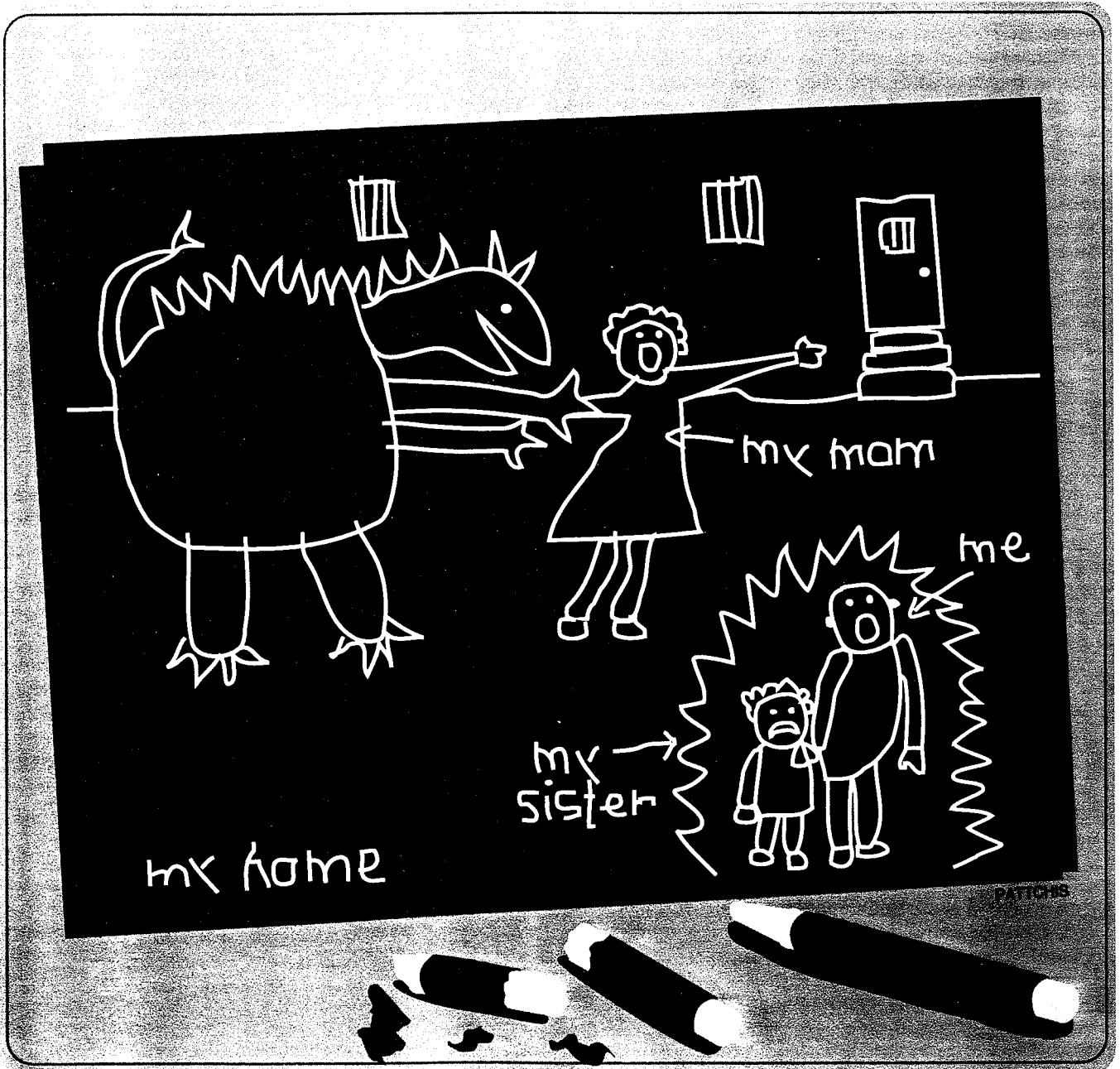


Opinion

The Children of Crack: A Status Report

Have the children of drug-addicted parents been forgotten?



Douglas J. Besharov

Douglas J. Besharov is a resident scholar at the American Enterprise Institute for Public Policy Research, Washington, D.C.; a visiting professor at the School of Public Affairs, University of Maryland, College Park; and the editor of *When Drug Addicts Have Children: Reorienting Child Welfare's Response* (American Enterprise Institute and Child Welfare League of America, 1994). He was the first director of the National Center on Child Abuse and Neglect.

In the Fall 1989 issue of *PUBLIC WELFARE*, Doug Besharov authored an article entitled "The Children of Crack," in which he charged that "as a society, we seem tragically unable to do what is necessary to protect [the] vulnerable children" of parents addicted to crack cocaine. "Each day that we fail to take decisive protective action," he concluded then, "means suffering, even death, for thousands of children."

More than six years later, Besharov believes that, although the attention of child protection agencies and public welfare policymakers has shifted to other pressing child welfare issues, the tragedy of crack- and other drug-addicted parents continues for thousands of children throughout the United States.

Remember all the news stories about crack babies a few years back—about children being born with a host of serious physical problems and being brutally abused and horribly neglected by their drug-addicted parents? We do not hear much about such children anymore.

But, as anyone familiar with child protective caseloads knows, the tragic problem of drug-addicted parents continues to threaten the health and safety of large numbers of children. In 1994, between 30,000 and 65,000 children were exposed to cocaine in utero.¹ That's about the same number as in 1987.² The number of children in foster care, moreover, continues to rise—from about 276,000 children in 1985 to an estimated 462,000 in 1994, the last year for which there are statistics.³ (See Figure 1 on page 34.) And, of course, hundreds of thousands of other children remain in the care of

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drug-addicted parents, where they are being raised under conditions of troubling inadequacy.

Hence, even if parental drug abuse is no longer news, child protective and child welfare programs across the nation continue to struggle with the problem. No one thinks that these programs are doing as well as they should. Too many children, for example, are left in the uncertain limbo of shifting foster care placements due to our inability—and, sometimes, unwillingness—to move them into permanent placements or to free them for adoption.

What Needs to Be Done

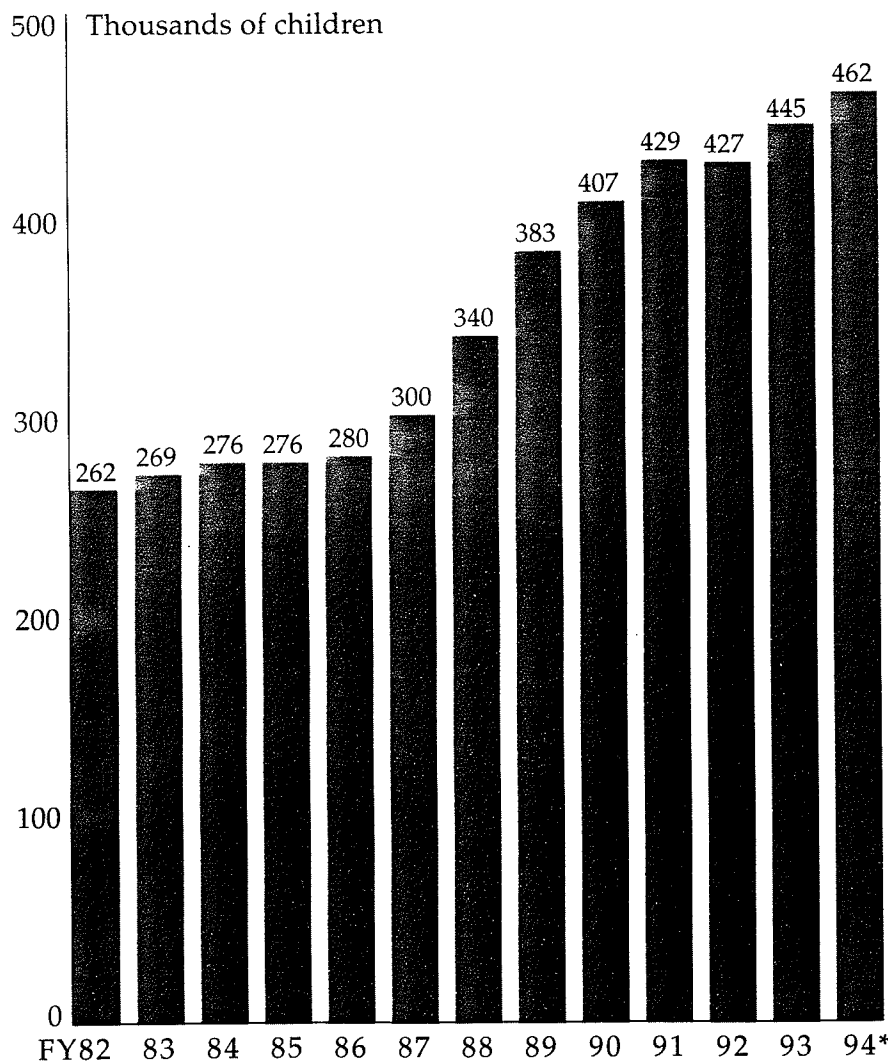
Concerned about improving services to this vulnerable population, 66 researchers, clinicians, program administrators, and government officials met at a four-day conference in Williamsburg, Virginia, in 1991, hosted by the American Enterprise Institute for Public Policy Research and cosponsored by the American Bar Association, the American Public Welfare Association, the U.S. Departments of Health and Human Services and Justice, and the U.S. Office of National Drug Control Policy. Twenty-eight papers presented at that conference were updated and published in 1994 in *When Drug Addicts Have Children: Reorienting Child Welfare's Response*.⁴

Although summarizing the views of such a large and multifaceted body of scholars and professionals is risky, one theme ran through the Williamsburg conference and is repeated in the book: If the children of drug addicts are to have a fair chance in life, we will have to be much more realistic about the problem and its likely solution.

Seven key principles emerged from the papers presented in Williamsburg:

Recognize that widespread parental drug addiction will continue to endanger children. After rising steadily during the 1980s, the number of frequent cocaine users has now stopped rising and appears to be beginning a period of slow decline. According to a recent RAND Corporation analysis, in 1993 about 1.7 million Americans were frequent users of cocaine, up from about 1.3 million in 1985; adding in heroin addicts raises the figure to over 2 million users. The RAND researchers estimate that by

Figure 1. Children in Foster Care



* Preliminary estimate

Source: American Public Welfare Association, *VCIS Research Notes*, August 1995

2004—a decade from now—there still will be at least 1.3 million addicts.⁵ (See Figure 2.)

Thus, notwithstanding the apparent small decline in drug addiction, hundreds of thousands of parents continue to be addicted to drugs. On their own, most true addicts simply cannot take adequate care of their children. Without societal intervention, their children are condemned to lives of

severe deprivation and, often, violent assault.

Assume that parental addiction to crack and other drugs will not be cured. According to Peter Reuter of RAND and the University of Maryland School of Public Affairs, "Drug treatment programs are not the primary source of the decline in drug addicts; in fact, they seem to have little impact on the size of the problem. Instead, there has been a

sharp decline in new users; not many people are taking up crack for the first time."⁶

What seems to be happening is that younger people in the neighborhoods have seen for themselves the way that crack wrecks people's lives and, as a result, are staying away from the drug. A similar process of social learning is what stopped the spread of heroin use in the late 1960s. Some specialists in the field regard the way that drug-taking spreads as a form of social contagion and describe this social learning as a form of social inoculation.

What about current addicts? Since treatment has only modest effects, most current addicts are expected to continue in their habits until they die or get too old for a life on drugs. That is what happened with heroin addicts. For example, a recent 24-year follow-up study of California narcotic addicts found that of 581 admitted to the California Civil Addict Program between 1962 and 1964, only about 25 percent had stopped using drugs and were not in jail.⁷ Of the remaining addicts, about 28 percent had died, about 19 percent tested positive for drugs, and about 5 percent refused to give urine specimens.⁸ With the exception of the mortality rate, which shot up dramatically between the first and second follow-up interviews, the sample demonstrated relatively stable patterns of drug use, incarceration, and participation in methadone treatment programs.

For the foreseeable future, therefore, even the best drug treatment programs should not be expected to do more than break patterns of crack use temporarily—because of the addictive qualities of the drug and the social factors that encourage addiction. That is why drug treatment professionals consider crack addiction to be a chronic, relapsing syndrome. So should child welfare professionals.

Provide intensive—and prolonged—child protective supervision. Many children of

addicts remain at home in their parents' custody. At present, child protective agencies provide only short-term services to these families, assuming that referrals to drug treatment programs will cure the parents' addiction. Since drug addiction, even if treated, is likely to be a long-term affliction, this short-term orientation is a grave mistake. Case planning should be based on the assumption that, for an extended period of time, the family will require regular home visits—perhaps from a newly created corps of case aides—and other services that include a continuing cooperative relationship with the drug treatment program.

Formalize kinship care programs. Members of the extended family can be an invaluable resource in efforts to treat the parents and as providers of substitute care. But, too often, children are placed with relatives

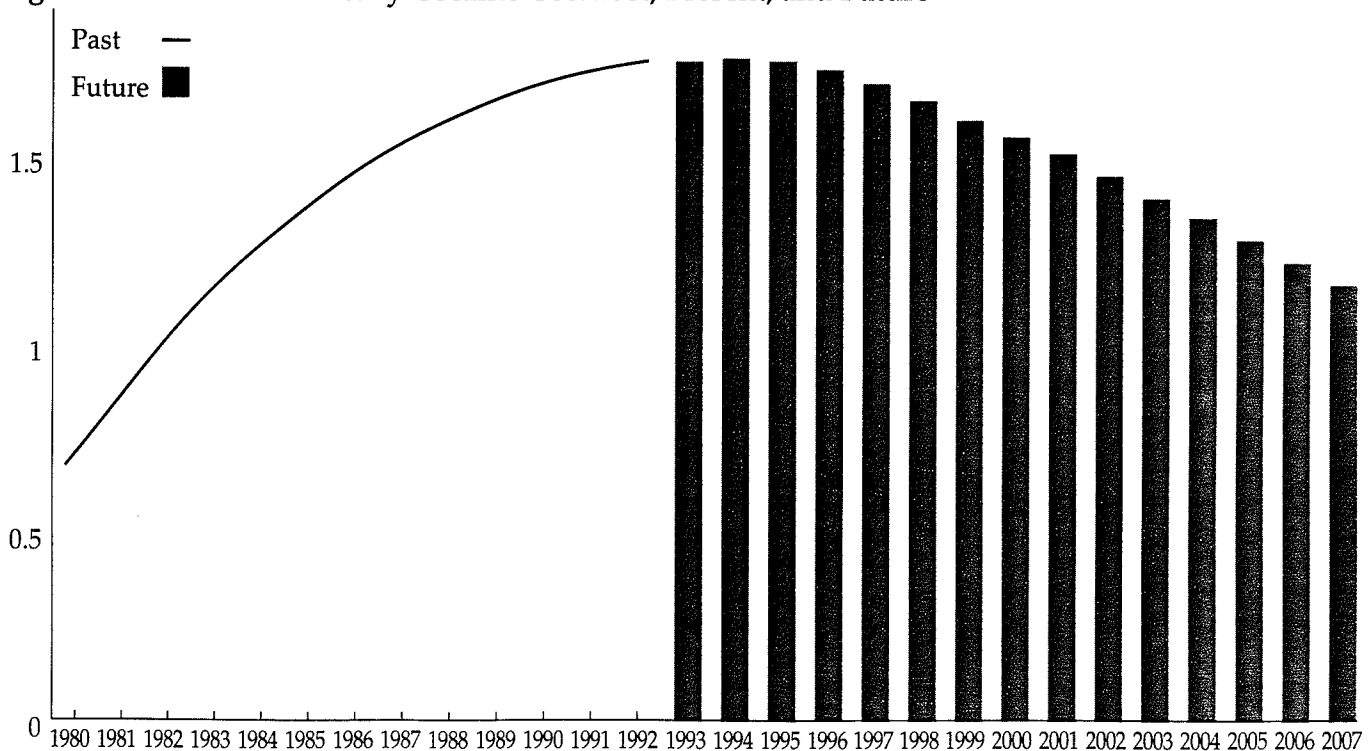
without due regard to their need for a stable and nurturing home environment. Although applying all the formalities of nonfamilial foster care to placements with relatives would be a mistake, child welfare policymakers should develop minimum standards for licensing, monitoring, and supporting such placements. In addition, the disparities in many states between kinship foster care payments and grants through Aid to Families with Dependent Children should be reduced to lessen the incentive to leave children in these temporary situations. This should be easier to accomplish under the new welfare block grant legislation. Child welfare agencies should also employ innovative legal mechanisms, such as permanent guardianship.

Increase adoptions, especially of abandoned infants. Child welfare agencies do a poor job of

identifying children who should be freed for adoption, because of negative attitudes toward the termination of parental rights, breakdowns in administration and decision-making, and current statutory provisions. The test should be the parents' demonstrable inability to care for their children, coupled with their unwillingness to accept or respond to a reasonable offer of drug treatment. Since termination should only be pursued when there is a reasonable likelihood of adoption, the focus should be on younger children, especially abandoned infants.

Create new, long-term substitute living arrangements that are stable and nurturing. Many children who are not appropriate candidates for adoption because they are older or have behavioral problems, and who cannot be placed with relatives because they have none or because

Figure 2. Prevalence of Heavy Cocaine Use: Past, Present, and Future*



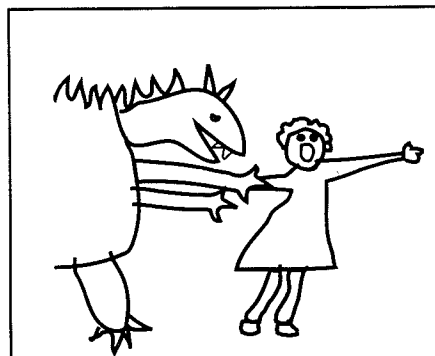
* Projections based on 1993 calculations
 Source: *Modeling the Demand for Cocaine*, RAND Corporation, 1994.

their relatives do not want to take them or have problems of their own, are likely to spend many years, if not their entire childhoods, in substitute care. These children are in desperate need of the kind of constancy and support that only secure home environments can provide. Among the possibilities are explicitly designated long-term family foster care homes, group homes, and larger residential care facilities. Various innovative legal arrangements, such as permanent guardianship, also should be used to obviate the inappropriate application of periodic foster care review requirements.

Make family planning a child welfare service. Most drug-addicted women would do much better if they had better control over their own fertility. How many times have we seen a drug-addicted mother's children taken from her, either all at once or one by one as they are born? Although some of these mothers want to have more children, many others do not—but their lifestyles, and the men in their lives, limit their ability to use contraceptives effectively. Family planning should be offered to clients automatically, just as parenting education is now. The aim should not be to coerce abstinence or contraception, but rather to help motivate clients to gain control over their own lives.

Advances in contraceptive technology may also help. Both Norplant and Depo-Provera provide protection against pregnancy without the need to use a contraceptive every time one has sex and without the woman needing to remember to take a pill every day. Unfortunately, however, unlike barrier forms of contraception, neither protects against sexually transmitted diseases.

The main obstacles to these and other reforms, however, are budgetary and conceptual. Ironically, it is the second that probably poses the bigger challenge.



In a horribly distorted sense, we already have long-term services. We open a case on a family and we close it, and we open another one on the same family and we close it again, year after year, generation after generation.

Fiscal Limitations

Because of the tight financial situation of most state and local governments, this is a difficult time for child welfare agencies. In recent years, over 30 states have had such substantial budget deficits that they have cut or frozen child welfare spending. Cuts in services of 20 and 30 percent are all too common. At the same time, the problems that child welfare clients face have worsened. Aggravating the problems of drug and alcohol abuse are rising poverty rates. More clients live in violent, hurtful neighborhoods where powerful environmental forces add an extra obstacle to their doing better. These are the realities within which services must be planned and provided. They shape our understanding of what contemporary child welfare services

can—and cannot—accomplish.

It would be wrong to kid ourselves about long-term services being somehow cheaper than short-term services. Yet they are not as expensive or out of reach as is sometimes feared. The key lies in the structure and orientation of the services.

Cases involving parental drug addiction are characterized by patterns of repeated reports on the same family—made over the course of many years and often across generations. The best estimate is that, over time, the families in at least one-third of all substantiated cases are reported again.⁹ The cases in the other half, significantly, are not re-reported, suggesting that child protective intervention has an immediately beneficial impact on many families. In any event, in a horribly distorted sense, we already have long-term services. We open a case on a family and we close it, and we open another one on the same family and we close it again, year after year, generation after generation.

Hence, child welfare agencies often end up providing services to drug-involved families for many years. But there is a cost: More time is spent investigating the repeated reports than is spent trying to help the family with its problems. And, of course, there is neither the continuity of service nor the continued momentum of sustained therapeutic involvement so needed to achieve personal change.

I do not mean to suggest that keeping such cases open would result in vast savings. It seems clear, however, that we could achieve real efficiencies—as well as more effective services to clients—if we recognized that many drug-using parents will be reported again and again and again. Thus, a long-term approach to services would save investigative and administrative resources that could be better used for treatment services.

Other efficiencies also are possible. We could achieve considerable savings by reducing

the number of inappropriate reports of suspected child abuse and neglect.¹⁰ Better professional and public education about what should and should not be reported, and improved screening at intake hot lines, are needed here.

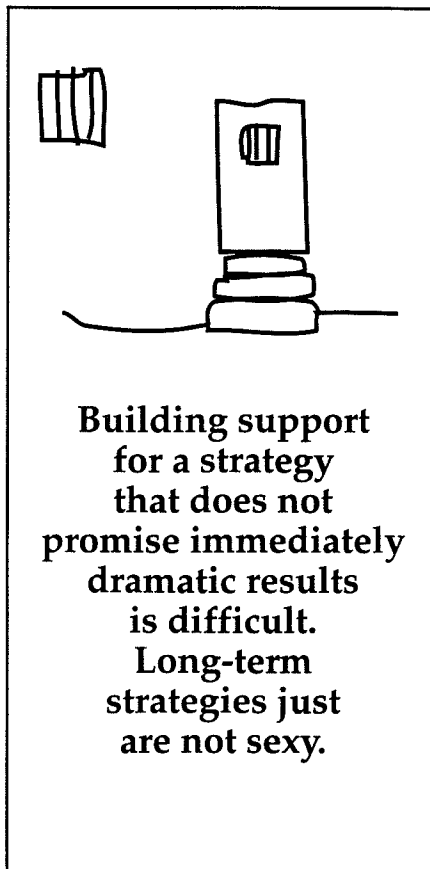
Thus, even in the current fiscal atmosphere, calling for an increase in the amount of long-term services available to the clients of child welfare agencies is not as quixotic as it might seem. Nevertheless, long-term services can be prohibitively expensive if agencies do not know how to turn off the service at some point. Clearly, some constraint on the amount of services provided would have to be imposed. Agencies would have to decide which services could be provided reasonably over the long term.

My own preference for the core of a long-term service strategy would be a modified version of a home-visitor service, an idea that C. Henry Kempe, a pioneer in efforts to combat child abuse, personally nurtured for many years. This concept was endorsed by the Federal Advisory Board on Child Abuse and Neglect and is being actively promoted by the National Committee to Prevent Child Abuse.¹¹ I say "modified" because I think that home visitors should be an adjunct to the standard package of child welfare-child protective services. In addition, agencies should attempt to recruit entry-level staff who have more in common with the families they are seeking to help—that is, staff who share social and economic backgrounds with their clients.

Thinking Long-Term

A larger barrier to developing long-term services, though, is conceptual and perhaps ideological in nature. Long-term services began to disappear long before the last recession. As a field and as a society, we do not like to think long-term.

Building support for a strategy that does not promise immediately



dramatic results is difficult. Long-term strategies just are not sexy. In fact, they require agencies to lower their programmatic sights from cure to stabilization. That simply is not an inspiring goal; it is hard to generate excitement for a program that, instead of promising to *cure* drug-related child abuse, seeks merely to *manage* it.

Working with drug-addicted parents and their children is not for the faint-hearted. Often, parents—and sometimes children—do not welcome intervention, however well-meaning. Instead, they can be unpleasant and even outright hostile to caseworkers and other helping professionals. Even when family members do want help, they can be frustratingly unable to keep appointments, let alone to follow through with treatment plans. Behavioral change, in other words, often comes slowly, if at all.

Finally, a long-term perspective on client needs raises many controversial and discomfiting issues. Family planning and contraception come immediately to mind. One need not agree with me about contraception to recognize how the issue is much more likely to arise during a long-term service relationship than in a brief one. That is the point. Making a real commitment to these families means trying to address their real and multiple needs, whether for education, job training, employment, or contraception.

Can these recommendations be adopted? Making it easier to terminate parental rights, for example, is sure to be controversial and may come about only with the active support of the disadvantaged communities most affected. Similarly, the restructuring of foster care into a long-term supportive environment will require a level of administrative commitment and capability that has too often been absent in foster care agencies.

The obstacles to adopting these recommendations are great, and there can be legitimate debate about their specifics. But if we are to meet the needs of the children of drug-addicted parents, we cannot avoid these issues. The continuing tragedy of drug-addicted parents and their suffering children imposes a moral duty to respond. To ignore their needs diminishes us all. PW

See page 38 for notes and references.

NOTES AND REFERENCES

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