

Master Workshop

Identifying and Responding to the Needs of the Drug-Endangered Child

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The risk of injury and harm that may occur to children living in drug homes, particularly those exposed to methamphetamine, was presented. Developmental, behavioral, and emotional effects of drug endangerment were explained. Major research findings and future research needs were highlighted. Opportunities to respond to children's needs were discussed. A video was screened, featuring a husband and wife who were recovering methamphetamine users. They described their experiences producing and using the drug. More information can be obtained at www.drugendangeredchild.org. The website includes various resources, such as trainings and downloadable materials.

A drug-endangered child experiences physical harm or neglect from direct or indirect exposure to illicit or diverted drugs such as methamphetamine, as well as cocaine and marijuana. The methamphetamine production process is highly toxic, exposing individuals to over 200 toxic chemical combinations. Components of methamphetamine labs are often common products stocked under kitchen sinks. There are both acute and chronic risks from methamphetamine exposure, such as breathing difficulties, rashes, or burns due to explosions. Chronic exposure is also dangerous because many methamphetamine components are known carcinogens, but long-term risks of these exposures have not yet been determined.

Endangered children may experience developmental delays, depression, attachment disorders, malnutrition, and failure to thrive as a result of a lack of nurturing and emotional response. Several risk factors in the home, including marital conflict, parental psychopathology, and poor parenting practices, are the strongest predictors of negative mental health outcomes, particularly when they co-occur. Children are exposed to multiple risk factors that lead to a synergistic effect. Four percent of children nationwide are victims of child abuse and neglect. Of these children, 60 percent are victims of physical, educational, and emotional neglect. A majority of all neglect cases and abuse cases are drug-related. Secure attachment occurs when there is a sensitive caregiver; insecure attachment occurs when parents, such as drug addicts, or emotionally uninvolved. Children who are environmentally exposed to the production and smoking of methamphetamine may also exhibit depression symptoms that may be caused by depletion of the neurotransmitter dopamine.

Traumatic experiences change the psychological structures of the brain, which involve personality and the ability to regulate emotions. Posttraumatic stress disorder may occur among children, particularly when loud noises, dangerous people, and weapons are in the home. Children may recall traumatic events for many years after they are removed from the danger. These children are also at significant risk of failure to complete school and of addiction when they get older. Much remains unknown about the long-term chronic effects of exposure; however, 48 percent of children who experience trauma have learning difficulties within the year following that event.

Children may also be prenatally exposed to drugs, resulting in central nervous system

damage. Drug-using mothers suffer from high blood pressure, premature labor, and ruptured placenta. Low-birth-weight babies are common. The impact of drug use on the infant depends on the length and quantity of use. Gestational exposure increases the risk of poor neurodevelopmental outcomes of all types. Marijuana is associated with the greatest long-term learning effects.

Many children in these situations do not have food or home security. Failure to protect occurs in a number of ways. Parents may loan their child out for a few hits of a drug, and there is an increasing rate of child sexual abuse in this population. In addition, emotional abuse occurs on a regular basis and is extremely damaging to children. These children do not have a regular routine at home, and dangerous people come in and out of their homes. There are loaded guns in many of the homes. Housing may be unsafe and poorly ventilated. Electricity may be disconnected and there may not be running water. Methamphetamine produces 5 to 7 pounds of waste for every pound of product; one hiding place for that waste is the child's play area. Dangerous animals may be kept around the home, in order to protect the drugs within. If drugs are injected, children are exposed to Hepatitis C and HIV risk from dirty needles.

The number of abused children in this country could be significantly reduced if addiction problems were addressed. Parents do not notice their child's health problems when they are high. Furthermore, they may not take their child to the emergency room or to a physician if it poses a risk of their drug problem being discovered. When addiction occurs, drugs become the parents' top priority. As a result, children can be forced to participate in illegal activity either by shoplifting or by being a lookout, because they quickly learn that if they are not contributing to the drug activity in the home, they have no place in that home. They become skilled at lying and stealing and they are also highly informed about drug use. They may be skilled at rolling joints, mixing drinks, and handling needles.

Some common physical complaints and observations might indicate exposure to methamphetamine among children. When methamphetamine is cooked in the home, food will test positive. Tainted food causes diarrhea, vomiting, and upset stomachs. Anorexia is another symptom of exposure to methamphetamine because it decreases children's hunger and therefore they do not eat. Children may also smell like unusual chemicals, causing eye irritation or difficulty breathing in individuals near them. There may be patterns of anxiety and crashing, such that children may easily switch from being energetic, agitated, then sleepy.

Some symptoms presenting in emergency rooms or medical offices include vomiting, agitation, crying, stomach pain, burning eyes, burning or tingling skin, ear infections, rashes, increased blood pressure, and hyperactivity. Seizures may also occur. If a child has a seizure but no history of seizure, it is important to obtain urine samples to test for cocaine, benzodiazepine, and methamphetamine. Constipation can also be a sign of sexual abuse, a co-occurring issue for many children.

Teachers should be encouraged to report children perceived to be at risk. The best prevention occurs through the protection of children. The earlier children are identified and placed in a safe environment, and the earlier they receive developmental testing, follow-up care, and comprehensive health and mental health services, the better opportunity children will have to

be successful in school. It is recommended that developmental screening occur within 72 hours of the intervention, and partnering with First Steps, Early Head Start, Head Start, and other programs that have these resources can help to obtain a timely screening. Children under 5 years of age undergo rapid development, so they must be monitored for any neurocognitive impairments, or speech and language delays. Once identified, interventions must be immediately and continually provided.

Unfortunately, although teachers are most likely to report abuse, they are the least likely to elicit a response. Information included in a child abuse report should primarily focus on factual observations. Observing a single symptom may not be indicative of methamphetamine exposure, but observing a cluster of symptoms is cause for concern. It is also important to consider the parents' behavior, such as sleeping through the mornings so that their child is either absent from or late to school. The presence of methamphetamine labs is linked with an increased risk of domestic and community violence. This poses an additional risk to officers, home visitors, or child protective service workers who enter these homes. Most child care providers are not involved in a crisis intervention, but they should be aware of what it entails, should they need to care for a child who has experienced it.

The ideal training scenario in communities would consist of a protocol for every agency, including childcare providers. Developmental assessment should note prenatal drug exposure. This information is considered protected medical information, requiring special paperwork or agreements in order to be shared, but it is crucial for teachers to be aware of children's prenatal drug exposure in order to optimally support them. Proven best practices are needed. It is important to meet regularly to discuss a case, ensuring that everyone involved understands others' roles in the care of the child. Tracking systems are useful as well because drug-abusing families tend to be transient. Partnerships for success in child protection include narcotics investigators, child protection workers, law enforcement, community mental health centers, and coalition groups.

Users often do not want to quit because they do not see a problem with their drug-using behavior. Any guilt they may have regarding the impact on their child can easily be alleviated with another hit of a drug. Forced treatment is effective, but treatment and recovery is terrifying for people. Treatment occurs over a 28-day period of time, which most people can suffer through. But recovery lasts for an indefinite time and is physically painful. Depression levels can dip so low that people feel like they must either use drugs again or commit suicide. There is a high rate of suicide in methamphetamine addicts who attempt to recover. The dopamine depletion exists for 18 to 24 months. After that point of time, the brain begins to repair itself. There is evidence that within 4 years, recovered users can return to normal.