate effect will be perceived as punitive. This hesitancy to come forward may have a backlash on other pregnant women who may not come in for treatment.

DR ALICIA MONROE *(Assistant Professor of Family Medicine)*: As I listened to the initial discussion, it occurred to me that when a woman becomes pregnant, if she is a substance abuser, then she loses her rights. The question is—how can we support women and encourage them to get into treatment? If we threaten the woman with losing the infant, if all of our techniques are perceived as punitive, then I cannot see that our ultimate goals will be reached. The challenge is—how can we make pregnant women understand that our agenda is to care and provide service for them rather than use their pregnancy as a vehicle to invade their privacy and deprive them of their rights?

DR JACK: Our discussion has emphasized that substance abuse in the prenatal period is related to many clinical problems. Our multidisciplinary discussion has opened lines of communication about some of these issues. There are many other issues raised by these cases, but unfortunately, we do not have time to discuss them now.

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