Substance Exposed Babies

Some limited data is available for Virginia. A statewide survey of pregnant women seen by the Virginia Health Department was done in August 1990. One hundred twenty clinics (80 percent of the total) responded to the survey. These clinics estimated that 9,740 pregnant women were being served. The prevalence of substance use for these pregnant women was 71.8 percent (for cigarettes, 24.8 percent for over-the-counter drugs, 14.5 percent for alcohol, 9.4 percent for prescription drugs and 6.5 percent for illegal drugs). Additionally, 11 percent (209) of women referred to BABYCARE (high-risk program) were referred due to substance abuse. The Virginia Health Department also surveyed their 13 Child Development Clinics. Of the 1,371 infants and children under age 5 tested last year, 59 had fetal alcohol syndrome, 63 showed fetal alcohol effects and 133 had developmental delay due to maternal drug use. Sixteen of the 157 infants had a history of neonatal withdrawal syndrome. Clinics reported that referrals by caseworkers for grandchildren who knew or suspected parental drug abuse was a growing...
Virginians for Child Abuse Prevention

Merger of SCAN and PA

April is Child Abuse Prevention Month

April will again be declared Child Abuse Prevention Month by Governor Wilder. Senator Joseph Garلان, a foremost child advocate, is the Honorary Chairman of Prevention Month. The Blue Ribbon Campaign is being promoted to raise awareness about child abuse and neglect and how it can be prevented. Readers of VCPN are urged to wear a blue ribbon on their laps during April.

Spider-Man will tour Virginia making appearances at schools, parades and community centers in Northern Virginia, Fredericksburg, Richmond, Tidewater, Roanoke and Winchester. Marvel Comics and NGPCA have developed a new Spider-Man comic to prevent physical abuse.

New prevention materials developed by SCAN and now available to child advocates are: "Self Esteem Tips for Parents, Teachers and Children," "Grocery and Shopping Center Tips to Help Children Behave," and "Report Card Tips!" in Spanish, Farsi, Lao, Vietnamese, and Korean. To receive a copy of these materials please send a self-addressed-stamped 6 inches by 9 inches envelope to Virginians for Child Abuse prevention, 2222 West Main St., Richmond, VA 23220.

ADVOCACY MESSAGE
Children cannot advocate for themselves, so it is crucial now for all of us who care about them to make our voices heard. Think of how many discussions and meetings you have attended where you have not once heard the word "child" mentioned — yet their welfare was being affected by the decisions being made. We need to be the people in Virginia asking the vital questions... WHAT ABOUT CHILDREN? HOW WILL THIS AFFECT THEM? Please join us in advocating for those who cannot.
Specific drug effects have, in many cases, been difficult to assess. Some are addictive, some are toxic, and some are non-specific (causing acute changes, such as altering neurological pain thresholds or resulting in anatomical changes in the cardiovascular system). Symptoms may be seen immediately or may not be seen until a specific developmental stage, such as in childhood or even adolescence. (Chasnoff, 1986; Hill & Kleinberg, 1984; Waltzer et al., 1987) A complete list of symptoms must prevail before the specific teratogenic effect becomes real. Not only the drug... is important. Timing and frequency of administration, as well as genetic and maternal susceptibility of the embryo are important factors." (Hill & Kleinberg, 1984, p. 707)

Several drugs are implicated as problems for the fetus. Cocaine is the newest. However, equally important are heroin, alcohol and nicotine.

Cocaine
Cocaine is a powerful central nervous system stimulant. It is a white powder made from the leaves of the South American coca plant. It is often "snorted," resulting in a high of only about two minutes before effects are felt. Low doses produce a feeling of euphoria, intense well-being, increased energy and self-confidence. The effect is short-lived and is sometimes followed by an emotional and physical depression. Users are motivated to use cocaine again to regain that feeling of well-being.

"Crack" is formed by mixing cocaine with water and another substance, usually baking soda, and cooking it until it forms a rock. This rock is then smoked. The effects of "crack" are the same as the effects of cocaine, except that "crack" reaches the central nervous system much faster. It is this sudden, intense feeling of euphoria combined with the "crack" after the effects of the drug make this drug so reinforcing to the user. "The road to addiction is short... People often snort cocaine for a year or two before getting addicted. Those who smoke crack can become addicted within a few weeks or months." (Kopelman & Jones, 1989, p. 13)

If a woman is using cocaine during pregnancy, there are significant risks to the fetus. Cocaine enters the blood stream of the fetus. It is partly metabolized in the liver. Since the fetus is immature, and since other metabolic systems are poorly developed, it can take the fetus much longer than an adult to metabolize the drug. In addition, the metabolites are more soluble, making it difficult for them to pass through the placenta to the mother's system for more rapid excretion. "Therefore, it is not surprising that it is often takes five to 10 days for the urine of the nonuser to be cleared of cocaine and its metabolites as compared to approximately 48 hours for an adult." (Chasnoff, 1987, p. 7)

There appears to be some controversy about the effects of cocaine on the infant. Populous belief in the media is that the child is being addicted and that when the baby will experience withdrawal. However, some medical professionals dispute that belief. "If the baby has withdrawal problems, they are minor compared to heroin. Medicinally, withdrawal is not the problem." (Hill & Kleinberg, 1984, p. 707)

Robert Boyle, M.D., neuropathologist at the University of Wisconsin, makes comments that support this position. Increased rates of prematurity are a problem. We have all the medical problems with cocaine babies that we have with any other pre-term baby."
Substance-Exposed Babies

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McGregor, et al., 1987; U.S. Department of Agriculture, 1990; U.S. Department of Health and Human Services, 1989; On the Bradenton Neonatal Behavioral Assessment Scale, a test for an infant's interactive abilities and neurological status, cocaine-exposed infants show poor interactive ability and poor self-regulation. These infants are characterized as irritable, hyperactive infants who are easily overstimulated. They demonstrate poor quality of movement (tremors) and feeding problems may occur due to the abnormal tone and movement patterns. Parents often view these infants as demanding and unresponsive to the parent's attempts to comfort them. (Schneider & Chasnoff, 1987, p. 62)

Very recent research led by Irk Chasnoff, M.D., suggests that cocaine babies display a problem in organizing their environment regardless of timing of cocaine intake.

"During the first year of life, when the young child is not yet able to distinguish directly from direct or indirect effects of cocaine. They found that the excitability of the baby's crying patterns results from the direct effects on cocaine on the fetus, while the depressed behavior results from the indirect effects and is related to low birth weight." (Adler, 1990, p. 14)

Another very recent study by Barry Laster, Ph.D., suggests that drug-exposed infants have a different development pattern than non-exposed infants. Further evidence that suggests that patterns may be different depending on the degree of exposure to cocaine. (Laster, 1990)

"Whether the effects are direct or indirect, whether they are due to the drug or to related factors such as poor nutrition, the costs to the public are the same. The costs of care for these newborns skyrocket. Larry Jackson, commissioner of the Virginia Department of Social Services, speaking at the Virginia conference in December 1990, detailed the tremendous impact that substance-exposed babies impose. "We must work together to find a way to deal with high-technology care. The costs for care for drug-exposed babies can be four times as much as for babies without exposure." Long-Term Effects

Regardless of cause, the short-term effects and resulting costs are wanting to be documented. What are the long-term effects to the child of cocaine exposure? It is too soon to tell. Longitudinal studies are just now under way and the inability to separate cocaine use from variables such as poly-drug exposure, prenatal and postnatal nutrition, poverty, and environment make studying the problem very difficult. "Available data is limited to infants up to 2 years old," explains Myers. "What we know so far is that a small number of children show significant developmental problems and another small number show subtle developmental problems. Many show no problems at all. Most cocaine-exposed infants are no different than other infants." Other researchers disagree. Howard and Beckwith (1989) note that effects of prenatal drug exposure are found in a continuum from infant death to more subtle behavioral effects. They feel that developmental and intelligence tests alone are inadequate for assessment. Control groups of non-exposed, pre-term (low birth weight), and infants born to marital and non-marital ethnic and low socioeconomic environments were compared with drug-exposed toddlers. The drug-exposed children scored significantly lower than controls on standardized developmental tests, but scores were still in the low-average range. The extreme deficits become apparent only in free play situations where the drug-exposed children showed striking deficits in self-organization, self-initiation and ability to follow through without assistance. Behavior characterized by disinhibition and poor quality speech was found in a number of measures.

Thus, prenatal drug exposure is likely to compromise social development in the organization of relationships, cognitive development because of lack of sustained interest and exploration, language development because of lack of representation, play, and emotional development because of lack of mood (affect) regulation. Howard and Beckwith predict "an increasing impact on educational, medical, social welfare and justice systems." (1989, p. 12)

With the crack epidemic 5 years old, educators are being themselves for the influx of cocaine-exposed infants into the educational system. Articles such as "The Shadow Children" which first appeared in The American School Board Journal (1990) make statements such as: "The arrival of these children will aid us in understanding the beginning of a struggle that will have your resources depleted and your continuity tested. And just about your only chance of being equal to the task is to appreciate it now and begin at once to prepare your schools. This is something new and bad." (Rin, 1990, p. 1)

According psychologist Theresa McNichol, Ph.D., a consultant to private foster care agencies in Los Angeles, "While some children have verified handicaps attributable to prenatal drug exposure, there can be a bias against these and other drug-exposed children. It is assumed that they will have problems, and that the drug exposure is the cause. Schools are not trained to know the names of children who were drug exposed. This raises the risk of blaming all the problems on the drugs when actually they may be caused by a multitude of factors that these children face in their lives."

Herion/Methodone

The cocaine epidemic has overshadowed the problems of heroin addiction. The belief that heroin is a problem of the 60's and 70's and that it had disappeared is untrue. Rather, it is the expectation that there will be a resurgence of heroin use following any interruption of cocaine importation. According to Cassel, "Heroin is still around. In fact, it is not uncommon to see addicts using cocaine and heroin at the same time."

Heroin is an opiate and is classified as a depressant. Its immediate effect may be one of euphoria, but it results in a slowing of breathing and in drowsiness. These effects are enjoyed by people seeking escape. Therefore, in addition to being physically addictive, heroin is psychologi- cally addictive.
Neonatal and Pediatric Complications of Drug Abuse

- Small for age
- Prematurity
- Jaundice
- Intracranial hemorrhage
- Infection (STD's, HIV, hepatitis)
- Sudden infant death
- Neonatal Abstinence Syndrome
- Hypertactivity
- Infections
- Poor interactions
- Learning disability

which will reduce the craving yet not cause insufficiation. The woman will have to be closely monitored for intoxication and withdrawal symptoms, and adjustments made accordingly. Methadone reduces, but does not eliminate, negative effects to the fetus. The lower the dose, the better the outcome for the infant. "Experience has demonstrated that a dose of less than 20 milligrams per day at the time of delivery significantly reduces the presence of neonatal withdrawal signs and symptoms." (Chasnoff, 1986, p. 10)

The heroin/methadone-addicted baby clearly suffers with neonatal narcotic abstinence syndrome, or withdrawal. "Well over 50 percent of infants born to mothers who continue narcotic abuse during pregnancy show symptoms of neonatal narcotic abstinence syndrome, symptoms of which may last for weeks after birth." (Yanai, 1984, p. 5)

The signs and symptoms of neonatal narcotic withdrawal are many. These include tremors, high pitched cry, sneezing, increased muscle tone, frequent sucking of fins, irregular sleeping, increased respiratory rate, poor feeding, loose stools, sweating, frequent yawning, projectile vomiting, fever and generalized convulsions. "Severely affected babies are very difficult to comfort and hold themselves stiffly rather than cuddling against the mother or care giver. Sleep patterns are disrupted with much less sleeping time than the normal infants." (U.S. Government Printing Office, 1978, pp. 45-66)

The onset of withdrawal usually occurs within 24 hours after birth, appearing sooner with heroin than with methadone. The syndrome can last for several weeks or months (Chasnoff, 1986; U.S. Government, 1978; Yanai, 1984). Some parents report differences between symptoms of methadone-maintained babies and heroin babies. "Behaviorally, methadone infants were reported by their mothers to be more difficult to care for than were infants of drug-free controls, but less difficult than the infants of untreated addicts." (Willsen et al., 1981, p. 721)

There are dangers to the heroin/methadone-exposed fetus. There are small for gestational age, and the weighted only 3.5 pounds at birth. She was born with bilateral hip dislocations and limited motion of both elbows. At 2 months she was admitted to the hospital in congestive heart failure. At 18 months, she was diagnosed as mentally retarded. "Party's mother is an alcoholic, and Party has fetal alcohol syndrome." (Lube, 1977, p. 924)

Fetal Alcohol Syndrome (FAS) is the worst possible scenario resulting from alcohol consumption during pregnancy and it occurs is approximately two of every 1,000 live births. (Abel & Sokol, 1986) There is a conusion of possible effects resulting from exposure to this drug. The term "Fetal Alcohol Effects" (FAE) is used to describe problems not severe enough to be diagnosed as FAS.

Just as with other drugs, transport of alcohol through the placental barrier occurs. The fetal liver is too immature to metabolize alcohol and the fetal kidneys are not able to excrete the metabolites as rapidly as the mother's. Therefore, not only is the fetus exposed to the same alcohol level as the mother, but the alcohol stays in the fetus' system longer. (McCarthy, 1983)

The amount of alcohol being consumed by women of childbearing age continues to climb. Alcohol is easy to consume, affordable, and the drug of choice among Americans.

Alcohol

"Party is 18 months old, but her size and development are about those of an 8-month-old child. In terms, she has been small for gestational age, and the weighted only 3.5 pounds at birth. She was born with bilateral hip dislocations and limited motion of both elbows. At 2 months she was admitted to the hospital in congestive heart failure. At 18 months, she was diagnosed as mentally retarded. Party's mother is an alcoholic, and Party has fetal alcohol syndrome." (Lube, 1977, p. 924)

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continued on page 6
Recognizing Fetal Alcohol Syndrome “FAS”

Small Size
- Length and weight lower than normal
- Small head (microcephaly)
- Body tends to be thin

Mental Retardation
- Central Nervous System Problems
  - Hypoperfusion
  - Motor Skills Impaired
  - Learning Disabilities

Distinctive Facial Features
- Flat nose
- Small eyes
- Short nose
- Normal size
- Little neck
- Low set ears
- Jaw blunted at infant

Possible Problems with Major Organs
- Heart murmur
- Cleft palate
- Liver abnormalities
- Cataracts
- Numerous bone problems
- Marche herniae
- Defective kidneys

Adapted with permission of CUHLC Inc.

Nicotine

One of the most popular drugs in our culture, nicotine is a stimulant and is the most addictive of all. Tobacco use is thought to be the cause of the addictive nature of smoking. Nicotine crosses the placental barrier to the fetus and is believed to be associated with specific problems.

The most serious effects of smoking during pregnancy are fetal death and infant death from respiratory difficulties or Sudden Infant Death Syndrome. (Hill & Kleinberg, 1984) A recent four-year comprehensive study of infant mortality found that women who smoked a pack a day or more had a 16 percent higher incidence of infant mortality among their first born than non-smokers. For later children, there was a 30 percent higher incidence of infant mortality among smokers regardless of amount smoked. (Kleinberg, 1988)

Other problems associated with nicotine are vaginal bleeding, placental abnormalities, ruptured membranes and early delivery. Smoking is a primary cause of low birth weight. Low birth weight has been associated with the development of many serious health problems, some chronic. (March of Dimes Birth Foundation, 1986) However, if smoking stopped before or during pregnancy, the risk is reduced by 50 percent or more. (Kleinberg, 1986)
mother quits smoking by the fourth month, the risk of delivering a low birth weight baby is similar to a non-smoker. (Drug Program Office, 1987)

Problems with smoking do not end with birth. Prenatal smoking can lead to problems for children as well as adults. C. Everett Koop, the Surgeon General during the Reagan administration, reported that chil-
dren of parents who smoke, compared with children of non-smokers, had more respira-
tory infections, more respiratory symp-
toms and slightly slower rates of increase in lung function. Babies exposed to smoke absorb nicotine, carbon monoxide and other components of smoke. The mother's smoke, the more her baby absorbs these harmful chemicals. Koop states that even the healthiest baby suffers if exposed to tobacco smoke. (Drug Program Office, 1987)

Because he was very concerned about the effects of passive smoking on children, Koop established a set of rules he believes are essential in households where parents smoke: 1) never smoke while holding the baby; 2) never bring a cigarette into the baby's room; 3) put off smoking when babies are in the room, or, if that is impossible, make sure there is good ventilation; 4) insist on non-smoking areas in public restaurants. (Drug Program Office, 1987)

Drug Use as a Lifestyle

On Sunday, July 30, 1989, the Washington Post published the story of Donny Waters. In what is reminiscent of the opium dens of the '60s, one finds Donny living with his cocaine-addicted mother, brother and any drug dealer or drug user who may decide to remain at the family's apartment. It was a 4 mark reminder in many children are exposed to drugs in ways other than parenally.

Donny, age 4 when the article was written, did not always live in a "crack house." Three years before, his father, who was employed as an electrician's apprentice, and his mother had a job as a typist and was attending classes in interior design. They were recreational drug users and both came to the marriage with a legacy of drug abuse. However, they were functioning. It was not until "crack" was introduced into their lives that it became chaotic for Donny. The parents separated and independently attempted to support their drug habit.

Donny's mother sold the family belongings, including toys. She left her job, and in her words, "became a slave to crack" until he dragged herself out of bed to attend school. He rarely bathed or groomed himself before going to school, however, was his haven from the chaos in his life. His 13-year-old brother, Russell, was living the nomadic life, selling "crack" for a living.

Donny represents many children who are living with parents who are addicted to drugs, whether cocaine, heroin, alcohol or others. Addicts have difficulty providing both emotional and physical support to their children. Also, the nature of the drug fuels the addict into using everything he can when, in fact, children are not being fed, clothed or getting a good night's sleep.

"Crack" poses more threats to children than drugs of the past because a higher percentage of women are users. Because the addiction is so strong, children are often neglected. "Some babies die of neglect. In one case a 10-month-old died after being left overnight in an overheated room reaching 100 degrees while his mother visited her boyfriend. In New York City, 99 percent of the child abuse and neglect fatalities involving children provincially known to the authorities — usually drug babies — occur within the first six months of life." (Bestarow, 1989, p. 17) Neglect and fatalities occur, not because women wish to avoid care of their children, but because they want euphoric effects of the drug:

Children whose parents use "crack" are also at risk of batteries. Cocaine induces extreme violence in some people. "Nation-
wide, reports of child abuse increased by 100,000 to 2.3 million in 1988 according to a survey conducted by the National Committee on the Prevention of Child Abuse. In more than two-thirds of the states providing background information on each case, substance abuse was cited as a major factor. In New York City, reports of child abuse and neglect of children were involved with drugs more than tripled — from 2,727 in 1986 to 8,521 in 1988. City officials blame crack for driving up the number." A review of the New York City cases of children who died as a result of neglect and abuse in 1987 showed that 79 percent of the deaths resulted from adult drug abuse, up from 11 percent in 1985. (Koppleman and Jones, 1989)

There are many factors other than actual drug use that can lead to a high-risk situation for the child of an addict. Much of the research done with methadone-
maintained women indicates that their attempts to parent are compromised by many factors. Their children may suffer negative effects because of an addict's low self-esteem (Ragan, Estellrich & Finnewe, 1987; Spikler & Mc-ushands, 1976; U.S. Department of Health and Human Services, 1980), high level of stress (Kamson & Thompson, 1983; Ragan, Estellrich & Finnewe, 1987), poor emotional state due to a history of abuse in childhood (Ragan, Estellrich & Finnewe, 1987), lack of psychosocial resources, deficient knowledge of child development (Burns, 1986), and poor parenting skills. (U.S. Department of Health and Human Services, 1980; Wollstein & Steinberg, 1980.) Risk of abuse and neglect is also elevated due to characteristics of the child. Infant risk factors include interaction deficits, defiant state control and difficulty in being comforted. (Chamoff, 1986; Jeremy & Bernsteinc, 1984; Ragan, Estellrich & Finnewe, 1987; Wilson, Desmond & Wait, 1981)

Legal Intervention

One approach to intervention is to use the legal system in an attempt to protect the child. Howard Davidson, Director of the American Bar Association Center on Child-
ren and the Law, suggested four possible legal approaches.

The first approach is to use civil law under which an infant or young child can sue his or her mother for damages. An adult uses for the child "based on damages caused by the transmission of harmful substances from the mother's body to the child's." Davidson asserted that he explained that he was unaware of any case brought because of maternal illegal drug use. He did mention, continued on page 8

Children, A Matter of Substance

On Dec. 30-11, 1990, more than 300 pro-
fessionals from a variety of backgrounds met in Richmond to consider the issue of substance exposed infants. The two-day conference was sponsored by the Virginia Department of Social Services in conjunc-
tion with the Virginia Innsituement for Devel-
opmental Disabilities.

The keynote address was by Howard Davidson, Enquiries, Director of the American Bar Association Center on Children and the Law. The conference also featured Dr. Derene Van Landingham reporting on HRJ 41/AR 11 (see separate article), two plenary sessions led by state and national experts.
Substance-Exposed Babies continued from page 7

however, a Michigan case where a court permitted a child to use for a negligently inflicted perinatal injury caused by the mother's use of prescription drugs.

Davidson suggested that civil damage suits have generally not been accepted by the courts, particularly in the case of an unborn child. "Although there is a trend toward an expansion of the concept of fetal rights, courts are always likely to balance this, using the 'strict scrutiny test,' because of the very real potential infringement of the pregnant woman's right to privacy," he explained.

A second approach to legal interposition is to use existing civil commitment procedures to hospitalize substance-abusing preg-nant women. Tom Castella, senior assistant attorney general for Virginia, does not believe that, at least in Virginia, this can be done using the current commitment statutes. "To be committed, there must be a reasonably probable danger to self or others," he writes. "If someone picks up a gun and threatens to shoot another person, we can deduce a direct threat of danger to the other person. There is a causal relationship. I don't believe we have empirical evidence that that causal relationship between prenatal exposure to drugs and predictable danger to the fetus," he adds.

Richard Bonnie, professor of law and director of the University of Virginia's Institute of Law, Psychiatry and Public Policy, views the commitment proceeding somewhat differently. "If civil commitments we are assessing risk," Bonnie explains. "When we commit someone we are not doing so because we are certain some harm will occur. Rather, we are assessing whether we are willing to assume the risk of a dangerous act occurring or not. The goal of committing a person to protect self or others from risk of harm is the better course. I think that, viewed this way, assessing risk to the fetus of drugs used is well within the therapeutic reach of civil commitment. Using commit-ment statutes as a model for preventive intervention may be appropriate." Davidson and Bonnie both suggested that present commitment laws need to be modified to specifically address perinatal drug exposure as a threat. Davidson said that Minnesota has explicitly addressed this issue. Child protective service workers may now initiate civil commitment actions against substance-abusing pregnant women. "Before any court-mester there must be a referral for chemical dependency assessment, relevant out-patient treatment, and pre-natal care. Only after the woman has refused to enter, or failed in treatment, may involuntary commitment procedures be implemented," he explained.

A third approach is criminal prosecution of mothers of substance-exposed children. This approach has received the greatest amount of publicity and public debate. Several states have attempted to use current civil or criminal protection statutes to criminally prosecute women who have given birth to drug-exposed children. According to Davidson, few of the protection attempts have resulted in convictions, however.

While arguments can be made for the state's interest in protecting the child, serious constitutional questions are raised. A recent decision from the American Bar Association Centemr on Children and the Law (1990) explains that criminal penalties intrude on the mother's right to privacy and that "to overcome the mother's strong interest and constitutional rights, the state must show that any proposed statute is necessary to serve some compelling state interest and that it is the least intrusive measure necessary to serve that interest." (1990, p. 43). Other questions such as "Must informed consent be obtained from the mother before a child is tested for drugs?" and "Can evidence obtained without a warrant in the absence of probable cause be admissible in court?" made the issue of criminal prosecution even more complex.

Some believe threats of criminal prosecu- tion to be an appropriate means of inter- est. Paula Keller, director of Women's Initiative Program in Greenville, S.C., states, "Our experience is that a woman does not stop using drugs unless she is in crisis. So, we put her in crisis. Every woman I have worked with would have quit if she had not been arrested." In Greenville when there is a reason to believe that a newborn infant was exposed to drugs, the hospital tests for the presence of drugs in the baby's urine. If the test is positive three times, the sheriff goes to the hospital room and arrests the mother. Keller meets with the mother in the hospital to discuss her treatment program. "This initial contact has been effective in determining that the patient keeps her first appointment with me," she explains. If the mother attends treatment, she is not prosecuted. If she does not, she is mandated to explain to the court her reasons for not complying.

The Greenville treatment program includes a weekly group session for the mother and child care for the baby. Attendance at Alcoholics Anonymous and Nar- cotics Anonymous meetings is encouraged. This has not been sufficient support for all clients, so Keller is presently creating a more intensive program.

Keller reports discouraging results. In the last year there were 28 prosecutions. Three women successfully completed the program. She reported that another program similar to hers had only one woman successfully complete the program. While discouraged, she notes that any success with a crack addict is cause for celebration. "The recidivism rate is extremely high. Therefore, anyone work- ing with crack addicts would consider any success a major accomplishment," she said.

Others believe criminalization attempts are counterproductive. When asked what he thought of the idea, Dr. Boyd said that prosecuting mothers is not effective in helping infans. "This approach to the problem is very arbitrary," he explained. "In the first place, our system is very prone to prejudice. We won't see the middle-class, white suburb in jail. Secondly, this approach keeps women away from prenatal care because they fear prosecution. It ruins any chance of education and necessary care for the baby." The National Association for Perinatal Addiction Research recently took a stand against criminalization for drug use during pregnancy. It states that rather than solve the problems, criminal penalties are likely to make matters worse. The woman may forego the prenatal care which can improve outcomes for exposed infants. Criminalizat- ion also puts health care practitioners in a conflict position, "forcing them to choose between maintaining their patient's confi- dentiality and reporting them, ultimately to the police." The position paper continues, "It is unwise to punish a woman who needs society's help when society has done little to assist her." (p. 7)

A second issue arises when considering criminal prosecution as preventive interven- tion to protect the fetus from the harm of drugs. Bonnie believes this approach could be very useful as a deterrent. "If the pregnant woman's conduct is itself criminal or is associated with other criminal conduct, a legitimate basis for intervention is present," he writes. (1990). He cites the case of Brenda Vaughs who was jailed for second-degree theft despite the fact that it was her first offense. According to Bonnie, the judge stated that she was being jailed in order to protect her fetus from her drug use.
In a recent conversation Bonnie asserted that he believes the judge has the authority to intervene on the behalf of the fetus, but wonders if jailing mothers is the appropriate action. "I'd really see the correlation made leverage to get the woman into treatment," he says. The fourth legal approach is through the child welfare system. Two possibilities exist: CPS intervention before the fetus is born and CPS intervention after childbirth. Let us address legal intervention first.

Davidson asserts that the use of pre-birth CPS-initiated intervention has rarely been recognized through either a state statute or a judicial decision. He cites the State of New Jersey as having a law that extends child abuse and neglect protection to the unborn fetus. But, he also states that this law has yet to be tested in an appellate court ruling on the forcible intervention through child protection laws into the life of a pregnant, substance-abusing woman. He notes that legal intervention involving forcible blood transfusions and Cesarean sections deemed medically necessary have been receiving more attention. It is in this point that Richard Bonnie addresses in a recent issue of Developments in Sexual Health Law. His research into legal issues surrounding surrogates and non-surgical intervention leads him to believe that pre-natal intervention "should not be regarded as categorically objectionable either as social policy or constitutional law." (1990, p. 31)

Bonnie states that he does not believe that pre-natal intervention is always a good idea. In fact, he asserts that a pregnant woman's autonomy should be respected except under the most exceptional circumstances. "However, I think it is possible to draw a line with reasonable specificity between conduct that warrants coercive intervention and conduct that does not. For example, permissible interventions would include mandatory diagnostic testing and screening procedures, even if they would be invasive. For extreme cases, mandatory hospitalization or outpatient supervision should be permissible if women are unable to unwilling to refrain from using alcohol and other drugs in a way that poses an imminent and substantial danger to fetal well-being." (pp. 31-32)

CPS can also intervene after the fetus is born. This again raises a detention issue. Is parental consent for drug testing of an infant required? According to the American Bar Association Center on Children and the Law (1990), without immunity hospitals or physicians are vulnerable to suits for slander, malpractice and discrimination. Bonnie finds the immunity argument persuasive, but he does not believe hospitals and physicians are at much risk. "If I were a hospital's attorney and my doctors wanted to know if their patients were abstaining they believed to be medically at risk due to possible drug use by the mother I would tell them yes," he states. "In fact, they could be held liable if they failed to do everything medically necessary for the child, including screening for drugs. Of course, the testing would have to be done on every child that is at or at risk."

According to the ABA Center on Children and Law (1990), other very complex questions regarding CPS intervention after birth include: "How do recognized principles emphasizing family preservation and expediting permanency for children who are removed from the home apply to cases involving parental substance abuse?", "What home based services should be readily available for use in cases where substance-exposed newborns have to remain in hospitals because their parents are unable to provide for their needs?" and "How should existing termination of parental rights laws be modified to specifically address the needs of infants whose parents are chronic drug abusers?"

These are issues which concern Virginia's Committee on Children as well. Like most other states, Virginia's child abuse and neglect issues do not directly address the substance-exposed infant.

Carello, legal counsel for the State Board, says it is his ideal opinion that the present law does not extend to the fetus or to the newborn exposed prenatally to drugs. "I don't think it is a good idea to treat the present law," Carello admits. "Without new legislation, we would be asking for a baby and inviting defeat. I would neither see the board working along with the initiatives brought by the legislators as they address this issue."

(For information regarding legislative initiatives, see article titled "Virginia's Legislative Subcommittee on Perinatal Drug Exposure.")

Social Services Response

Where does the leave social services? "I'm not sure," answers Mike Ryan, chief of services in Alexandria. "Most people believe these children are at risk and so reinforce
to get referrals. However, prenatal exposure to substance abuse is not, by itself, sufficient cause for a finding of abuse or neglect." Brenda Herron, child protective services supervisor in Norfolk, agrees. She gave an example of a referral that shocked her.

"A local physician called me concerned about a mother's emotional instability and drug use. However, upon further investigation we found a very healthy, well taken care of child. There were no visible signs or symptoms of neglect. Therefore, neglect was unwarranted."

Despite the unfortunate label, many agencies attempt to provide services to addicted parents. Ryan states that his agency will provide a full range of services on a voluntary basis. These services include case management, health care and substance abuse treatment.

Joan Kammrath, child protective services supervisor for the Charleston Department of Social Services in South Carolina, attempts to extend its services to these families, too. "In 1989, 12 infants were referred to us from the hospital for suspected drug exposure," Kammrath explains. "Unless there were additional signs of abuse or neglect, the services that were offered were voluntary, and very few families took advantage of them. The hospital's simultaneous referrals to the public health department for follow up were more effective." According to workers in several settings, while referrals of substance-exposed babies continue, the numbers are dropping. Ryan stated that they had 50 referrals from August to September of 1990, which went down from 50 in 1989. Kammrath said that in 1990 she had 12 referrals. Last year she had only one.

Treatment and Intervention

Intervention begins with understanding the addict. "For the addict," asserts Deborah L. Haller, Ph.D., associate chair, Division of Substance Abuse Medicine at the Medical College of Virginia, "the drug is the number one priority." Dr. Haller feels that denial is very strong in addicted women. Denial is fostered if the woman is surrounded by users. "They need to perceive consequences before they will seek treatment. Most come to treatment under duress," Dr. Haller says. The addiction can be hidden for years because of the social roles of the workplace. Thus, women addicts, as a group, are more deteriorated than male addicts when they do seek treatment.

Descriptions of the pregnant women addicted to cocaine seem to differ according to the location of programs. Some clinicians insist that cocaine use during pregnancy cuts across geographic and socioeconomic lines.

Mary Jordano, Families First program director, sees a relationship between the rise in "crack" related family problems and the triploid demands on the foster care system in Michigan. "Foster care is a precious resource," states Jordano. "Family preservation is an alternative to utilizing foster care as a first resource (or intervention) when out-of-home placement may not be necessary." Families First accepts families with substance abuse problems. In fact, 67 percent of the Detroit area caseload involved substance abuse problems. "There is a continuum of use for substance abuse. Not all 'crack' using families are incapable. One can't tell which families are hopeless just by referral information," notes Jordano. Families with abusers are families at risk. This fact and a willingness to make them good candidates for the Families First program.

Families First receives referrals from local departments of social services' protective services, delinquency and foster care units. A worker responds to a referral within 24 hours, meeting with the family and assessing, first, the safety issues, and second, the family's needs. Workers carry a caseload of no more than two families for each four- to six-week service period. This allows the worker to be available to the family for extended periods of time each week (an average of 50-12 hours per week per family) facilitating stabilization and diffusion of the crisis, and enhancing opportunities for change.

The program has some unique components that Jordano believes enhance its effectiveness. One is the approximately $300 per family that is available to help with concrete family needs. "The $300 figure is an average. Some families may need more, some less. Regardless, this money can help at a time of crisis. For example, one family was homeless and had no furniture. Once we found an apartment they could afford, we were able to use our flexible funds to assist them with obtaining furniture." Other uses for the flexible funds have included food, rent, learning materials, appliances, toys, diapers and transportation.

"We enter into a partnership with the parent or parents. There is mutual goal setting, with our respecting the parent's understanding of themselves— their values, their beliefs and their problems," Jordano emphasizes. "Our involvement is intense, time-limited and brief. It usually takes four to six weeks for us to assess the needs and get the family members headed in a positive direction with a solid support system," she adds.

Jordano believes that an ecological approach is needed, focused on the entire family, with substance abuse seen as just one problem. "An inpatient setting is not the only option," remarks Jordano. "An integrated program can work."

The program's statistics are impressive: more than 500 families with 2,000 children served, approximately 80 percent were on the streets. In 1991 there were an approximate 20 percent of families served needed to have their children placed out of their homes. The cost? Less than half the estimated cost of foster care placement.

Further information is available from Families First, 215 S. Gradac, P.O. Box 30037, Lansing, MI 48909.

Sixth Annual Working With America's Youth Training Conference


More Information Available from: National Resource Center for Youth Services, University of Oklahoma, 202 West Eighth St., Tulsa, OK 74119-1419.
The Honorable Marian Van Landingham

Because of the concern for the growing number of children being directly affected by drugs, Virginia's Senate and House of Delegates established a joint subcommittee to study the problem of maternal perinatal drug exposure. Chaired by Delegate Marian Van Landingham, the committee's task is to:

- examine the undertakings and the health and social consequences of maternal and perinatal drug exposure and abuse;
- determine the prevalence of the problem in Virginia;
- estimate the number of babies born to such mothers and also abandoned in the years;
- ascertain the impact of maternal and perinatal drug abuse on subsidized adoption and foster care systems in the commonwealth;
- assess the fiscal aspects of maternal and perinatal drug exposure and abuse on the delivery of health and social services and on infant mortality and morbidity;
- determine the potential for long-term effects on the cognitive, health, and emotional and social adherence of drug-exposed babies;
- assess the need for and the cost of long-term health, psychological, educational, and rehabilitative services to babies who survive;
- determine the status of the health healthcare delivery system and the capability of state agencies to coordinate multiple, multidimensional, health-related, educational, rehabilitative and social services for such mothers and their babies;
- recommend ways in which such care and treatment may be increased and enhanced cost effectively;
- review the various approaches taken and services provided in other states;
- review the relevant state and federal health, social, child protection, drug enforcement treatment, statutory, policies and programs, and case law to assess the sufficiency of such provisions to address the problem in Virginia, and ensure the maximum effectiveness of such policies and programs.

- review any other related issues and recommend such policies, programs, and regulatory changes as it may deem necessary.

House Joint Resolution 41

The committee was charged to prepare their findings for presentation to the 1991 General Assembly.

Delegate Van Landingham spoke in Richmond at the December 1990 conference, "Children: A Matter of Substance," sponsored by the Virginia Department of Social Services in conjunction with the Virginia Institute for Developmental Disabilities. Since the report was not complete, she was not able to present the results of the study. She did, however, discuss several aspects about the information gleaned so far.

Delegate Van Landingham's presentation emphasized the need for treatment rather than prosecution as a means of intervention.

"Prevention is counterproductive. There are no treatment programs available to assist these people. They will run rather than attempt to turn their lives around as long as there are no available services."

Delegate Van Landingham noted that Virginia has very few beds available for pregnant women seeking substance abuse treatment. There are only seven at MVC in Richmond and seven at Domingo House in Arlington. Very few treatment facilities accommodate children of substance-abusing mothers. "We look at the New York and Massachusetts know they are the leaders in social programs. Still, New York has a more robust program than Massachusetts."

"Money is a problem at this time of budget shortfalls, and Delegate Van Landingham does not expect much money to be set aside for treatment programs. At this point she does predict that the committee will recommend that some of Virginia's funds under the National Drug Act be decoupled for drug treatment, not programming. She believes that the best strategy is to use the money for pilot programs with existing agencies. The focus needs to be intensive outpatient care and case management. "It is ideal when we can pay to modify already existing programs and community resources. We get more for our dollars," she emphasized.

According to a summary of 1990 legislative committee reports published in the December (1991) edition of Airways, the committee heard testimony from professionals representing legal, health, mental health and social work concerns. To date, it has not finalized recommendations. The committee is considering mechanisms to ensure that services are provided to families, and has considered delivering reports of drug exposure and to child protective services. The subcommittee has heard calls for a need for data on women's infants and children in Virginia and will seek to balance the rights of the mother with the child's interest in growing up.

In addition, one bill and three joint resolutions have been presented to the House of Delegates. House Joint Resolution 387 calls for the continuation of the joint subcommittee studying the problems of maternal and perinatal drug exposure and abuse and the impact of subsidized adoption and foster care.

House Joint Resolution 388 requests that the Secretary of Health and Human Resources in cooperation with the Secretary of Education, develop and implement an interdisciplinary approach to providing services to women who are substance abusers and children who have been previously exposed to drugs. Services are to include pre-natal care and delivery and out-patient services. The bill stipulates that the agencies shall (1) collect data; 2) evaluate the extent of the problem; and deliver treatment and support services including transportation care, child care, residential services, and employment training. The focus is to be on treating the whole family.

House Joint Resolution 389 requires that the Coordinating Mental Health, Mental Retardation, and Substance Abuse Services submit a report implementing programs through the Community Service Boards.

The committee is requested to encourage the development of programs designed to serve women who are substance abusers and children who have been exposed to drugs.

House Bill No. 1602, the convening of a task force formed by the Secretaries of Education and of Health and Human Resources. The mission of the task force is to work with the Joint Subcommittees on Perinatal and Perinatal Drug Exposure and Abuse and The Impact on Subsidized Adoption and Foster Care is to develop an effective mechanism of services to such children and their families. In developing the mechanisms the task force shall consider 1) ways to avoid stigmatization of such children; 2) ways to encourage the viable families and avoid perceptions of threat or penalties; 3) any relevant confidentiality requirements stipulated by federal law; and 4) the analysis of the cost of such a stipulation. All four pieces of legislation were passed during the 1991 sessions.
National Helpline & Organizations

National Drug Abuse Information and Treatment
Referral Line, a service of the National Institutes on Drug Abuse

The HELP hotline is a free service and is available from 9-5 a.m. EST Monday through Friday, and noon - 3 a.m. EST Saturday and Sunday. Anyone calling this number can get a variety of printed information from the National Institute on Drug Abuse or telephone numbers of treatment centers.

For further information, contact: National Drug Abuse Information and Treatment Referral Line, 5600 Fishers Lane, Rockville, MD 20857, 1-800-662-HELP.

National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) was established in 1974 and is the lead federal agency for research with the incidence and prevalence of drug abuse, its causes and consequences and improved approaches to prevention and treatment in drug abuse.

For further information, contact: National Institute on Drug Abuse, (NIDA), 5600 Fishers’ Lane, Rockville, MD 20857, (301) 496-2455.

National Association for Perinatal Addiction Research and Education

“NAPARE”

NAPARE is a national multidisciplinary organization which provides education and leadership in the development of programs for preventing and treating drug/alcohol abuse during pregnancy.

NAPARE is involved in several research projects with multiple funding sources including the National Institute on Drug Abuse and the State of Illinois. Their educational programs include an internship program; a national training institute for social service agencies, hospitals and clinics, government agencies and other professionals groups; hospital Morale workshops aimed at preventing burnout and low staff morale; programming which is presently for Chicago area hospitals; judicial training for family court judges and court personnel who work with drug related cases; and a National Resource and Information Center for Perinatal Addiction which provides a central, coordinated source of information in the field of perinatal addiction.

An Individual membership fee of $45 annually provides a person with a quarterly newsletter, reduced fees for conferences, training sessions, the internship programs and educational materials, and a membership directory.

For further information, contact: National Association for Perinatal Addiction Research and Education, (NAPARE), 11 E. Hubbard St., Suite 200, Chicago, IL 60611, (312) 320-2512.

National Perinatal Association

“NPA”

The National Perinatal Association (NPA) is a non-profit, multidisciplinary membership organization dedicated to promoting perinatal health through fostering delivery of optimal care, education, research, and ordering of national priorities. Membership in NPA is open to any individual interested in perinatal health care.

The goals of the organization are to: 1) foster the improvement of perinatal care; 2) foster cooperation in education, planning and health care through multidisciplinary and interdisciplinary approaches; and 3) to foster access by all the nation’s families to a full range of perinatal services is determined by patient need. These goals are accomplished through education, research, leadership training seminars and several publications.

For further information, contact: National Perinatal Association, Suite 525 University Professional Center, 3500 E. Fletcher Ave., Tampa, FL 33613, (813) 971-1008.

Alcohol Anonymous

World Service Inc.

“AA”

AA World Services Inc. provides a catalogue of AA conference approved literature and AA service material. The array of resources are vast, including pamphlets on AA and their recovery process; books, pamphlets and guides for persons or groups beginning or already running on-going groups; resources for professional and business people; public information packets and workbooks; and an array of audiovisual materials. The catalog includes a brief description of each resource and its cost. For further information, contact: Alcohol Anonymous World Service Inc., Box 459, Grand Central Station, New York, NY 10016, (212) 686-1100.
March of Dimes Birth Defects

March of Dimes is a national organization founded in 1938 and dedicated to the prevention of birth defects. Its mission is to coordinate the efforts of volunteers and researchers who are dedicated to the prevention of birth defects. The services they provide include research grants, public education and professional education. Public education includes audiovisual materials, books, pamphlets and brochures. Several of the materials cover topics specifically related to the risks to the developing fetus when exposed to drugs and alcohol. A catalog can be ordered from the address below or from a local office.

For further information, contact: March of Dimes Birth Defect Foundation, National Office, 1714 Mamaroneck Ave., White Plains, NY 10605, (914) 428-7100.

March of Dimes Birth Defects Foundation

Virginia Capital Area Chapter
1900 Main Street
Richmond, VA 23230
(804) 551-9108

Central Virginia Division Office
P.O. Box 256
Lynchburg, VA 24502
(804) 237-6228

Southwest Virginia Division Office
P.O. Box 1534
Abingdon, VA 24210
(703) 628-1256

Shenandoah Valley Division Office
P.O. Box 542, 159 High St.
Harrisonburg, VA 22801
(703) 644-7199

Piedmont Division Office
359 W. Roy Road, Suite 202
Charlottesville, VA 22901
(804) 973-5663

The Virginia Perinatal Association Inc.

"VPA"

A member of the National Perinatal Association, VPA was formed to improve maternal and child health in Virginia. The organization serves as a clearinghouse for providers to network and exchange information. It also serves as a lobby for legislative activities related to mothers and children. Available from VPA is a presentation titled "A Good Starr Lasts a Lifetime: Prevention of Premature Labor." The cost of 50 brochures is $8 plus shipping. The video-cassette costs $55 plus shipping and includes 50 brochures. There is also a slide/tape presentation which costs $55.

For further information, contact: The Virginia Perinatal Association Inc., P.O. Box 7265, Richmond, VA 23221, (804) 783-1701.
Spotlight on Richmond: Center for Perinatal Addiction

Historic Richmond in the renovated 18th-century home of John Marshall's brother-in-law is an unlikely place to look for the Center for Perinatal Addiction, but that is exactly where it is located.

Associated with the Medical College of Virginia of Virginia Commonwealth University, the perinatal addiction unit was founded in 1988 "on a shoestring budget" according to Linda Redmond, L.C.C.W., administrative coordinator for the program. The history of the program centers around Dr. Sidney Schnoll, a neonatologist who had worked in Chicago with Dr. Ian Chambers before coming to MCV approximately five years ago. He came asking what drug problems the physicians were seeing in their pregnant mothers and newborn infants. He was told that there were none! However, after talking to people in the community, he found that cocaine use had increased significantly in recent years. Believing this would be true in the program population as well, Dr. Schnoll started training all premature labors and deliveries for drugs.

He found there was, indeed, a problem. Data gathered by the center in 1988-89 show that 21 percent of women coming to MCV for prenatal care admitted to drug use. An additional 6 to 8 percent are positive for cocaine on drug screens.

Beginning with two staff and very little money, the center was fortunate to find a home near the medical facilities and the university. It is a large and warm environment which can accommodate as many as 45 in its program with living space for approximately 10 women and their children who need temporary housing while in treatment.

Women and children enrolled in the program participate in services three and half days each week. There are a wide variety of therapy sessions: psychodrama, individual, group and family. Educational programming include nutrition, prenatal care, preparation for childbirth, skills building (teaching skills related to stress management, problem solving, communications, assertiveness and anger management), substance abuse education, and parenting classes which involve the children as well as the mothers. There is day care on the premises for the children while the mothers are involved in therapy and activities. Also available are medical services, self-help groups using the 12-step model, and referral services. The program is free to the participant.

To enroll in this program, a woman only needs to be referred, either by a professional or by herself. She can come into the program at any time during her pregnancy or until her infant is six months old. A participant must be at least 18 years old and planning to maintain the pregnancy or to keep her already born child. The client's condition is assessed by the intake nurse. If detoxification is needed, the mother will enter the MCV Inpatient Substance Abuse program first. If not, she begins the outpatient program.

Since the program's inception in 1988, many changes have occurred. The center has recently received a five-year, $9 million grant from the National Institute of Drug Abuse. This has allowed the program to expand to six staff and a team of 30 physicians and researchers from 12 departments throughout MCV/VCU. The grant also funds extensive research. Thus, the team will be able to determine the most effective program components, study the withdrawal process on the mother, and better document the effects of drugs on the development of the unborn child and newborn infant. Other areas of research include a large psycho-pathology study and evaluation of treatment process and outcome variables.

The program has attempted to remove as many barriers to treatment as possible. "We found that significant external barriers include housing, finances, child care and transportation," Redmond explains. "So, we provide housing, have no fees, provide child care, and have a supply of bus tickets."

Another external barrier to the program is attempting to hurdle is public misconceptions. "Some drug addicted mothers live with the street myth that if she comes forward she will be prosecuted. That is not done. We need to address that myth," Redmond emphasizes. "As for the professionals, they just need to know we are here and available to their clients."

Outcome data is not yet available. Since July 1990, the program has screened 135 women and 26 women and their families have entered treatment.

More information is available from Center for Perinatal Addiction, 217 West Grace St., Richmond, VA 23220, (804) 786-8410.

Substance-Exposed Babies (Weston, et. al., 1989) and wary against stereotyping. Weston, et al. (1989) emphasize that drug use includes many patterns, ranging from occasional casual use of low doses to episodic intake at high doses or the compulsive use associated with drug dependency. Other clinicians describe addiction as an intergenerational problem, linked to poverty. Haller of MCV in Richmond describes these women by summarizing the data on the first 20 subjects in an NIDA-funded research project. "Most are depending upon social services and are from multigenerational welfare families. Most of the women started drug use in their early teens. Many admit to prostitution; at minimum, they have traded sex for drugs. Few have any stable relationships. Their 'significant others' are frequently addicted and abusive."

Debra Haller

Judy Howard, M.D., and her colleagues at the Department of Pediatrics at the University of California, Los Angeles, agree with Dr. Haller. They state, "Substance-abusing parents are unemotional, more frequently, lack telephones, fail to keep appointments and drop out of sight when abusing illicit drugs. They often come from a history of impoverishment, abuse and intergenerational chemical dependence."

(1989, p. 8)

Dr. Haller offers observations on cognitive abilities and personality styles. "A significant number of these women score in the borderline or miniarily reared range, which suggests that they will have difficulty with traditional educational approaches. The majority have at least one personality disorder and many have anxiety disorders and low-grade depressions," related Dr. Haller. "The drug use is, in part, adaptive since it compensates for feelings of low self-esteem and functions as a chemical defense against overwhelming negative emotions."
Spotlight: Parent CARES

Prince William County, Va., has taken what they already had, restructured it and created programming for substance abusing mothers. "The program is a blend of existing services from our parent-infant education (PIE) program and substance abuse services (SAS)," explains Stephanie Parks, program coordinator. She continues, "When you have a substance addicted mother, coordination of services is essential. It's crazy to have separate services for SAS and PIE! We need to work on infancy issues in infancy — not as adult children of alcoholics."

Blessing the services was not an easy proposition. "The PIE staff was not 'tuned in' to symptoms of substance abuse," notes Parks. "They put effort into 'parents that want us.' They also worried that a referral to SAS might mean losing the client." The SAS staff, meanwhile, had little interest in infants, according to Parks. "Infants were considered to be a distraction by SAS staff. A mother who did not want to leave her infant in order to attend treatment was termed 'denial.' Since infants can't talk, SAS staff felt they couldn't treat them. In many cases, the SAS staff didn't even know if their mothers had an infant!" Parks exclaimed.

Despite roadblocks, the SAS and PIE staff did join forces to develop Parent CARES. Laurie Andrews leads the vestige group for the women. "We receive referrals from various sources," says Andrews. "We visit with a home visit. From the beginning we acknowledged why they were referred. We present ourselves and our services." The intake is similar to other intakes at the Community Services Board, but does go into substance abuse history. The client is encouraged to offer her perceptions of the problems and to identify her own needs.

The treatment group has evolved over about a year. The first hour of the two-hour block is spent parent-child interaction. Jill Donaldson, speech pathologist, describes some of the techniques used to facilitate positive interactions. "We use videotaping Frequently. The staff can coach the mothers, especially assisting in reading and interpreting the child's cues. We also take pictures of positive interactions and give these to the rooms to keep."

The emphasis is on helping the parent to be in control. Much positive reinforcement is given as well as instruction in specific techniques. One session may be devoted to having the occupational therapist teach the mothers to do infant massage. Another group might focus on how to develop empathic imagery.

Interactive goals are developed for both the mothers and the infants. For example, the infant's goal may be to sit independently. The goal for the mom is that she will sit facing her child and engage him in an activity. Or, the goal for the child may be that she will learn to creep. The mom's goal is to set up a room to be safe, then encourage her child to creep.

While many materials are used to facilitate learning, the HELP at HOME series, 1996, VORT Corporation) is preferred because it offers specific interactional activities at each age. The staff has also created handouts written from a baby's point of view.

Parent CARES is too new to evaluate. However, some of the statements and goals of the clients are revealing. Asked to write their goals, one mother responded, "To get a better understanding of how to take care of my baby. Get to know other women and their experiences. Things to watch for in my baby's development. To be a better woman."

More information is available from: Parent Infant Education Program, 8007 Ashton Ave., Manassas, VA 22110, (703) 355-7752.
The Effects of Maternal Alcohol and Drug Abuse on the Newborn, edited by Betty Stimmel, M.D., 1996.
Available from: The Haworth Press Inc., 10 Alice St., Binghamton, NY 13901-1580
This is a book of highly technical articles related to the effects of drug and alcohol abuse on the developing fetus. It begins by examining pathological effects of narcotics use both on the mother and on the developing fetus. The authors then move on to discussing the outcome of children born to women dependent on narcotics use or to perinatal mortality and morbidity and neonatal abstinence. Little, if at all, examines the effects of maternal use of alcohol on fetal development.

Courage to Care, edited by Gary Anderson, M.D., 1996. 416 pages, $75.50
This book contains several essays, all dealing with the effects that the AIDS crisis is having on children. It is divided into four general categories: (1) general information about AIDS and children; (2) programmatic responses to the AIDS crisis; (3) training strategies, and 4) a叫做 needs and resources to serve HIV infected children, adolescents and their families.

Available from: The Haworth Press Inc., 10 Alice St., Binghamton, NY 13901-1580
Based on the belief that prevention and risk are irrevocably interlinked, this book focuses on our attention on relevant intervention programs and studies of prevention linked to early development of children. Risk-producing issues are divided into three parts: (1) professional characteristics, (2) developmental and health status, (3) environmental conditions critical to the care of infants. They then describe different approaches to preventing developmental delays in infants and children.

A Special Baby's Book, 52 pages, available at cost.
(713) 625-9357
The book was developed for an interprofessional, health-based, and environmental and delivery of care that is the needs and the behavior of families. It contains three sections. 1) Health information includes birth data, growth recot, immunization records, medical tests, and all medical treatment arn well-baby checks. 2) Social history includes the baby's first and last activities. 3) Placement information includes a summary of each major section. A program for family and agency visits, and important telephone numbers. A grant from the U.S. Department of Education makes this resource available for only printing costs.

This very interesting publication was written for administrators who develop public policy in child protection and family care, for lawyers who practice in the field of child abuse and neglect, and for legislators developing laws pertaining to these issues. Concerns of professionals from several disciplines as well as aid in addiction are discussed. Many experts in the field of child abuse and neglect, and for legislators developing laws pertaining to these issues. Concerns of professionals from several disciplines as well as aid in addiction are discussed. Many experts in the field of child abuse and neglect, and for legislators developing laws pertaining to these issues. Concerns of professionals from several disciplines as well as aid in addiction are discussed.

The appendix includes statistics containing definitions of neglect, attorneys that specifically mention drugs and alcohol. Civil cases relating to drug abuse are not specifically included.

This publication summarizes much important information. It should be nevers everyone bringing ten module of the program woman who is鸡蛋 for fetus to drugs.
Available from: Community Product Innovations
175 Amary St.
Brookline, MA 02146

The convention roundtable brought together many well-known professionals with disparate specialties such as law, public policy, human services, medicine and education. Therefore, the issues surrounding substance abuse and relationship violence are addressed from several perspectives.

The roundtable was moderated by Daniel Schovar, who skillfully kept the topics alive by raising issues or asking one professional to respond to another. The concerns and perspectives were as varied as the discipline represented; however, there were some similarities. Most obvious was the degree of frustration about the problems expressed by all members.

Any person concerned with the present” problems in our communities as they relate to drugs and resulting violence would be most interested in hearing the topic addressed by this panel. It is an interesting 60 minutes which raises many issues and does not pretend to address any mutually agreed upon solutions.

Available Soon
Crack and Other Addictions: Old Realities and New Challenges — Proceedings of a CNLA Symposium, March 10-11, 1990. ($18.55 +0.50 handling charges.)
Available from: families of Crack & Other Addicts
240 First St., N.W., Suite 310
Washington, DC 20001-2085
(202) 338-2902

This volume will include presentations by 25 national experts on policy and practice issues related to chemical dependency and violence to the child welfare field.

A Cry for Help: The Felon Drug and Alcohol Crisis, 1990, 29 minutes.
A Cry for Help: Drugs, Alcohol and Pregnancy, 1990, 34 minutes. Cost: Sold each, series $50; rental $75.
Available from: Croupier/MEF Film and Video
108 Wawon Road
Deserted, IL 62055
(800) 621-2137

Fetal Alcohol Syndrome Education Kit. Fee: $89 plus shipping.
Available from: The California Urban Indian Health Council Inc.
801 Broadway
Sacramento, CA 95818
(916) 444-0480 or (800) 767-0513

The FAS Education Kit is a comprehensive educational tool for professionals or community groups who desire to educate awareness about fetal alcohol syndrome during pregnancy. The kit includes a training manual with guidelines for training leaders, a video featuring local FAS prevention efforts, a script for facilitated FAS presentations, a glossary of terms, a reference list and techniques for approaching women at risk. Also included are support materials such as fact sheets, book markers, bumper stickers, posters, a recipe booklet for non-alcoholic drinks, brochures, message postcards, decals and a photograph of a young boy with FAS.

The comprehensive kit is complete and simple in its presentation of infographics information. It is attractive and useful. Although it was designed for the American Indian, the kit can be used effectively and easily with diverse populations.

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Sue is a foster parent of 20 years. She recounts her experience with Mark who was drug-exposed prenatal. Sue received Mark directly from the hospital. Her first week wasn’t too bad. Mark slept and had slight tremors when awake. However, the second week he began to scream. Sue was surprised. She was not prepared for the intensity and the longevity of the crying. Mark screamed eight to 10 hours each day for almost three months. Nothing soothed him. Not soaking, not singing, not talking, not walking. Nothing helped. When Mark screamed he was incontinent. Sue thought about quitting, but she knew Mark needed consistency. Eventually the screaming slowed to two to three hours a day and then subsided. Now Mark is doing well. His developmental scores appear normal. No extended problems from the drugs have been identified. Mark is now living with his grandmother.

Mark is one example of the problems a drug-exposed baby can exhibit. Jane’s baby was a little different. Heihi came to Jane when she was 4 months old. Heihi had gone home from the hospital with her mother, who remained addicted to cocaine. Heihi was finally removed because of parental neglect. She came into foster care with an apex monitor. Heihi had long and frequent episodes of apnea the first few months. In addition, Heihi showed increased muscle tone, displaced projectile vomiting, contractures, and a rash. His repeat ear infections was easily over-stimulated, had seizures, displayed sensory integrative dysfunction (had trouble organizing herself) and displayed tremors. During her time in foster care, Heihi was under the care of five medical specialists for her several medical problems. She is now 22 months old and living with her father.

Christy’s drug-exposed foster baby was entirely different. He was a sleeper. He had to be awakened to eat. Jennifer preferred to sleep day and night. She was easily over-stimulated which culminated in vomiting or having a seizure. She had a heart monitor and a machine to help her breathe.

Among the five foster children Chris is parenting is a child with a fetal alcohol syndrome. This child, now 2 years old, is hypertensive. Professionals did not realize until she was 8 months old that Amy had no pain sensation. She needed constant supervision to ensure that she did not get badly hurt. One time, after Chris removed Amy’s shoe, she noticed the foot was swollen and bruised. Apparently Amy had broken three toes when she dropped a toy on her foot. Amy had given no sign of pain. When Amy came to Chris’ home, she also seemed blind and deaf. Now, as age 2, she is finally able to hear, see and feel pain. Her neurologically deficits are improving.

Nancy Abell, foster home finder for Lowrie County, comments, “Until recently we seldom saw very young children who were abused and neglected. Now we are in jail for drug related crimes, or are neglecting or abusing their children due to drug addiction. We are seeing younger and younger children,” she says.

Having enough foster care homes is been a longstanding problem both in Virginia and nationally. Some states, faced with overwhelming challenges, are leaving the system. For example, a New York Times article (Blakely, May 19, 1990) tells of 20 foster parent couples who meet regularly to discuss the problems they face. They are attempting to raise children who were potentially exposed to drugs. After two and a half years of struggling, 10 couples are about to give up. They found the problems to be too difficult to handle than they initially thought and are “burned out.” These couples also make a strong case for advice and support from the placement agency staff.

Finding foster care homes is becoming harder and harder. According to Abell, “Virginia has 4,000 foster homes. We have 5,200 foster children.” Many parents work outside the home and many are single, making fostering less attractive and less feasible. Most foster parents are reimbursed only $239 to $354 a month per child. This sum is too little to meet the expenses of food, clothing and child care. Foster parents must supplement the state stipend with their own funds.

Drug-exposed children often need one person at home to give the child individual attention. Because of the high cost of living in metropolitan areas, potential foster families with only one parent working are few to find. "The problems drug-exposed children face are different than we have seen in the past," Abell explains. "The child welfare system is not responding in a flexible fashion, such as providing money for child care for working foster parents," she adds.

Recruitment efforts have been under way all over Virginia. James Weaver, regional specialist for Northern Virginia, tells of one such program: “In Virginia we have a recruitment program that was made possible due to the efforts and cooperation of TV station WRC and the Freddie Mac Corporation. We did an intensive media campaign which focused on young abused or neglected children and their need for caring foster home. We included an 800 number for interested persons to call.” According to Abell, the response has been disappointing. Potential foster parents may be wary of accepting substance-exposed infants due to the problems shown by some babies. Theresa Mooney, PhD, an Atlanta clinical psychologist and consultant to family foster care agencies, stresses that many babies don’t experience major problems. “We see drug-exposed babies who do not experience a lot of problems. Parents should consider each baby individually and not assume that major management difficulties will occur.”
Emerging, too, is an increase in the use of institutional care for the elderly in the District of Columbia. The number of institutionalized patients in the District of Columbia is more than 150 seniors (1998). These seniors had nowhere else to go. Elderly shippers are picking up in metropolitan areas all over the country in the last two years. New York saw the number of patients increased. We need more money for the elderly who are housed in the facilities. In Los Angeles, the Infant and Therapeutic Center, houses up to 45 infants and toddlers. Each child lives in one of four nurseries which are family-style units with several caregivers. Some children stay as long as 17 months. (Washington Post, Jan. 19, 1990)

Residential care has been used for years. However, it has primarily been a temporary, short-term alternative during crisis, or for older children. This trend is now without controversy. Literature reviews of the effects of institutional care on children are being used as an argument against developing residential care. Problems for the children, such as poor psychological development, prevention to develop interpersonal relationships because of multiple and unaccepting associations and language and cognitive deficits are documented. (Ford, 1990) Popular media and professional titles written within "Dickensian England." Many professionals are concerned about the trend of institutional care for abandoned infants. McNichol is concerned about the effects of institutional care on children. He believes that institutions can offer the essential ingredients for bonding that children need for development," she asserts. Her feelings are shared by Franki and others, such as for the foster care (foster care) in Fairfield, Va., and who also worked at the Child Development Center in New York City. They assert that therapeutic care (foster care) is an important aspect of the child. However, training specific to foster care is not yet systematically available. (The Children's Defense Fund, 1990) America is developing a curriculum for foster parents of substance-exposed babies. The training will be developed for use nationwide, but will be field tested in Northern Virginia in fall 1991. This is very exciting because we will get the benefit of "state of the art" training at no cost.

Northern Virginia Family Services is one of many private foster care agencies helping to meet the need for care of drug-exposed children. Matthew Mcnichol, director of the agency, said that 16 (46 percent) of its 35 children currently in care were drug exposed or addicted. "I believe we saw our first childcare worker with symptoms of substance dependence in 1987," he says. "However, we didn't know what we were seeing. It was not until 1987 that the first identified child was assigned to our agency. The numbers continue to grow," he adds.

Foster parents special child care is nothing new to parents who work with Northern Virginia Family Services. The agency provides a 180-hour training program which attempts to educate parents in the realities of the special problems drug-exposed children have. In addition, commitment on the part of the foster parents is required. "We work very hard at making good matches," McGee says. "We do not want children to be moved from one foster home to another unless it is an "act of God" or a family is relocated due to employment. The pressure on us, then, is to find committed people and to know them well enough to know what they can handle. This is a critical part of our success."

Northern Virginia Family Services, the test of Virginia, needs more foster parents. "We have 31 children in 16 homes. We have 21 licensed homes now, but our needs do not always match the needs of the children we are growing," McGee feels that foster parents with substance-exposed infants need a tremendous amount of support. "Can you imagine having a baby that sleeps for days or even months at a time? These people are special. We stay in constant touch with them trying to offer support. We encourage them to take advantage of the therapeutic care weekends that we offer. We strive to be attentive to their needs," McGee says.

Another avenue also has started to respond with additional support to foster parents. "Foster parents in Fairfax County receive special needs paychecks in addition to the board rate when they care for addicted babies," says another coordinator who works with foster families. "Lounsbury, special needs payments range from $1 to $50 dollars per day and are available to families who have received special training. Fairfax County also provides support care for foster families," Lounsbury continues, "While this does not address all the needs, these services have significantly provided for the needs of some of our most vulnerable children."

References Available Upon Request

This pamphlet is written for the family member or friend of a cocaine abuser. It includes information about the chemical and emotional affects of cocaine, signs and symptoms of use, special risks to family members, where family members can get help, and the possibilities of recovery. It is easy to read and contains some important and helpful information.

Cocaine/Crack: The Big Lie, by U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, 1989, 9 pages, free of charge. Available from: Office for Substance Abuse Prevention P.O. Box 2345 Rockville, MD 20852 (301) 468-2360

This pamphlet is designed to educate the general population about the effects of both powdered and crack cocaine. It is easy to read and very informative. It includes specific research information as well as pictures of and quotes from people who are recovering from cocaine/crack addiction. It includes information about the effects of cocaine on the developing fetus.

Special Care for Special Babies, 8 pages, 1061 copy. Available from: UCLA Intervention Program 1000 Veteran Ave., Suite 23-10 Los Angeles, CA 90004-1797 (213) 825-9527

This pamphlet provides important information for caregivers of infants prematurely exposed to drugs. Typical signs and symptoms are listed, as well as likely health problems. A section on feeding offers seven helpful hints to make feeding more satisfying. Eight ideas for dealing with an irritable baby are offered, along with tips to “take care of yourself.” Play activities for infants to one year are given, as well as basic developmental information.


While it is uncertain as to the exact amount of alcohol and the exact time of consumption that is dangerous to the developing fetus, it is certain that abstention will prevent any alcohol related birth defects. This short, educational pamphlet presents information about the research which has led to this conclusion, the effects of alcohol on the developing fetus, what the risk factors are and alternatives to using alcohol during pregnancy. It is nicely illustrated with photographs of healthy children and pregnant women.

Caring About Virginians, 1990, 14 pages, free. Available from: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services P.O. Box 1797 Richmond, VA 23214 (804) 785-3569

This handbook lists services provided by the mental health, mental retardation and substance abuse services network throughout Virginia. Names and addresses of facilities are given as well as descriptions of services. The locations and telephone number of the 40 community service boards are given as well as descriptions of their services.


Specialist Foster Family Care provides an international perspective on the care of children with special needs: emotionally disturbed, sexually abused, mentally retarded, physically handicapped and autistic. The authors of the many articles come from England, Ireland, the United States and Canada, bringing their unique perspectives of the principles of community care, program issues and practical approaches to delivering services.

The authors present quite diverse program models and strategies. Model programs include the Kent Project in Canterbury, England; the New Brunswick, Canada, project; and fostercare in Northern Ireland. Other concerns include recruitment strategies, placement programming, birthright, the role of social workers and characteristics of the youth and children served. The book concludes looking forward to future needs in policy, program and research developments.

The book is a valuable resource to social work managers and practitioners interested in non-institutional foster care policy and practice. The articles vary from research to practice, providing a broad perspective on foster care issues.
Women Alcohol and Other Drugs is a forum of thought and trends concerning within and addiction. The authors are professionals: women all over the country who represent all aspects of the field including research, intervention, treatment, prevention and education. Their findings and opinions are voiced and evaluated by the editor. Therefore, one author's view may be inconsistent with another's, and many may be controversial.

This book is divided into six parts: Introduction, Psychosocial Aspects, Physiological Aspects, Prevention and Intervention, and Special Issues. The book does not include articles about substance abuse, minority women and women and women opposition. It is intended for readers who are familiar with women's addiction and women's specific needs. The book offers a wealth of information to practitioners particularly concerned about women's addiction. Each chapter is valuable in its examination of the causes of the problem as well as intervention and treatment techniques.

Journal of Adolescent Chemical Dependency. Edited by Paula H. Davis, AAMFT. Published quarterly. Subscription price is $32 for individuals and $42 for libraries. Available from: Reinhold Press Inc. 10 Alice St. Binghampton, NY 13904-1580 (800) 342-8678

This new professional journal is devoted entirely to issues of interest in professionals who work with chemically dependent or abusing adolescents. It explores issues related to treatment, clinical and prevention strategies and applications. The first issue of the journal was released for fall of 1990 and sampling of the articles include "Incest and Adolent Chemical Dependency" by David W. Lologi, and "Adolescent Chemical Dependency as a Handicapping Condition: An Analysis of State Regulations" by Richard W. Williams. Plans for fall 1991 are unknown.


The Broken Cord is a poignant and starkly potent piece of one of man's unending conflicts and dilemmas: the emotional and physical violence, sexual perversion and despair, borderlines, and possibly, the improperly perceived, broken cord. It is difficult to confront, to accept, to understand, and to overcome.

Adam and Snake Hill is adopted by Dorian, Native American. He was 3 years old. Believing Adam's life was unconnected with that union, Dorian showed little interest in Adam's history. It was even in the history that had not told him the story of Adam's previous. It was not until Adam was 13 years old that Dorian finally understood that Adam was born with fetal alcohol syndrome.

Women who suffer from pregnancy are at high risk of fetal alcohol syndrome. These are staggering statistics and suggest a higher incidence of fetal alcohol syndrome among the Indian population.

The Broken Cord is a beautiful story. When one finishes reading it, there is a better understanding of the problem of fetal alcohol syndrome. More importantly, there is a feeling of knowing this woman's young heart, her adoptive parent and her struggles they encounter as they develop together.


9 a.m. 3 p.m. EST EST or order

Aggression, Family Violence and Chemical Dependency is a volume of selected articles which deal with the relationship between substance abuse and family violence. Included in the articles the professional will find information regarding the nature and extent of the problems, identification and assessment of family members, effective strategies for dealing with the problem and policy issues. The book is recommended for clinical and prevention professionals who work with people struggling with substance abuse and those who work with family members.

The book is easy to read and direct. It appears to be thorough and well researched in its presentation of data and evidence. It is also quite useful because of its presentation of intervention strategies.

Assessment/Intervention Guides, UCLA Department of Family Therapy, 1989, 14 pages. Available from: Susan B. Edelson, M.S.W. UCLA Department of Pediatrics 10031 Venice Blvd., Room 23-10 Rehabilitation Center Los Angeles, CA 90024-1797 (213) 206-5758 or (213) 206-4622

These guides were developed to assist therapists in making an appropriate assessment and intervention plan for prenatally drug and alcohol-exposed infants. The guides were developed by a multidisciplinary team. Three guides were available. One is for evaluation of the psychological family, one for assessing the service needs of resilients as primary caretakers and one for assessing the needs of foster parents for assuming one of a substance-exposed infant. Also available are sample contracts with the mothers enrolled in the UCLA program. These guides appear to be invaluable for continuing education and training. They would also prove extremely beneficial for case-requiring court intervention.


This instrument was adapted from Family News Survey, by Vincent and Simonson of the University of North Carolina at Chapel Hill. Parents complete 43 items, rating their interest in each on a five-point scale.

First, parents are asked to rate their initial interest in learning about their child's experience. Examples are interest in learning about effects of drugs, services available, and the child's special needs or delays. The second section asks about what services in the community they already use, including doctor, treatment for substance abuse. The third section asks about the parents' knowledge about help. Here they are asked to indicate whether they have a history of drug use and what they believe about the treatment program. The fourth section asks about their beliefs about the treatment program and whether they would accept it for their child. The fifth and sixth sections ask about the parents' beliefs about drug use and the effects of drug use.

This survey appears to be a practical way to involve families in the health care process. Those doing intake or assessing parents should find it a valuable addition.
Substance-Exposed Babies

Starting Intervention

Anne Thursen, M.D., is the family services coordinator at Virginia Commonwealth University's Perinatal Center in Richmond, Va. (see separate article, this issue, for a program description.) Thursen notes that the first contact is with a pregnant woman addicted to drugs is in the context of a psychosocial emergency. "She may have no home, no income, legal charges, a college degree, education, limited work experience, her children may have been removed from her custody, she has a pregnancy at risk and she sees like she's going to die if you don't solve her problems right away." States Thursen.

It is crucial to adopt a non-blaming approach during intake. The client is very vulnerable: frightened, guilty, shameful, so filled with self-blame," notes Thursen. "Your approach must be one of genuine caring and concern."

The clinician must make a series of decisions about the type and drugs of treatment. Treatment of both drug use and the woman's situation virtually guarantees that decisions will be made without sufficient information. (Thursen, 1990; Westoff, et al., 1989) This is what Thursen terms "vicious cycle." Major goals at this juncture are establishing trust and stabilization. The clinician must arrange for provision of basic necessities as immediate assistance to the client that she is worthy of help.

Assessment

A complete and thorough assessment lays the groundwork for planning and evaluating treatment services, according to Susan Baldwin, M.I.W., and Vickie Kropenok, P.M.N., of UCLA's Department of Maternal and Child Health. These components are essential in assessment interviews with the client, at least one home visit and collateral contact.

Use of a standardized measure, such as the UCLA Assessment of Exposure to Drugs (see separate review, this issue) can coordinate services professionals (child protective services, health departments, mental health) and save assessment time between team members. A standardized measure ensures that busy staff need not forget to inquire about key areas. Assessment will vary in privatizing services according to areas of greatest need. Standardized measures help eliminate bias. They are invaluable in cases where client recommendations are requested by courts.

There are several important areas to assess: Current drug use is one. It is helpful to know how frequency of use and what substances are used. Drug treatment history should be recorded, as well as the amount of prenatal care. Motivation and level of cooperation are also crucial, as is degree of awareness about the impact of drug use on the baby.

Assessment of the parent also includes more traditional areas such as intellectual abilities, physical limitations, impulse control, past history of emotional disturbances and criminal behavior. Parenting skills and responsibilities to the infant are important. If the infant is the first-born child, the clinician should check carefully for a history of prior abuse or neglect complaints.

Environmental factors we examined, is there a father or boyfriend in the home? If so, is that person supportive or does that individual have problems with drugs and/or violent behavior? What is the strength of the family support systems? What other household members use drugs? Are the needs of other children being adequately met? Is the home clean and free of hazards? Have preparations for the infant's arrival been started?

Finally, the infant, if already born, is assessed to determine what specific needs exist. There are three areas of focus. First, does the infant show drug withdrawal symptoms and to what degree? Second, what medical or physical problems are present? Third, the projected amount of medical care necessary is rated.

Vickie Kropenok and Susan B. Edelstein

"A comprehensive assessment," states Kropenok, "is gathering status of parenting parents focus on the area's needing intervention. By comparing the initial assessment to results from later evaluations, both the family and the professional can determine progress with some accuracy."

Another type of assessment is utilized by the Prince William County Parent-Infant Education Program in Manassas, Va. They use an instrument called Family Interest Survey II (see software review, this issue). This three-page form asks the parent to rate the degree of interest in obtaining help in all four areas. By making the woman an active participant in the evaluation, staff can encourage her involvement in treatment." says group leader Laurie Andrews.

Staff also ask the women to write goals for themselves for the next six months. One mother wrote "My goal is to have my baby with me and be a better mother. And learn from you another in the group. And be proud that you are off all drugs. Have a good home for myself and your child."

Systems Intervention

"Systems intervention is similar to family therapy," explains Thursen. She defines systems intervention as including offering help to a situation that involves the client. "Empowerment is important throughout," says Thursen, "the client must take charge of her life and her environment in order to succeed." Such systems such as welfare services, health clinics with long waiting lists and congregational drug treatment typically impose, rather than encourage empowerment. Teaching client how to use systems to work for her is a major goal.

Thursen suggests using a systems checklist to assist in identifying relevant contacts. Systems include family in the household, extended family, friends, church community resources, and agencies such as social services, mental health, and the health department.

When identifying the systems, the worker should try to evaluate the relationship the client has with each, as well as any relationships between systems. "Who has power in this woman's situation? Her mother? Her grandmother? Her husband? Probation officer? CPS worker? Who does she feel supported by? Make sure you include clients people in the right away," suggests Thursen.

A contract is utilized by a number of programs. The contract clearly states what each party will do and what will happen if parties do not fulfill their agreements. For example, if Mary, in an outpatient drug program, has two missed sessions comes back positive, staff may wish to institute care for detox. Many refusals. A contract agreement is reached stating if Mary's happens positive screening within the next six weeks, she will agree to inpatient care.

Thursen advocates that the therapist must be willing to endure contract consequences, therefore consequences should be determined with care. All systems working with the client should be aware of the contract. Edelstein agrees, "Having clear expectations and caring enough to put client into the context is important. That helps the client with initial control."

Thursen maintains that contracting can be empowering for the client, if she is able to voice concerns, request specific help and identify consequences for herself. Contracting can be combined with service delivery and goals. For example, the worker might offer to set up nutrition or assist the client begin treatment or arranging for different housing might be contingent on client's drug-free period of time.

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Spotlight on Boston: Project STAR

Project STAR provides community-based programs for children ages birth through 5 who are at risk or diagnosed with HIV infection and their families. The project grew from experience in similar efforts. In 1975, the South Shore Mental Health Center began to work with children with special needs. The focus was on work with young children who had cerebral palsy or severe developmental problems, and the goal was to prevent institutionalization. Over the years, children in increasing numbers were identified as at risk because of environmental needs such as a mother incarcerated or a drug-related change in their living situation or underlying infant drug treatment.

Between 1986 and 1989, the staff began to notice some children were all the time. These children were often HIV infected. Thus, the staff to focus on the special needs of this population began.

STAR is currently a collaborative effort of five agencies. These are Action for Boston Community Development which oversees Boston's Head Start Program, Aid to Incarcerated Mothers which provides services to women in prison, La Alianza Hispana which provides a range of services to Boston's Hispanic community, Women Aloud Risk Network, a street outreach education, counselling and referral program and the South Shore Mental Health Center which provides a broad range of services in mental health and mental health treatment. The services are free due to funding from the Robert Wood Johnson Foundation.

"Our families come from a variety of sources," explains Geneva Woodruff, director of STAR. "In the first two years of the project, the families would come in to have their children identified and referred to us. We also have the more traditional sources, such as hospitals and courts. The referral is for the women are most likely to come from the family members when we hear of people of our families have a partner with AIDS, most often because he or she is the sexual partner of someone with AIDS or due to his or her own intravenous drug use. All of our babies are at risk for HIV infection if they have not already been diagnosed as being HIV positive. Some of our children have also been exposed to drugs during therapy," she adds.

Woodruff describes the project as family members might expect when coming to the STAR Project. Once referred, the family members undergo an intake assessment designed to determine the family's needs. Assessment includes developmental health assessments for the at-risk child using standardized tests.

The assessment also identifies the professional with whom the family is already working. "We take a transdisciplinary approach when working with our families," Woodruff says. "If a staff and service providers are involved, then we get them all together to plan and coordinate service delivery. We include the family in case conferences, which helps build a bond between the family and the agencies as well as ensures that the family is involved. From the case conference we develop an Individual Family Service Plan."

Once the intake is completed, a case manager is assigned. While the case manager is usually a STAR early intervention team member, there may be reasons for another agency to take the case management lead. Regardless, the process is one which includes coordination of all services, regular conferences with all involved service providers and the family members and frequent telephone contact with service providers. The STAR early intervention team meets weekly to discuss the care and develop strategies for meeting the identified needs.

"Information services can be provided in the home or at the center," says Woodruff. "Where the family is served depends on the needs identified by the assessment. For example, if the mother is very sick, we try very hard to get them into our day care program at the center so the mother can get some rest," she adds.

In addition to the case management and day care services, direct services include early intervention groups to deal with developmental needs, group support groups, and training for communities that would like to develop a program for families affected by HIV. Education of the general public and advocacy for AIDS families are also programs.

Several things make STAR unique. "We are the only program serving HIV-infected children that I am aware of," states Elaine Sterrin, director of development, "the community based, rather than hospital based." The program also seeks out women "on the streets (those who have not sought prior services) through outreach workers living within the community. Also, the combination of center-based services and home services is important. We learned in prior years that home-based services were not enough," explained Sterrin. "We have better attendance rates with center-based services."

There are several additional services the center would like to offer. For instance, STAR would like to develop an art and music programming for siblings who often "get lost in the shuffle" but need special attention. Staff also wants to expand volunteer services to include a "buddy" program for families and to train volunteers to help with the day care program. Sterrin says she is in the process of writing grants right now. "We need money to continue the program at the present level as the Robert Wood Johnson Founding funding is a diminishing grant. Without our present level of funding we would, for instance, have trouble continuing to all of our children to the day care program," she emphasizes. "This is extremely expensive. But, if we didn't have them, they would not be able to get them." STAR presently works with 50 children from 46 families. Total family members serviced is 100. More information is available from STAR, 800 Columbus Ave., North Quincy, MA 02151, (617) 462-5822.

Substance-Exposed Babies

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Many drug-exposed babies are initially placed in foster care. For example, Kerensky relates that as many as 40 percent of drug-exposed babies are placed in foster care. When babies are in foster care, special efforts must be made so that the babies are able to learn about growth, changes, accomplishments, health information, placement changes and agency contacts. To accomplish this goal, the Infant and Family Services Program at UCLA created..."A Special Baby's Book." (See separate review, this issue) Created especially for parents and foster parents, this book helps the task of record-keeping. Resuming moths and their babies is generally contingent upon the concurrence of these. The assessment tools of a well-written foster care plan can be an invaluable aid. Everyone consulted agreed that careful, intensive monitoring was essential. Dr. Halter remarks, "Some substance-using mothers show significant attachment problems with their infants and have to be encouraged to interact, especially if the child...continued on page 24
 Substance-Exposed Babies
continued from page 23

is damaged. The mother may avoid inter-
tervention as it not to be confronted with the
consequences of her behavior.12

Programs vary in approach to short-term
intervention. Services may be crisis or agency-based, offered in the home or a
continuation. Respite or day care may be
offered. A few places offer residential
programs. Some programs stress working
with the mother's addiction. Others focus
on services to the child. In order to give
the reader information about model pro-
grams, several are described in the
Spotlights.

Prevention

Unlike many other birth defects, effects
from exposure to drugs and alcohol are
completely preventable. To avoid damage
from substance abuse in pregnancy, atten-
tion must occur before conception. Thus,
education and treatment must be aimed at
all women of childbearing age. (Nield, 1985)

A telephone survey of 700 residents of one
county in Washington State and one county in
Oregon indicated that while most respon-
dents knew that drinking during pregnancy
may be harmful, one-third believed that
more men than those drinks was safe for daily
use during pregnancy. The study concluded
that awareness of risk does not necessarily
result in low-risk behavior. (Saltzman, 1985)

In 1986, the United States Surgeon
General issued an advisory warning that all
health professionals should inquire about
alcohol consumption by pregnant women
and those considering pregnancy. Doulas
were required to include a warning to women
that they should not drink during pregnancy
because of the risk of birth defects. Bars often
display this warning for the public.

The efficacy of education for alcohol abuse
prevention among pregnant women was
reported by the Final Alcohol Syndrome
Prevalence Program of the Washington
School of Medicine (1980). The aim of the
project was to provide model public and
professional education on FAS along with
clinical and community services and evalua-
tion. The evaluation unit documented a
decrease in alcohol use among Seattle's
pregnant women corresponding to an
increase in the overall public knowledge
about the risk to normal fetal development
posed by maternal alcohol use.

Despite the known positive effects of
education in prevention of alcohol use during
pregnancy, the government and public
health officials have been slow to respond
to the surge of pregnant women using cocaine
and crack. Because young mothers use other
addicts giving birth to apparently normal
babies, they do not believe crack is harmful
to the fetus. In addition, cocaine is seen as
a foreign drug endorsed by the rich, famous
and glamorous.

According to Bleshay (1989), there must
be a concerted government effort to educate
young women about the dangers of using
Drugs during pregnancy. He says "continued
silence is inexcusable. The Department of
Health and Human Services must use every
media avenue to get the word out. Whether
it is in sex and health education classes or
in public affairs television spots, the message
must be blunt: 'Using drugs while pregnant
is wrong.'" (p. 9)

Conclusion

The problems of drug abuse are multi-
faceted and difficult. We are presently
experiencing a drug epidemic which child
welfare services and mental health systems
are not equipped to handle. Crack cocaine
has families in 10,000 and large numbers of
children at risk of serious problems, whether
they stay in their families or leave them. It
will take the coordinated efforts of health,
mental health and social service providers
as well as modest expenditures to develop a
comprehensive, coordinated approach.

References Available Upon Request

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