

Implications for the Drug-Endangered Child (DEC) in Head Start

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Presenters: Catherine Nolan, Holly Hopper

- **History of Federal Substance Abuse Initiatives**
Catherine Nolan
- **Community–Research Partnerships in Crafting a Best-Practice DEC Response**
Holly Hopper

Nolan: The Children’s Bureau efforts over the last 10 years to address substance abuse treatment and child welfare by promoting partnerships between the two fields were discussed. The focus was specifically on the issue of methamphetamine addiction.

The Children’s Bureau is embedded in the Administration on Children, Youth and Families, which is within the Administration for Children and Families, which is in turn part of the U.S. Department of Health and Human Services. The Adoption and Safe Families Act, which passed in the late 1990s, included a clause indicating that the Children’s Bureau would be responsible for submitting a report to Congress on the issues of substance abuse and child welfare, including a discussion of the barriers to communication between the two domains. The resulting report, *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, was issued in April 1999. It included five sets of recommendations each for localities, states, and the federal government.

After the report was published, a national meeting was hosted among various stakeholders, to discuss the report and work together to plan next steps. There was clearly an issue regarding communication among different groups. For instance, substance abuse treatment providers used different confidentiality regulations than child welfare providers.

The Children’s Bureau also entered into an interagency agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA), which is also part of the U.S. Department of Health and Human Services. In 2001, a series of four regional meetings were hosted throughout the country, with the goal of team building and developing action plans to implement at the state level. Some groups were already quite advanced in their collaborative work and were already evaluating their efforts, and others had never worked together before. Regardless, at the end of each meeting each group had developed an action plan.

It became clear that states and communities needed technical assistance to support their efforts. In response, the Children’s Bureau provided \$450,000 to \$500,000 per year to SAMHSA to run a National Center on Substance Abuse and Child Welfare. The center is managed by the Center for Substance Abuse Treatment under the direction of Dr. Nancy Young, who is a nationally renowned expert regarding the intersection of child welfare and substance abuse.

The Children’s Bureau also started a discretionary grant opportunity called Quality Improvement Centers. The centers were asked to focus on a topic that was relevant to their region, with

flexibility given in defining “region.” For example, one applicant defined their region as the state of Virginia. The Rocky Mountain Quality Improvement Center, which was organized by the American Humane Association in Denver, defined their region as several states. They funded four local projects, and their main concern was engagement and retention of clients who are involved in both the substance abuse and the child welfare systems.

Another discretionary grant activity provides funding for sites to create a model to implement the Child Abuse Prevention and Treatment Act requirement. Under this requirement, hospitals that become aware of substance-exposed newborns must notify the local child protective services agency, which works collaboratively with health care staff to devise a safety plan and ensure that supports are in place for mothers and their babies. Model development is underway, with evaluations planned in 4 years’ time.

The Children’s Bureau also created the National Resource Center for Child Protective Services, which serves as a source of information, consultation, and technical assistance to those people working in the areas of substance abuse and child welfare. The center’s main mission is to support the training of state and local child protective services agencies and workers on the topic of substance abuse, with a focus on safety and safety interventions. It has also compiled an extensive resource list, including various publications and studies addressing the issue of methamphetamine addiction, treatment, and outcomes. Additionally, it has developed two papers on safety interventions for methamphetamine-using families and methamphetamine-using caregivers.

Research from SAMHSA indicates that treatment outcomes for methamphetamine do not differ from other drugs; quantity and the quality of treatment are more important than the type of drug. Recent studies have found no deficits in motor function, memory, learning, attention, or executive function in methamphetamine users after 4 years of abstinence. Positive treatment outcomes can be achieved with specific treatment modalities, including intensive outpatient, cognitive behavioral approach, motivational interviewing, and brief intervention models. Compared to previous epidemics of different kinds of drug use, the typical methamphetamine user is much more likely to be a female of childbearing age; 18- to 25-year-old women are the largest group of methamphetamine users. The implications for child welfare are enormous because of the risks due to prenatal methamphetamine use.

Hopper: Various issues relating specifically to the methamphetamine epidemic were discussed, including successful partnerships that can address this complex issue.

DEC is an acronym for drug endangered child, a term used to describe children who experience physical harm or neglect from direct or indirect exposure (prenatal or postnatal) to misuse of illicit or diverted drugs, as well as children who live in homes where illegal drugs are manufactured or produced.

Children’s exposure to methamphetamine in the home was described. Children are exposed through airborne toxins as a result of methamphetamine production in the home and parents smoking the drug. Children may be present while methamphetamine is being cooked, or they may help their parents during the production process. They are also exposed through ingestion

because of tainted food and toys in the home environment. Health hazards can persist in production sites from residual methamphetamine. Many prescription drug abusers will inject drugs instead of smoking them because as the addiction progresses, the main objective is to get the drug into the body as quickly as possible to get the reward. Addicted parents expose their children to needles potentially contaminated with Hepatitis C or HIV.

Urine is an important identification tool for children exposed to methamphetamine; 80% of children who are tested within 12 hours of exposure will test positive for methamphetamine and 35% will test positive for heavy metals. It is also important to be aware of what children do and say, which might give clues regarding their parents' drug problem. If they have seen someone use drugs, they may mimic those behaviors in their play. Other signs indicating possible methamphetamine exposure include a disheveled appearance, wearing the same clothes on consecutive days, a particular body odor associated with methamphetamines, and skin injuries (bruising or open sores) due to active lithium in the body.

The consequences of living in a methamphetamine home were illustrated. Because their parents behave unpredictably, children living in drug homes do not have the benefit of living in a stable environment that will nurture their emotional development and attachment, which is crucial in the early years. As a result, preschool-aged children can suffer clinical depression. However, it is important not to diagnose children who have normal reactions to these unsafe methamphetamine environments by displaying adult psychiatric disorders, such as bipolar disorder or ADHD. Children whose parents have irregular behaviors respond by also displaying irregular patterns. It is important to consider how children's home environments might be influencing their behavior. These children also experience oral neglect issues, due to consuming sugary beverages and junk food and not maintaining proper oral health. Drug-exposed children may experience various behavioral difficulties, including depression, anxiety, attachment disorders, decreased attention, difficulty adjusting to change, and interpersonal problems. Eating abnormalities may result if they are consuming tainted food at home that upsets their stomach. They may also hoard food because they are not fed on a regular basis at home.

Parents may also trade children for drugs. Children in these homes may be exposed to emotional, sexual, and physical abuse, pornography, and weapons in the home. Parents may disconnect smoke detectors. There may also be standing water, posing a potential risk of drowning. When children reach age 2 or 3, it is developmentally normal for them to test boundaries. However, some children in these homes do not explore their boundaries because they know that they may become injured.

Children in drug homes learn that love is conditional. They are aware that in order to be accepted in their own home, they must contribute to their parents' drug dependence by, for example, shoplifting or being a lookout for law enforcement officers.

Developmental outcomes among prenatally exposed children were described. These infants exhibit poor tone and have trouble feeding. During the first week of life, infants experience sleep disturbance and sleep 23 out of 24 hours per day, putting them at an increased risk of failure to thrive due to poor nutrition and dehydration, as well as an increased risk of Sudden Infant Death Syndrome. Their mothers also often perceive them to lack an attachment bond. Preliminary

research indicates that the patterns of sleep disturbance during the first 3-week period are related to dopamine levels. According to the research of Rizwan Shaw, MD, swallowing may be problematic as infants age, therefore speech and language therapy is important for these children.

Researchers have identified a “honeymoon” period that occurs between 18 months and 4 years of age. During that time, children appear to be asymptomatic. Children who have been identified as exposed or at risk and who receive services during that time seem to do well after 5 years, and within a couple of years, they can meet normal standards of development. However, children whose services cease because they appear asymptomatic can begin to display various delays (e.g., speech and language, central nervous system effects, learning retention) at the age of 5 years.

Gestational exposure increases the risk of poor neural developmental outcomes. Interestingly, prenatal marijuana use is associated with the greatest long-term learning effects compared to all other drugs. The risk increases with number of prenatal exposures and current drug use in the home. If mothers continue using drugs in the home, then the delays increase.

Methamphetamine-using mothers are the least likely to stop using during pregnancy, but typically show a decline in use of other drugs during later pregnancy. It appears that there are some similarities between cocaine and methamphetamine effects on the human placenta. Prenatal health status of cocaine- and methamphetamine-using mothers is similar in terms of high blood pressure, infant low birth weight, decreased uterine-placenta blood flow, premature labor, and placenta abruptio, which can cause early labor and/or low birth weight. Placental damage is also related to central nervous system damage. Obstetricians who provide prenatal care and discover these damages are faced with both addressing substance abuse issues and ensuring that mothers continue receiving prenatal care. Referrals to drug treatment must be made as early as possible, and physicians must be aware of referral sources.

Much work remains to be done regarding long-term effects of environmental exposure to methamphetamine production. However, it is known that 48% of children who experience trauma have learning difficulties within 1 year of the event, even if they were not previously diagnosed as learning disabled. Cocaine, benzodiazepine, methadone, and methamphetamine exposure among young children is related to seizures, ear infections, rashes, constipation, and delayed treatment of injuries. Constipation is a sign of child sexual abuse as well as a sign of drug dosing; parents may give children opiates to make them sleep, which causes constipation.

Strategies for addressing the problem of methamphetamine homes were delineated. Multidisciplinary teams are essential, including law enforcement officers, trained school counselors, hospitals, nurses, dentists, and the health department. These partnerships help guide child protective workers to properly respond when they become aware of methamphetamine-exposed children.

Training first responders helps them be more effective in dealing with situations where children may be exposed to drugs. Law enforcement officers learn to consider the children in the home before they raid the home. They may deliberately schedule a bust while the child is in school, so that they do not get caught in the middle. Training also explains to teachers how to report

suspected cases of drug-endangered children. Rather than voice a general concern, they are able to identify signs of possible exposure, which can be followed up. Physicians may be a challenging group with whom to work because of the high claims on their time. However, medical professionals are key partners in the community, particularly when they become involved in research on the issue.

Two-year-old drug-exposed children take less social initiative and their mothers are less likely to vocalize or offer toys because they do not know how to play with and engage their children. Maternal sensitivity and positive vocalizations are also less frequent among low-birth-weight children. In response, the University of Kentucky, College of Social Work, Department of Psychiatry has developed a program called Comprehensive Assessment and Training Service (CATS), which teaches parents how to play with children, as well as why play is important and how to build attachment. The program also addresses the guilt that mothers may feel for causing their children's developmental delays, which may lead them to be less engaged.

The Appalachian Regional Commission has awarded a grant to support the Drug Endangered Child Training Network, which provides training to Child Protective Service workers on medical and social issues. This network aims to (a) improve physical and emotional protection of children; (b) break the cycle of child abuse; (c) protect exposed children's health; (d) establish community protocols through cooperation, information sharing, and case coordination; and (e) restore families.

The Drug Endangered Child Training Network also provides technical assistance to local groups who are assembling multidisciplinary teams. Partnerships are essential, and teachers, child care providers, and Head Start teachers can be advocates for children. The Network has developed a public awareness campaign, as a result of multiple focus groups. It provides a phone number for reporting child abuse, as well as a toll-free phone number for adult drug treatment referrals. Addiction assessments and treatment vouchers are available. 1-800-CHILDREN is a phone number operated by Prevent Child Abuse Kentucky, which people can call for referrals or simply talk to somebody.

Teachers can often accurately predict which children will be at risk for drug use when they become older. Their input can help determine which services to provide to at-risk children. Children from drug homes may be bored in the classroom, particularly if they have a learning disorder or a developmental delay. From the adolescent addiction literature, boredom has been shown to be a sign of future addiction risk. This, in combination with early home exposure to drugs, may lead to drug abuse in children. Schools are key settings for the delivery of preventive mental health interventions for children. Children may feel responsible for parents' substance abuse and problems, and they may equate substance abuse with not being loved. They may know of adults who have overdosed and died. They may be ashamed or embarrassed by their parents' behavior.

Discussion and Audience Comments: Audience members shared their experiences with addressing methamphetamine exposures among children. Efforts included providing training to Head Start staff, partnering with realtors' associations who inspect apartment for

methamphetamine laboratories, and reaching out to high school youth leadership groups to encourage them to develop methamphetamine awareness programs aimed at middle schools.

Session participants discussed the anecdotal evidence, which indicates that many communities are overwhelmed by the methamphetamine epidemic, and are unable to provide sufficient treatment resources, causing parents to lose custody of their children. The methamphetamine epidemic is unique among other drug epidemics because it is more prevalent in rural regions than urban areas. Rural areas have fewer resources (including staff) to address the issue and they have larger geographic expanses to cover. There is a need to increase support to these areas, including increasing access to and availability of dental health, mental health, and physical health services.

Another unique feature of the epidemic is gender. For most drugs, particularly heroin and cocaine, the more common users are male, but many methamphetamine users are young women between the ages of 18 and 25 years. Methamphetamine causes frenetic activity and a lack of interest in food so a common reason for initiating use is weight loss.

Most parents care about their children and do not wish to harm them, but they may not be aware that exposure to drugs delays children's development. Public education is crucial in communicating these facts to drug-using parents. The National Resource Center for Child Protective Services has developed two papers regarding methamphetamine use in families and safety interventions. They are available on the center's website: <http://www.nrccps.org>. In addition, the U.S. Department of Health and Human Services has a methamphetamine website with various resources.