

SUBSTANCE ABUSE

INTERVENTION WITH SUBSTANCE ABUSING FAMILIES

—by Robert T. Kinscherff and Susan J. Kelley

Maternal use of drugs and alcohol during pregnancy and child rearing is one of the most significant contemporary problems facing professionals in the field of child maltreatment. Fetal alcohol exposure is the "leading cause of mental retardation in the Western world" (American Medical Association, 1989). The National Institute on Drug Abuse estimates that six million women of childbearing age use illegal drugs, with one million using cocaine (Office of Inspector General, 1990).

Of particular concern is the dramatic increase in cocaine use among pregnant women (MacGregor, Keith, Chasnoff, et al., 1987; Zuckerman, Frank, Hingson et al., 1989). Nationwide, it is estimated that at least 100,000 infants are born annually who have been exposed prenatally to cocaine (U.S. General Accounting Office, 1990). Frank, Zuckerman, Amaro et al. (1988) examined the use of cocaine during pregnancy in a sample of 679 urban women in Boston who were enrolled in prenatal care and found that 17% of the sample used cocaine at least once during pregnancy. In New York City the rate of all drug affected births has more than doubled since 1981, primarily due to increased use of cocaine (Habel, Lee, and Kaye, 1988). And since 1983, cocaine affected newborns have exceeded opiate affected newborns in New York City (Habel, Lee, and Kaye, 1988). The arrival of "crack" cocaine has dramatically altered the picture in substance abusing families. In contrast to the predominance of men among the addicted population when heroin was the drug of choice, women currently abuse crack cocaine at a rate at least equal to that of men (Daro and Mitchell, 1990). Crack cocaine possesses a combination of two dangerous characteristics: it is highly addictive and relatively inexpensive. Furthermore, users of crack cocaine are typically users of other substances to which the fetus is also exposed during pregnancy.

Although to date no studies have established a cause and effect relationship between maternal substance abuse and child maltreatment, children in substance abusing families are clearly at increased risk for child abuse and neglect (Massachusetts Department of Social Services, 1989; Kelley, Walsh, and Thompson, 1991; Kelley, in press; Famularo, Kinscherff, and Fenton, in press; Chasnoff, 1988; U.S. General Accounting Office, 1990; Famularo, Kinscherff, Bunshaft, Spivak, and Fenton, 1989; Murphy, Jellinek, Quinn, Smith, Poitras, and Goshko, 1991). It is estimated that 675,000 children are seriously mistreated annually by an alco-

holic or drug abusive caretaker (National Committee for Prevention of Child Abuse, 1989). Yet a recent national survey of state child protective services agencies revealed that only fourteen states (28%) routinely collect information on substance abuse (Daro and McCurdy, 1991). Rates of substance abuse in these states ranged from 5% to 78% of confirmed cases of child maltreatment, with the average being 40%. Nineteen states now require that medical personnel and others report drug exposed infants to child protective services (Daro, and McCurdy, 1991).

The dramatic rise in drug abusing parents has placed a serious strain on an already overburdened child protective service system. The demand for foster care nationwide has increased nearly 30% from 1986 to 1989, and is attributed to the increased number of substance abusing families (U.S. General Accounting Office, 1990). In Washington, D.C., during that period, parental substance abuse generated a 58% increase in the number of children placed in foster care (National Committee for Prevention of Child Abuse, 1989).

First and foremost, drug dependent parents must address their chemical dependencies.

A combination of characteristics of drug dependent mothers and drug exposed infants places the mother-infant dyad at increased risk for difficulties during a critical period for attachment. Problems common to drug dependent women, such as depression (Burns, Melamed, Burns, Chasnoff, and Hatcher, 1985; Kelley, in press), lack of confidence in parenting abilities (Kelley, in press), decreased attachment to their children (Kelley, in press) and feelings of guilt concerning their drug use during pregnancy (Griffith, 1988), place drug-dependent women at increased risk for parenting dysfunction. Characteristics of drug exposed infants, such as increased irritability and depressed interactive abilities, may pose special difficulties for their mothers.

Interventions

Drug treatment. First and foremost, drug dependent parents must address their chemical dependencies. In most instances, maternal use of drugs during pregnancy is not a temporary experimentation with drugs, but an enduring pathological dependence (Burns and Burns, 1988). Unfortunately, due to denial and fear, many drug affected parents refuse treatment. Others are unable to find treatment programs without long waiting lists. Women, especially pregnant women, need greater access to drug treatment programs. Unfortunately, many treatment centers are unwilling or unable to admit pregnant addicts. Many drug dependent women will not enroll in residential drug treatment programs because they do not

want to be separated from their children, or fear losing their children to foster care. Some mothers have no one with whom to leave their children voluntarily.

Drug treatment programs need to treat drug dependent mothers within the context of their family. A few innovative residential treatment programs do treat drug dependent women during pregnancy, then allow them to keep their infants with them after delivery in order to address issues related to parenting and chemical dependency. Substance abusing parents may benefit from self help groups such as Narcotics Anonymous and Alcoholics Anonymous. Research is needed to demonstrate the efficacy of drug treatment programs with substance abusing parents.

Predominant types of drug use vary geographically and over time. Studies indicate that although cocaine is currently the most commonly used illicit drug, most substance abusing mothers are actually polysubstance abusers (Kelley, Walsh, and Thompson, 1991; Kelley, in press; Famularo, Kinscherff, Bunshaft, Spivak, and Fenton, 1989; Murphy, Jellinek, Quinn, Smith, Poitras, and Goshko, 1991). It is important, therefore, to elicit careful, detailed histories of drug and alcohol use during pregnancy and childrearing. In addition to determining which drugs are used, it is important to determine the amount and route of administration. Women who use crack cocaine or intravenous drugs are usually the most severely affected by their drug dependency. In a recent study of cocaine exposed infants, 21% of their mothers were found to be intravenous drugs users (Kelley, in press). Maternal use of intravenous drugs greatly increases both the mother's and infant's chance of contracting the human immunodeficiency virus.

Psychological evaluation and treatment. Many drug dependent women are moderately to severely depressed (Burns, Melamed, Burns, Chasnoff, and Hatcher, 1985). The use of stimulants such as cocaine may in some cases be an attempt to self medicate and escape feelings of low energy and depression. Therefore, while substance abuse counselling is important for recovery, a psychological evaluation and therapy are often warranted. Some times, addiction is an attempt to cope with the negative effects of childhood trauma. One study of childhood sexual abuse among patients in an inpatient substance abuse treatment program found that 75% of the female patients had a history of childhood sexual abuse (Rohsenow, Corbett, and Devine, 1988). Other characteristics of drug dependent mothers that place them at increased risk for inadequate parenting include feelings of guilt concerning the harm their drug use during pregnancy may have caused their infant, fear concerning their ability to cope with and successfully meet the demands of their child, and unrealistic expectations about their infants' competencies stemming from lack of basic knowledge regarding infant development (Griffith, 1988).

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Housing. Helping an addicted mother meet her own needs may give her the stability to better meet the needs of her children. The necessary help includes referral for concrete services such as day care, housing, health care, financial assistance, and transportation to appointments (Walsh, 1991). Drug using mothers are less likely than nondrug using mothers to have a stable place to live. In a study conducted by Kelley et al. (1991), 38% of mothers who used cocaine during pregnancy did not have a stable place to live. Twenty-one percent were homeless and living either in shelters or on the street; 10% were in inpatient drug treatment facilities; and 7% were staying with various relatives and friends without a permanent residence of their own.

Infant health care needs. Drug exposed infants need careful health care supervision. The relationship between retarded intrauterine growth and prenatal drug exposure has recently been well documented. Infants exposed prenatally to drugs are more likely than non-exposed infants to have low birth weight (less than 2500 grams, or 5 pounds, 8 ounces), to have decreased length and head circumference at birth, and to be born prematurely (MacGregor et al., 1987; Chasnoff, 1988; Zuckerman, Frank, Hingson, et al., 1989; Kelley, Walsh, and Thompson, 1991). Prematurity and low birth weight are considered risk factors for infant mortality and child maltreatment.

A recent study found that even when corrected for prematurity, cocaine exposed infants continue to have growth delays in early childhood (Kelley, Walsh, and Thompson, 1991). The cause for the growth lags may be environmental or related to poor prenatal care and drug exposure. Therefore, professionals need to monitor carefully the drug exposed child's weight gain to assure there is adequate caloric intake. In some instances, drug dependent mothers may be diverting money from the food budget to purchase drugs. Food stamps are often traded for drugs.

Drug exposed infants are more likely than nondrug exposed infants to be medically neglected (Kelley, Walsh, and Thompson, 1991; Kelley, in press). Drug exposed infants are more likely to be inadequately immunized against childhood disease, and their mothers are more likely to miss routine health care appointments and to misuse emergency departments for minor health care problems (Kelley, Walsh, and Thompson, 1991). Innovative approaches to providing health care need to be implemented, such as health care providers going to shelters for the homeless and battered women, and into welfare motels to conduct health assessments and provide immunizations for high risk children. It is useful to have visiting nurses in the home after discharge from the hospital and during the first year of life to monitor the child's and mother's health care needs.

Infant characteristics. Drug exposed infants are often irritable, difficult to console, tremulous, and have difficulties with feeding and sleeping. They often demonstrate depressed interactive abilities and significant impairment in organizational abilities on the Brazelton Neonatal Behavioral Assessment Scale (Chasnoff, Burns, Schnoll, and Burns, 1985; Griffith, 1988). Once past the newborn period, cocaine exposed infants continue to have very low thresholds for overstimulation and quickly achieve an agitated cry state in response to most types of stimulation (Griffith, 1988). Some mothers erroneously interpret their drug exposed infant's attempts to shut out external stimulation as personal rejection of them as mothers. This perceived rejection is thought to increase existing feelings of depression and low self esteem which may lead to ambivalent and sometimes hostile feelings toward the infant (Griffith, 1988). Therefore, mothers of drug dependent infants need to be taught how to interpret and respond to their infant's behaviors. For instance, an infant who avoids direct eye contact may be overstimulated and needs to be held quietly or placed in a crib.

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Mothers of drug exposed infants need to provide a darkened and quiet environment which will decrease irritability and the likelihood of the infant becoming overstimulated. The use of a soft infant carrier, in which the infant is carried chest to chest with the mother, is believed to have a calming effect on drug exposed infants (Torrence and Horns, 1989).

Drug exposed infants are perceived by their mothers, both biological and foster, to be more distractable, more demanding and less adaptable than non-drug exposed infants (Kelley, in press). Drug exposed infants are often stiff and difficult to cuddle and handle. In a study conducted by Kelley, Walsh, and Thompson (1991) 43% of cocaine exposed infants had hypertonia or increased muscle tone beyond the newborn period. Therefore, it appears that drug exposed infants may be more difficult to parent than non-drug exposed infants.

Protective removal and placement of the child. There are substantial risks to children associated with parental drug and alcohol use, co-morbid psychiatric disturbances, and inadequate shelter and other social supports. These factors, particularly when combined with the special challenges posed to some parents by their substance-impaired infants, result in significant rates of maternal stress and risk of serious child abuse and

neglect (Kelley, in press). While it is critical to provide adequate social supports to reduce family stress levels and risks associated with socioeconomic and lifestyle factors, it is also important to appreciate that substance abuse is associated with a higher risk of severe maltreatment of a child *independent* of the family's socioeconomic status (Murphy, Jellinek, Quinn, Smith, Poitras, and Goshko, 1991).

The stakes are high. Children who are left in severely maltreating families have a 40-70% chance of reinjury (Ferleger, Glenwick, Gaines, and Green, 1988) and a 5% chance of being killed (Schmitt and Kempe, 1975). On the other hand, unnecessary removal of a child can be traumatic for the child, devastating for a family that may already be marginally functional, and burdensome for child protective and foster care systems that are already overwhelmed.

Substance abuse constitutes a high risk variable among parents that have maltreated their children. Substance abusing mothers appearing before courts on charges of severe child maltreatment are much more likely than parents who do not abuse substances to have prior reports of child maltreatment, to be repeatedly before courts after child protective interventions, to receive higher risk ratings from independent court investigators, and ultimately to have their children removed permanently from their care by courts (Murphy et al., 1991). Clearly, drug and alcohol treatment facilities must be made more accessible to substance dependent parents and especially to pregnant addicts. However, there is little empirical evidence that current treatment techniques are reliably effective in the treatment of the chronic polysubstance and/or alcohol dependency characteristic of maltreating parents who come before the courts. While the optimal goal is to be "clean and sober," experience teaches that the more common course is one of repeated relapse with elevated risk of child neglect or abuse particularly during periods of relapse.

Furthermore, among substance dependent parents who do maltreat their children, the rates of treatment compliance are extremely poor. Where courts have ordered drug treatment services, high-risk parents with substance abuse problems are more than three times more likely to reject services than are other maltreating parents (Murphy et al., 1991). In one study, only 21% of parents referred by courts for substance abuse treatment attended even half of the sessions, and less than 10% attended two-thirds of the sessions. There was no difference between the rates of compliance by parents who abused alcohol and by those abusing other substances, but polysubstance abusers had the lowest rate of compliance of any group (Famularo, Kinsherff, Spivak, and Fenton, 1989).

Probably due to attempts to treat the drug or alcohol abuse prior to effecting permanent removal of the child, substance abus-

ing parents appear to be given more chances by child protective and court systems than do parents without chemical dependencies. Nevertheless, the data regarding poor treatment compliance, child reinjury, and ultimate permanent removal of a child from parental custody indicate that these extra chances do not contribute to improved long-term outcome (Murphy et al., 1991; Famularo et al., 1989).

With mounting competition for resources, clinicians and policymakers will increasingly have to consider how to deploy resources and focus interventions most effectively. One approach may be to divert resources from efforts to maintain children in high risk, poor prognosis families in order to pool more resources for families with a better outcome prognosis. Another approach may be to focus upon intensive monitoring and early intervention. These strategies often rely upon risk profiles, bringing families under scrutiny of child protective systems before there is firm evidence of substance abuse or child maltreatment. Therefore, programs stressing monitoring and early intervention must balance the financial and social costs of overinclusiveness against the benefits presumed to flow from this approach.

The greatest controversy surrounds the protective removal of children when there is initially an allegation or evidence of maternal substance abuse but no specific evidence of child maltreatment. State intervention in these circumstances triggers debates beyond the scope of this article regarding child or fetal rights versus parental rights, the appropriate role of clinical personnel, and the deployment of criminal or public health approaches to maternal substance use (Popovits, 1991; Bennett, 1991; Dougherty, 1985).

One increasingly common scenario involves taking custody of an infant that tests drug positive at birth, or shows signs of drug withdrawal shortly afterwards. In some jurisdictions a positive toxic drug screen is legally *prima facie* evidence of child maltreatment. Another common scenario involves removal upon allegations of child maltreatment where the parent is suspected of substance abuse, particularly when the substances involved are illegal, and there is also evidence of domestic violence, use of "crack" cocaine, and/or past or current criminal activity.

Proactive family scrutiny or child removal pending investigation under such circumstances assumes that substance dependence is a legitimate "proxy" strongly associated with other risk variables such as family violence, dissipated family resources, or exposure to criminality. Critics of this approach object to the use of correlational or probabilistic risk assessments to justify intruding into families in specific cases. They argue that "statistical evidence that a person demonstrates characteristics associated with parents who have abused or neglected their children should not be a basis for legal

intervention" or protective child removal in the absence of evidence of overt and clearly specified kinds of harm (Bowman, 1991).

Relying upon data drawn from families already before the courts because of allegations of severe maltreatment does not validate the use of substance abuse as a "proxy" for maltreatment among a population with no independent evidence of maltreatment. Particularly if reports of parental substance use or fetal exposure are to be used to trigger routine and intensive state intervention, further research is necessary in order to document if or under what circumstances parental substance dependence acts in the general population as a sufficiently powerful risk factor to warrant its use as such a "risk-proxy." Equally important is intensive research that documents what intervention strategies are actually effective in reducing parental substance use and child maltreatment.

In the absence of careful research and public policy planning, the responses of child protection agencies, prosecutors, clinicians, and courts will continue to be erratic. Responses of the legal system to parental substance abuse have varied widely, including criminal prosecutions, probation conditioned upon long-term contraception, incarceration through the completion of pregnancy, referrals for substance abuse treatment monitored by court-ordered urine screens, temporary or permanent removal of children, dismissal of cases because parents cannot be charged under existing law, and enrollment in comprehensive medical-social rehabilitation programs.

In summary, standard evaluation of parent and child must include assessment and appropriate referrals involving these areas: (a) general physical and dental health; (b) drug and alcohol exposure and use; (c) maltreatment history; (d) psychiatric history and differential diagnosis; (e) social welfare and child protection history and current needs. Development of effective and coordinated case management and monitoring strategies are imperative.

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