The Children of Crack

WILL WE PROTECT THEM?

BY DOUGLAS J. BESHAROV

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In just three years, parental addiction to crack has become the single toughest issue facing child welfare agencies. Nationwide, hundreds of children are dying and thousands more are being permanently disabled. Ignored for so long, the children of addicts are finally being recognized as "the worst casualties" of the nation's drug problem, to use a phrase of Office of National Drug Control Policy Director William Bennett.

Almost 20 years ago, as the director of the New York State Assembly Select Committee on Child Abuse, I studied heroin withdrawal babies in New York City. Nothing I learned then prepared me for the devastating damage cocaine is doing to American children today. As a society we seem tragically unable to do what is necessary to protect these vulnerable children.

Mothers on Drugs

Although other drugs have plagued our society since the 1960s, crack, a derivative of cocaine, poses a threat to many more young children—because mothers use it. (See "Crack," page 12.) According to David Bateman, director of perinatology at New York's Harlem Hospital, "Heroin was a man's drug and we just didn't see as much of it in pregnant women. Many more women are on crack than ever were on heroin."

Cocaine is very harmful to the fetus. When pregnant women use crack, the cocaine constricts the blood vessels in the placenta and the fetus, cutting off the flow of oxygen and nutrients and often causing miscarriages, stillbirths, and premature, low birth weight births. Some cocaine-exposed babies suffer various physical and neurological malformations, such as deformed hearts, lungs, digestive systems, or limbs; others have what amounts to a disabling stroke while in the womb.[1] Death rates may be twice as high for these babies.[2] Many test positive for the human immunodeficiency virus (HIV), the precursor of acquired immune deficiency syndrome. (In 1987, one in every 62 New York City newborns tested HIV-positive;[3] most have parents who are drug abusers or whose sexual partners are drug abusers.[4])

The problem of fetally exposed babies, called crack babies, is spreading quickly—like the use of crack—from city to city and, more slowly, to smaller cities and suburbs. No one knows how many crack babies there are. The most widely cited estimate was made by Ira Chasnoff, director of the Perinatal Center for Chemical Dependence at Chicago's Northwestern Medical School. In 1988, he surveyed 40 hospitals, 36 of which responded. On average, the responding hospitals reported that 11 percent of the pregnant women they saw in 1987 were substance abusers. (The high was 27 percent; the low 0.4 percent.) Chasnoff took this 11 percent average and simply multiplied it against all live births in the country that year (3,809,394)[5] to arrive at the much quoted statement that "as many as 375,000 infants may be affected each year."

This estimate is much too high. The 36 hospitals in the study accounted for less than 5 percent of all live births in 1987, and, more importantly, they were hardly representative of the nation as a whole; roughly two-thirds were located in large cities. Also, in the study, "substance" was broadly defined as heroin, methadone, cocaine, amphetamines, PCP, or marijuana.

A better picture of the problem can be obtained by looking at the experience of a number of cities. Washington, D.C., is probably the area hardest hit by the crack epidemic, and yet in 1988 its approximately 1,500 drug-exposed babies[6] made up only 7.5 percent of live births in the district and 15 percent of live births by district residents.[7] Similarly, in New York City, another concentrated area of heavy drug use, the number of drug-exposed babies just about doubled between 1986 and 1987, increased another 70 percent in 1988, and is projected to increase another 70 percent this year—to nearly 7,000 drug-related births a year.[8] But these drug-related births represent only about 5 percent of all live births in the city.[9]

Thus, a national total of 1 or 2 percent of all live births, or 30,000 to 50,000 crack babies, seems a more realistic figure. (To get a better fix on the precise figure, the American Enterprise Institute and the American Public Welfare Association are now conducting a national survey of child protective agencies.) Even this more conservative estimate is large enough to make crack babies a national concern. At its peak in the late 1960s and early 1970s, heroin withdrawal affected only one-tenth as many newborns and it did much less damage to them.[10]

The problem of fetal exposure to cocaine and other drugs is so large that it raises overall infant mortality rates. In Los Angeles County, the number of drug-associated fetal deaths increased from nine in 1985 to 56 in 1987.[11]

Richard S. Guy, cochair of the Washington, D.C. Mayor's Advisory Committee on Maternal and Infant Health, has said that the district's infant mortality rate is "going to go up" because of the "tremendous increase in the number of mothers abusing drugs."[12]

Abuse and Neglect

"These mothers don't care about their babies and they don't care about themselves," says Jing Ja Yoon, chief of neonatology at Bronx Lebanon Hospital. "Crack is destroying people—I've never seen mothers like this before."[13]

Some crack babies die of neglect. In one case, a 10-month-old died after being left overnight in an overheated room—it reached 110 degrees—while his mother visited her boyfriend.[14] In New York City, 59 percent of the child abuse and neglect fatalities involving children previously known to the authorities—usually drug babies—occur within the first six months of life.

Some new mothers abandon their sick babies in the hospital, not even returning after the infant dies to help

bury the child. "Women sell their souls," according to Barbara Swiciki of New York's Jamaica Community Adolescent Program, "and with crack they are hitting rock bottom a lot faster."[15] "For the first time we've been in the business we don't know where the mothers are," says Lorraine Hale, who is executive director of Hale House, a nationally known refuge for the children of addicts. "She walks in the front door, she walks out the back door, and we don't see her again."[16]

"People who start using have got to find that money. Children aren't being fed," according to Maurice Macey, Western Regional Manager for Missouri's Division of Alcohol and Drug Abuse. "Mothers sell their food stamps. Young women sell their bodies, and that's done in front of the children. Even when heroin was at its worst, it wasn't like this—it wasn't openly done."[17] Caseworkers tell of three-year-olds feeding themselves from refrigerators and of seven-year-olds who know how to use illegal drugs after watching their parents use them.[18]

Crack children are also at great risk of physical battering. Crack is a mean drug that seems to induce some parents to great violence. Cases of crack-crazed battering of children are becoming more common. In one widely cited case, a five-year-old girl was found dead in her parents' apartment with a broken neck, a broken arm, large circular welts on her buttocks, and cuts and bruises on her mouth. Her nine-year-old brother was found the next day huddled in a closet. Both of his legs were fractured; he had eight other broken bones, and bruises covered his body.[19]

A Ramsey County Minnesota Department of Human Services study of 70 "cocaine-attached" households in mid-1988 found the parents to be "extremely volatile with episodes of 'normal' behavior interspersed with episodes of unpredictable, dangerous, and even violent behavior."[20]

Substance abuse has become the "dominant characteristic" in the child abuse caseloads of 22 states and the District of Columbia, according to a recent study of the National Committee for Prevention of Child Abuse. According to New York City's Human Resources Administration, "Following the influx of crack, the reports of drug-related child abuse surged by 72 percent in a year. The number of cases of abuse and neglect filed in the Family Court has increased almost six-fold since 1984."[21] In the District of Columbia, almost 90 percent of those reported for child abuse or neglect are active substance abusers.[22]

Substance abuse has become the "dominant characteristic" in the child abuse caseloads of 22 states and the District of Columbia.

Moral Wars

Instead of building effective child protective responses to the plight of drug children, we are in danger of fighting what Edwin Delattre, Bradley Fellow in Applied Ethics at the American Enterprise Institute, calls a series of "moral wars" over the question of treatment versus punishment of crack mothers.

On one side are those who call for a major expansion of prenatal care and drug treatment programs. But at least for now, such services would make little difference in the lives of drug children.

Better prenatal care might help somewhat, even though cocaine seems to do its damage no matter how well the mother otherwise cares for her unborn child. But crack addicts typically show little or no interest in prenatal care and are unlikely to seek it until very late in pregnancy, if ever. Often they present themselves at the hospital only in time to give birth.

In Boston, prenatal care is free for all low-income mothers. Yet between August 1988 and February 1989, of the 38 babies born at Boston City Hospital to mothers who had not obtained prenatal care, 37 tested positive for cocaine.[23] In fact, according to the hospital's Elizabeth Brown, "It is common knowledge in the streets that crack will induce labor. It is not extraordinary for a woman, bored and uncomfortable, to take crack purposely to induce labor."

Similarly, an expansion of drug treatment programs for women is long overdue; there are now long waiting lists for drug treatment programs, and many do not accept pregnant women or mothers. But more treatment services will not produce quick or substantial results.

Crack addicts are exceedingly difficult to reach. "To get off drugs one must be motivated by love or dedication to something greater than personal pleasure or pain," as Delattre explains. "But the circumstances of these young people—without education and opportunity—thwart the formation of such motivation, and this, plus the intense pleasurability of cocaine, make successful treatment almost impossible for many addicts."

What we cannot do for crack addicts in general, we cannot do for addicts who happen to be mothers. Years of effort have yielded no widely applicable therapeutic program for treating heroin addicts. Methadone maintenance proved to be the only practical treatment for large numbers of addicts. Up to now, no similar "blocking" agent for cocaine has been found. (There have been some

initially promising experiments with antidepressants, but years more work will be necessary to see whether they can help.)

"Crack is new enough that no one has yet figured out an effective treatment," according to Peter Reuter, a Rand Corporation expert on drugs. We could spend vast amounts without seeing any improvement in parental functioning. Given limited government funding, the same dollars would probably be better spent on preventive efforts—such as expanded Head Start and other preschool programs and better education, job training, and housing in general.

On the other side of the debate are those who argue for "getting tough" with crack mothers. Recently, there have been a number of criminal prosecutions of mothers. In May 1989, an Illinois jury refused to convict a mother whose daughter died of fetal exposure to cocaine. In July, a Florida mother was convicted of delivering cocaine to her baby through the umbilical cord. More attempts at similar prosecution are expected.

Some have suggested that pregnant drug addicts be placed in custody to make sure that they stop using drugs. Washington, D.C., judge Peter Wolf, for example, ordered a pregnant woman to remain in jail until she delivered her baby after she tested positive for cocaine use while awaiting trial on theft charges. After she failed to report for court-ordered spot drug checks at a drug treatment program and then tested positive in a presentencing screen, the judge told her, "You've got a cocaine problem, and I'm not going to have this baby born addicted."[24]

Some drug mothers undoubtedly "deserve" to be prosecuted. Most of us lose our moral tolerance for women who brutally batter their children or allow others to do so; who seem callously indifferent to their children's need for a safe environment; or who, even after clear warnings, give birth to two or three severely damaged babies in a row. But criminal prosecution simply cannot be pursued broadly. We lack sufficient prison space to house even serious criminals.

Furthermore, few Americans seem prepared to take this kind of harsh action against young mothers who, in many respects, are victims themselves. And there is a real danger that, faced with the possibility of incarceration, many pregnant women will not come in for prenatal care. This has been the experience of some prenatal clinics that do routine HIV and drug testing.

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Protecting Drug Children

Neither punishment nor treatment, therefore, is likely to help the children of drug addicts, but the controversy threatens to divert attention from what can be done—now—to protect these children. Immediate action is needed on four fronts.

Government and community leaders must make it clear that drugs and pregnancy do not mix. Some young mothers still do not believe that crack is bad for their babies. They see other addicts giving birth to healthy babies and they convince themselves that they will, too. It's a little like what some smokers say to defend their habit: "You should see my Uncle Harry. He's 70 years old and has smoked three packs a day for 50 years." The law of averages may not have caught up with Uncle Harry yet, but others are not as lucky.

Another problem is that cocaine still has great cachet. For years it was viewed as a benign drug, and all but endorsed by glamorous movie stars, athletes, and even presidential aides. The lesson the middle class learned from the death of Len Bias, a University of Maryland basketball star killed by cocaine soon after signing a multimillion dollar contract with the Boston Celtics, has not taken hold in poorer neighborhoods. Public health authorities must launch an effort to educate and change attitudes about drug use during pregnancy.

Despite all we know about the harmful effects of cocaine, no concerted government effort has been undertaken to educate young women about the dangers of using drugs while pregnant. Continued silence is inexcusable. The Department of Health and Human Services, perhaps under the personal leadership of Secretary Louis Sullivan, 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. It cripples and sometimes kills babies.

Hospitals should be given the legal power and financial resources to care for drug babies until they are medically and socially ready for discharge. In August 1989, the Greater Southeast Community Hospital of Washington, D.C, released a seven-week-old baby to her homeless, drug-addicted mother even though the child was at severe risk of pulmonary arrest. The hospital's explanation: the mother "demanded that the baby be released."[25]

The hospital provided the mother with an apnea monitor to warn her if the baby stopped breathing while asleep and trained her in cardiopulmonary resuscitation. But on the very first night, the mother went out drinking and left the baby at a friend's house—without the monitor. Within seven hours, the child was dead.

About half the states have laws that allow hospitals to hold endangered children against parental wishes. These laws protect children when there is no time to get a court order or obtain police assistance. All states should have them.

Recent amendments to the federal Medicaid program guarantee that most hospitals will be reimbursed for the added and sometimes extraordinary costs of caring for these children. But the word has been slow to get out, and many cost-conscious hospital administrators have been releasing children before they are medically ready for discharge. Again, an educational effort is needed.

After a drug-exposed child is born, hospital and child protective agency decision making should focus on the mother's ability to care for the child and past instances of physical violence—especially by men in the household. They should also make a realistic assessment of the mother's ability to meet the special needs of a fragile, drug-weakened newborn. (Some crack babies die because their mothers cannot provide them with the intensive care they need just to survive, care that many nonaddicted mothers would have difficulty providing.) Because of the close coordination and immediate communication often needed in these cases, some child protective agencies are posting workers in hospitals that see large numbers of drug mothers.

An estimated 25 percent of drug-exposed newborns have siblings who were also exposed fetally. Medical and social services agencies should provide follow-up counseling and instruction to discourage these women from having another drug-affected baby.

More medical knowledge about how to treat these children is also needed. This includes research on the treatment of immediate problems and remediation of long-term deficits and new hospital protocols that address both their medical and social condition to improve diagnosis and case planning.

Children should not be left with drug-addicted parents who cannot or will not care for them. Most communities with a serious crack problem have experienced a concomitant increase in foster care placements.[26] In New York City, the foster care population rose almost 50 percent between 1986 and 1989. (The increase was almost 100 percent if placements with relatives are included.)[27] But, although practices vary widely, in most communities the majority of drug children are left at home—in the care of their drug-addicted parents. Last summer, Washingtonians were shocked at the plight of Dooney Waters, a six-year-old living in his mother's drug den and all but abandoned by the authorities. The tragic fact is that there are thousands of other Dooneys.

Even in New York City, where foster care levels have doubled, 59 percent of babies who were held in hospitals—usually because of their parents' drug use—are later discharged to their parents or relatives.[28] Only about a third of the approximately 450 cocaine-exposed babies born at Harlem Hospital in 1988, for example, were placed in foster homes.[29] Older children are even more likely to be left at home.

Permeating all child welfare decisions are deeply felt—but overly simplistic—attitudes about the importance of preserving families.

Some drug-using parents are able to care for their children, at least with social service support. But most of their children remain at great risk while they stay at home. In 1987, of New York's child-abuse fatalities involving children previously known to the authorities, about three-quarters were alcohol- or drug-related.[30] Hundreds of others children suffer injuries short of death.

What's going on? Why don't judges and caseworkers remove more of these obviously endangered children from the custody of their drug-addicted parents? In some cases, they do not discover key evidence of the child's endangerment or simply make mistakes of judgment. But neither explains what appears to be a systemic tendency to leave children with their drug-addicted parents.

Part of the explanation is money. Foster care, especially for these children, who often need special treatment, is expensive—depending on the child's condition, from $5,000 to $20,000 a year. The District of Columbia, for example, seems unable or unwilling to find money in its budget to help these children. Earlier this year, nurses at D.C. Children's Hospital notified the district's child protective agency each of the two times that a one-year-old child was sent home after testing positive for PCP, and both times he was returned to the hospital with a higher level of drugs.[31] Normally, the district's child protective services agency will not become involved unless a mother abandons her newborn.

The other part concerns attitudes. Permeating all child welfare decisions are deeply felt—but overly simplistic—attitudes about the importance of preserving families. In recent years, much has been learned about diagnosing and treating abusive and neglectful parents; programs across the nation are helping parents take better care of

their children, thus avoiding the need for foster care placement. It is only natural to believe that these addicted mothers can be helped.

But crack and other drugs drastically reduce the ability of existing programs to treat parents successfully. "In my 20 years in this business, I've never seen anything like it," says Linda Spooner, director of a drug treatment center set up by New York's Jamaica Community Adolescent Program. "I've seen kids on angel dust, acid, speed, heroin, and cocaine; but I've never seen a drug destroy a person as quickly as crack."[32]

Reflecting attitudes of society at large, judges and caseworkers are unable to accept the realities of crack addiction. Instead, they convince themselves that, somehow, this parent will make it. Any sign of improvement in the mother's functioning is seen as an indication that the child can be left at home or returned, even though there is no reason to think that her drug problem has been licked.

One repeatedly sees admirable—but misplaced—efforts to give parents chance after chance to turn their lives around. Four months after one infant was discharged from a six-month foster care placement and returned to her mother and grandmother, she was found to have serious burns on her back, possibly made by an iron. The child was immediately returned to foster care. Subsequently, the mother admitted using crack to her social worker, and six months later; despite being enrolled in a drug treatment program, she gave birth to a baby with cocaine symptoms. Yet the agency's goal was still to return the girl, by then almost three years old, as well as the newborn, to their mother. [33]

We must face the implications of the mother's addiction—and our inability to break her habit. If parents cannot care for their children, the children should be removed from their care and placed in foster care. This may require overhauling state and federal foster care and adoption laws that have been wrongly interpreted to preclude early removal of these children. Of course, one can hope that these laws will be interpreted differently; but the fastest and most effective reform would come from a simple revision that emphasizes the need to remove some children from their parents' custody.

Adoption should be a real option for children whose parents show little prospect for improvement—even though this means terminating parental rights. Unfortunately, legal rules and social attitudes make it exceedingly difficult and time-consuming to terminate parental rights. In New York City, 60 percent of the babies discharged from hospitals to foster care—mostly crack babies—were still in foster homes three years later. Another 30 percent had been returned to parents or relatives. Only 7 percent had been adopted.[34]

Even in the most threatening cases, few children are quickly freed for adoption. One crack baby's father had served four months in jail for killing the boy's baby sister six months earlier. The mother, who was frequently beaten by her husband, was in touch with the foster care agency only sporadically. She subsequently gave birth to another cocaine-exposed child; three years later the child still lived in a temporary foster home.[35] In March, 1989, a Washington, D.C., Superior Court judge ordered the district to set up a $100,000 trust for each of two boys, ages 10 and 12, who had been known to the agency since 1980 and who had been free for adoption for six years.[36]

If parents cannot care for their children, the children should be removed from their care and placed in foster care.

Drug children should not be allowed to get lost in a foster care limbo. In New York City, for example, after three years, 56 percent of the babies discharged from hospitals to foster care had been in two or more foster homes; 20 percent had been in three or more homes.[37] One child had been in eight homes.[38]

Drug children should be given a permanent and nurturing home, even if it means terminating parental rights and finding them adoptive parents. Most are adoptable; there are even waiting lists to adopt babies with spina bifida and Down's syndrome. Those who are not adoptable should also have permanent arrangements made for their upbringing.

To make the termination of parental rights easier, the Washington, D.C., Mayor's Advisory Board on Maternal and Infant Health proposed that the "complexities" of the district's adoption procedures be reduced. The issue runs deeper, though. Laws and attitudes must also change. No one likes to give up on parents, to label them as "hopeless," especially since many are themselves victims of broader social problems. But these children deserve a chance—even if we must assume long-term responsibility for their care and upbringing.

These are not total solutions—but they would do more to protect the children of addicts than wishful thinking about treatment or arguments about criminal prosecution. Each day that we fail to take decisive protective action means suffering, even death, for thousands of children. ***PW***

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For "Notes and References," see page 42.

BESHAROV Children of Crack

Meredith Moore and Vincent Cannato helped prepare this article.

1. According to Gordon Avery of Children's Hospital in Washington, D.C., "Cocaine babies are at risk for respiratory failure, sudden infant death syndrome, pre-term delivery and some have actual brain infarctions, which could cause a reaction similar to a stroke in old people." Telephone conversation, March 27, 1989. See also Barbara Whitaker, "Tiniest Tragedies of Drugs," *Newsday*, July 11, 1988, p. 9.
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3. Chairman's draft recommendations for the *Final Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*, June 2, 1988, at 170.
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7. Stephanie Ventura, U.S. National Center for Health Statistics, telephone converstation, August 14, 1989. There were 20,529 live births in the District, of which 10,208 were by District residents.
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19. M. A. Farber, "Killing of a Child: How the System Failed," *New York Times*, January 19, 1989, p. A1, col. 3.
20. Clement, p. 49.
21. Wynhausen, p. 74.
22. "Drug Habits Called Factor in Child Abuse," *Washington Post*, March 31, 1989, p. A8, col. 1. Eighty percent of the last 500 cases seen by Child Protective Services (CPS) in the district were drug related, as were 70 percent of all D.C. General's maternity cases. Telephone conversation with Jean Bower, D.C.

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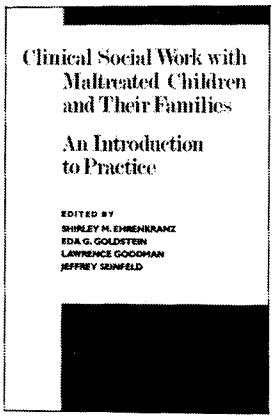

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24. Debra Cassens Moss, "Pregnant? Go Directly to Jail," *ABA Journal*, Nov. 1, 1988, p. 20.

25. Transcript of news broadcast, WTTG-TV, Washington, D.C., July 26-27, 1989.

26. Toshio Tatara of the American Public Welfare Association estimates that the nation's foster care population increased from 280,000 to 300,000 between 1986 and 1988. Tatara bases his estimate on the fact that the foster care rates in California and New York, comprising 17 percent of the total population, are up by approximately one-third.

27. Terry Weiss of the New York Human Resources Department provided the following figures of the foster care population: June 1986—16,939 children; June 1987—18,245 children; June 1988—23,960, including 3,460 who were living with relatives; February 1989—31,607, including 8,828 who are living with relatives.

28. Office of the Comptroller, *Whatever Happened to the Boarder Babies?*, City of New York, January 1989, p. 7.

29. David Bateman, Harlem Hospital, New York City, telephone conversation, March 27, 1989. There were 3,000 total births at the hospital.

30. Memorandum to Stanley Brezenoff, first deputy mayor, New York City, from William J. Grinker, human resources administrator, March 31, 1988, "Activities of the HRA Internal Fatality Review Panel during Calendar Year 1987," p. 3. It appears that about two-thirds were drug-related.

31. Greene, p. A1, col. 1.

32. Wynhausen, p. 70.

33. Office of the Comptroller, *Whatever Happened to the Boarder Babies?* , p. 23-24.

34. Office of the Comptroller, City of New York, untitled press release , January 31, 1989, p. 2.

35. Office of the Comptroller, untitled press release, pp. 2-3.

36. Marcia Slacum Greene, "Two Boys' 6-Year Wait for Adoption Reveals Cracks in D.C. System," *Washington Post*, March 6, 1989, p. B1, col. 1.

37. Office of the Comptroller, *Whatever Happened to the Boarder Babies?*, p. 15.

38. Office of the Comptroller, untitled press release, p. 2.

NORTH
Widening Horizons

1. The JOBS program implements the Family Support Act's objective that all recipients be working, looking for work, or involved in training or education. Together with their caseworker, recipients construct employability plans that lead to eventual self-sufficiency. Whether postsecondary education is an appropriate component in that plan, and thus eligible for JOBS funds for transportation and child-care, will be decided by the separate states in their state plans.

2. This description is largely extracted from the university's project proposal.

3. Roxanne Brown, "A College Program for Single Parents and Their Kids," *Ebony*, December 1987, pp. 136-40.

4. This material is largely extracted from the college's brochure on Berry Hall.

5. The following arguments for including postsecondary education in the JOBS program were developed in May 1989 by Beverly Purrington, director of the Women's Resource Center, University of Utah; Clifford Johnson, acting director, Division of Family Supports, Children's Defense Fund; and me.

6. Clifford M. Johnson, *The Vanishing Dream*, Children's Defense Fund, 1988.

7. "Working but Still Poor," *The National Journal*, June 18, 1988.

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