

Chemically Exposed Children: The Child Welfare Response

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ABSTRACT: Child Welfare Agencies, especially in urban areas, are confronted with multiple problems as they attempt to deal with the complex needs of chemically dependent families. Maternal chemical use places children at an elevated risk of placement and other negative events. This article critiques research on incidence and consequence of maternal chemical use and suggests strategies Child Welfare Agencies can employ in working with these vulnerable families.

After a period of decline in the number of children entering foster care, recent statistics indicate increasing numbers of children are entering care and that many of these children are young and minority. The factor which seems to account for much of this increase is the incidence of illicit chemical use by parents. Chemical use by pregnant women has become the basis for referral to child protective services in many states. This article critically examines the recent research on the incidence and consequences of maternal chemical use and suggests strategies for helping child welfare agencies meet the multiple needs of this vulnerable population. Chemical dependency is one factor in the lives of parents who have multiple needs and frequently live in unsupportive environments. By incorporating an ecological perspective, child welfare agencies can provide comprehensive services to this special population.

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Incidence

Obtaining accurate estimates of the number of people using mood altering chemicals is difficult. The reported incidence of drug use varies widely and is influenced by factors such as which drugs will be included in the study, methods of sampling, and the techniques used to determine drug use.

The National Institute on Drug Abuse (NIDA) is the federal agency which estimates drug use. NIDA relies on three sources of information; a national household survey, data from hospitals on drug related admissions to emergency rooms, and a survey of high school seniors. NIDA does not survey populations which may have a high incidence of drug users such as prison inmates or residents of college dormitories. Therefore, the data may underestimate the actual incidence of drug use.

NIDA (1989) data indicate that alcohol and tobacco, two legal drugs, continue to be the most widely used chemicals. More than 100 million Americans use alcohol, a chemical with the potential to harm a fetus. If only 30 percent of these 100 million users of alcohol are women of child bearing age, then a substantial number of infants could be exposed prenatally to this harmful agent. Marijuana continues to be the most frequently used illicit drug. The numbers of cocaine users are declining. Data from the high school seniors survey indicate that in 1989, only 3.1 percent of seniors had ever used crack (an inexpensive smokable derivative of cocaine) compared with a high of six percent in 1987 (NIDA, 1990). Of the five million regular users of cocaine, 40 percent are estimated to be women of child bearing age (Abelson & Miller, 1985).

Drug use by women of child bearing age is particularly troublesome since chemical use can be harmful to both the mother and fetus. Most studies of chemical use by pregnant women are conducted at large urban hospitals which serve poor women of color. One study of 36 hospitals reported an average 11 percent incidence of substance abuse in mothers using prenatal service (Chasnoff, 1989). Another study at Boston City Hospital reported 27 percent of mothers had used marijuana and 18 percent had used cocaine during the study period (Zuckerman, et al., 1989). A Miami study reported a 12 percent perinatal cocaine exposure rate (Bandstra, et al., 1989). A study at a public hospital in Detroit revealed that 27 percent of delivering women tested positive for one or more drugs with marijuana, the most commonly used drug (Land & Kushner, 1990). None of these studies in-

cluded alcohol in the definition of drugs nor tested for the presence of alcohol.

The federal government estimates that 100,000 infants are exposed prenatally to cocaine each year (Government Accounting Office, 1990). The Chasnoff (1989) study estimates as many as 375,000 infants may be drug exposed annually. These varying estimates are a result of different definitions and testing procedures. Hospitals which rely on self reports of drug use by pregnant women, or on indications of drug withdrawal in the newborn, report low rates of drug exposure. Hospitals which intensively screen for drugs, using toxicology testing, report a high rate of drug exposure. The location of a hospital and the type of patient the hospital serves also influences estimates. Hospitals which serve non-Medicaid patients may not view prenatal drug exposure as a serious problem and not test for chemical use (Government Accounting Office, 1990).

A recent study attempted to address some of the major flaws of prior incidence studies by testing for alcohol as well as illicit drugs and by screening women who used private obstetric clinics. The incidence rates for the two groups did not differ significantly. Using anonymous testing, 16.3 percent of the women seen at public clinics tested positive and 13.1 percent of the women seen at private offices tested positive for one or more drugs. There were differences in the type of chemical used. Black women were more likely to test positive for cocaine than white women (7.5 percent vs. 1.8 percent). White women were more likely to test positive for cannabinoids than black women (14.4 percent vs. 6.0 percent). While drug use rates for white and black women were similar, black women were ten times more likely to be reported to the state health agency as suspected drug users than were white women (Chasnoff, Landress, & Barrett, 1990).

Effects of Prenatal Chemical Exposure

Studies of the effects of prenatal chemical exposure report inconsistent findings. Most studies do indicate an elevated risk of negative fetal outcomes associated with maternal chemical use, although the results are often not statistically significant. The negative effects of chemicals such as alcohol and opioids have been known for years. Infants born with Fetal Alcohol Syndrome (FAS), for example, suffer from central nervous system impairment and growth deficiency (Streissguth, Sampson, & Barr, 1989). Perinatal alcohol exposure is

the leading preventable cause of developmental delay. Maternal opioid (heroin and methadone) use can result in low birth weight, pre-term birth, elevated risk of Sudden Infant Death Syndrome (SIDS), and an infant withdrawal syndrome (Wilson, 1989).

The effects of prenatal cocaine exposure has been a new area of research. The findings that are consistent across studies concern pre-term birth. Maternal cocaine use is consistently associated with negative fetal outcomes such as low birth weight, small head circumference and decreased length (Chasnoff, Burns, & Burns, 1987; and Zuckerman, et al., 1989). There are other studies which suggest an association between prenatal cocaine exposure and birth defects such as genitourinary malformations and limb abnormalities (MacGregor et al., 1987; Bingol, Fuchs, Diaz, Stone, & Gromish, 1987; and Cordero & Custard, 1990). These negative effects have not occurred at statistically significant levels, and other studies have not supported these findings. One study has reported that cocaine exposed children have an elevated risk of SIDS (Chasnoff, Burns, & Burns, 1987). Another study examining a similar population of infants could not report an elevated risk of SIDS (Bauchner et al., 1988).

Part of the difficulty in establishing causal relationships between cocaine exposure and negative outcomes is due to the nature of chemical use. The dose, timing, and frequency of chemical use may influence the effects of the chemicals. Another factor which is difficult to control in a research design is polyabuse. Abusers of cocaine are also likely to use alcohol and tobacco (Hutchings, 1990).

The Chasnoff et al. (1990) study suggested that economic status played a minimal role in drug incidence rates among pregnant women. However, economic status may influence the impact of drug use. Poor pregnant women, already at an elevated risk of negative outcomes due to environmental factors, may suffer more devastating consequences from drug use. Poor women who are chemically dependent are subject to other problems which can negatively influence the health of the fetus. Chemically dependent women may not receive adequate health care, live in hostile or non-supportive environments, experience financial deprivation, reside in inadequate housing, suffer from depression, be involved with a chemically dependent male partner, have histories of physical and sexual abuse, and be victims of domestic violence (Burns, Melamed, Burns, Chasnoff, & Hatcher, 1985; Amaro, Zuckerman, & Cabral, 1989; and Regan, Ehrlich, & Finnegan, 1987).

Costs of Chemical Use

The financial costs of chemical use by pregnant women are staggering. Cocaine, in particular, seems to contribute to pre-term birth. Premature babies are at risk for a number of negative outcomes such as neurological and respiratory problems and death. They require specialized care and neo-natal intensive care units are expensive with an average cost of \$1000 per day (Children's Defense Fund, 1989). California will spend one billion dollars because of the added time these infants need hospitalization and the costs associated with the complications of some premature infants (Select Committee on Children, Youth, and Families, 1989).

There are few longitudinal studies of cocaine exposed infants. These children are beginning to enter the public schools and the costs of educating these children are now being calculated. There is some research which suggests that cocaine exposed children have poor organizational skills, reading problems, and impaired mathematical abilities (Van Dyke & Fox, 1990). If these children need special education, states will have to allocate large sums of money. While costs vary, a year of special education averages \$7,900 per child (Subcommittee on Human Resources, 1990).

The legal system has responded to drug use by arresting, prosecuting, and incarcerating more people. The 1980s were characterized by more arrests and prosecutions for drug offenses than for any other crime. From 1983 through 1986, for example, arrests for drug offenses increased 52 percent, convictions for drug offenses increased 71 percent, and sentences to incarceration were up 104 percent (U.S. Department of Justice, 1989).

Criminal laws have been modified or enacted in order to prosecute chemically using pregnant women (Gustavsson, in press). In some states, women seeking prenatal care are subject to toxicology screening for drugs. If these results are positive the woman is reported to state agencies and subject to criminal prosecution and loss of custody of her child. This is a gender specific policy in that the father may also be using chemicals but is not subject to toxicology screens nor is he prosecuted for chemical use. There is some evidence to suggest that chemically abusing men face an elevated risk of infertility and chromosome damage (Close, Roberts, & Berger, 1990; and Shafer et al., 1990). The criminal prosecution policy may serve to discourage chemically using pregnant women from seeking prenatal care or de-

livering at hospitals, thus unintentionally increasing the risks of maternal and infant morbidity and mortality.

Some states (such as Florida, Minnesota, Illinois, California, Oklahoma, Massachusetts, Indiana, and Utah) have responded to the problems of chemically exposed infants by altering their child abuse reporting statutes to include prenatal chemical exposure in the definition of an abused child. Infants suffering from a drug withdrawal syndrome can be considered neglected and removed from the custody of the parent (*In re Baby X*, 1980). Infants not suffering any apparent negative effects of maternal chemical use are also subject to child welfare intervention. Using NIDA estimates of drug use, mandatory toxicology screening could increase the number of referrals to child welfare agencies by more than half a million children annually. It is unclear how child welfare agencies could respond to such a large increase in reports of maltreatment.

Some urban areas have witnessed a substantial increase in the number of children entering foster care. During a six year period in the 1980s, Los Angeles county experienced a 500 percent increase in the number of children in placement because of parental drug use and in some counties, drug exposed children comprise two-thirds of the foster care caseload (Select Committee on Children, Youth, and Families, 1989). Very young children are entering the foster care system in unprecedented numbers. In San Francisco county children under three years of age now make up 53 percent of all children in placement (Weston, Ivins, Zuckerman, Jones, & Lopez, 1989). Ten states (California, New York, Florida, Georgia, Illinois, Michigan, New Jersey, Massachusetts, Ohio, Pennsylvania) account for 55 percent of the foster care population and one-third of the foster care population resides in either California or New York (Subcommittee on Human Resources, 1990). States which are experiencing a drug problem are also experiencing an increase in their foster care population.

Data from NIDA (1989) indicate that whites are more likely to use drugs than blacks or Hispanics. Incidence studies report similar chemical use rates for black and white pregnant women (Chasnoff et al., 1990). Yet, minority children are at an elevated risk for placement due to parental drug use. This may be due, in part, to a two-tiered social service system. The affluent chemical user is able to avoid the public sector and obtain rehabilitation services from the private sector. This parent may not be referred to a public child welfare agency. The poor parent must rely on the public sector for serv-

ices. These factors may account for some of the increasing numbers of minority children referred to child welfare agencies.

Drugs such as crack (a smokable derivative of cocaine) have had an especially devastating impact in some poor urban areas (Koppelman & Jones, 1989). For example, one study of black children in foster care in five metropolitan areas (Detroit, Houston, Miami, New York, and Seattle) reported parental drug abuse was a contributing factor to placement in 36 percent of the sample (National Black Child Development Institute, 1989). California now reports that the majority of children in foster care are black yet only 10 percent of the state's children are black (Subcommittee on Human Resources, 1990).

Responding to the Need

Parental chemical dependency has challenged the resources and expertise of child welfare agencies. These parents need a variety of services, including drug treatment. However, there is surprisingly little information available on effective treatment programs for cocaine users and polyabusers, especially women. This may be a reflection of federal priorities. In fiscal year 1990, the Office of National Drug Control Policy requesting 10.6 billion dollars, with 29 percent of the money directed toward reducing the demand for drugs (the remaining 79 percent is directed at reducing the supply). Under this formula, one-half of the treatment funds are provided through Department of Health and Human Services block grants to states. States are required to set aside at least 10 percent of these funds to provide drug abuse prevention and treatment for women (Government Accounting Office, 1990).

Treatment for chemically dependent women has been a low priority. Long waiting lists for drug treatment services are common and in some areas of the country there are no or only a few facilities willing to accept pregnant women for drug treatment. More than half of the drug treatment programs in New York City refuse to admit pregnant women, and Massachusetts has allocated 15 residential treatment slots, statewide, to pregnant women (General Accounting Office, 1990). The lack of treatment adds to the risk of negative outcomes for both the fetus and the mother. Child welfare agencies may find it cost effective to join in a collaborative effort with medical facilities, mental health centers, and drug treatment agencies and allocate some of

their funds to purchasing drug treatment services for pregnant women. The infants of chemically dependent women are at risk for both serious medical problems and foster care placement.

Chemical abuse has forced child welfare agencies to develop a new area of expertise. Line workers now need training on how to identify and assess the seriousness of chemical use. In service training programs can provide this information and schools of social work have an obligation to include this content in child welfare specializations. In addition to refining assessment skills, workers should be able to encourage the chemically dependent parent to seek treatment, make appropriate referrals, and provide follow-up to ensure the delivery of treatment services. In one study which reported parental substance abuse was a contributing factor to foster care placement in 36 percent of the sample, referral to a drug treatment program was part of the service plan in only 27 percent of the sample (National Black Child Development Institute, 1989).

A collaborative arrangement between drug treatment agencies and child welfare agencies is essential, especially for chemically dependent mothers. These women bring many concerns about their children, and issues of abuse and neglect, to the drug treatment center. Child welfare issues have not, historically, been a part of the services offered by drug treatment settings. Child welfare agencies can provide assistance in program development to drug treatment agencies and help these agencies establish comprehensive, gender specific services. This is particularly important since there is relatively little research on effective models for treating the cocaine abuser and polyabuser, especially women who abuse these chemicals. Both drug and child welfare goals are appropriate for chemically dependent women. Recovery from dependency does not automatically produce an improvement in parenting skills. Older children placed in foster care of recovering chemically dependent mothers, for example, have to adjust to reunification and a new parenting style. This is stressful for both the parent and the children.

The disincentives to seeking drug treatment and prenatal care must be addressed. The fear of prosecution, incarceration, and loss of custody of her child, can discourage the pregnant chemically dependent woman from seeking services, which exacerbates the risks of poor outcomes for both mother and child. Women who voluntarily seek services should not be subject to criminal sanctions. The punitive policy of prosecution may serve political purposes but is inconsistent with social work goals of supporting families.

Until prevention strategies demonstrate their effectiveness and efficiency, early identification, and referral remain one of the best methods for protecting children. Child welfare workers are in a unique position to provide this service since they are one of the very few providers which visit parents in their own homes. The children of some chemically abusing parents may not be in imminent danger of abuse or neglect or there may be a lack of evidence to substantiate maltreatment allegations. The trained worker can still provide a vital service by identifying parents in need of drug evaluation and referring these parents to drug treatment agencies.

Chemical abuse is a serious problem. Effective intervention requires a perspective in which chemical abuse is viewed as a symptom of other problems, all of which need attention. Historically, chemical abuse has been regarded as a primary problem and not as a symptom of other problems. This is due to a number of factors. The chemically dependent are viewed as suffering from an illness, either physical or emotional, or as suffering from a character flaw. The ecological perspective views chemical abuse as one element in the life of the individual. Chemically dependent parents have multiple needs and drug treatment is one important need. The environment has been unresponsive to these multiple needs and may have actively contributed to negative outcomes such as chemical abuse. Intervention requires an assessment of the environment and the capacities, resources, and needs of the individuals.

Chemically abusing parents can be difficult to locate and engage, and they may be suspicious of the worker and the agency. Their extensive service needs require the skills of an accomplished case manager to locate, develop, evaluate, and coordinate the interdisciplinary elements of a comprehensive program. Environmental and psychosocial variables which can exacerbate or mitigate the negative effects of chemical abuse must be identified and are an essential element in designing intervention programs. Intervention programs include assistance with transportation, housing, education, job training, parent education, respite care, family life and child development education, social activities, crisis nursery, counseling, drug and mental health treatment, and health care.

The chemically abusing parent challenges the expertise and resources of child welfare agencies. Failure to respond proactively and offer accessible, coordinated services will prove costly. Medically fragile infants whose homes are threatened by parental chemical abuse are straining the medical and social welfare system. As these chil-

dren age, they will need extensive remedial services from the education, medical, juvenile justice, mental health, and child welfare systems. Increasing numbers of young, minority children will continue to enter the foster care system. One inexpensive method for limiting these social and financial costs is to provide drug treatment targeted at women and combined with health care, especially prenatal care.

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