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# CRACK BABIES

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**OFFICE OF INSPECTOR GENERAL**  
**OFFICE OF EVALUATION AND INSPECTIONS**

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JUNE 1990

## OFFICE OF INSPECTOR GENERAL

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## OFFICE OF EVALUATION AND INSPECTIONS

This report is produced by the Office of Evaluation and Inspections (OEI), one of three major offices within the OIG. The other two are the Office of Audit Services (OAS) and the Office of Investigations (OI). The OEI conducts inspections which are typically short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud and abuse.

The purpose of this report is to examine how crack babies are affecting the child welfare system in several major cities. A separate report identifies programs and procedures considered effective in working with crack addicted mothers and their babies. The study was prepared under the direction of Joy Quill, Regional Inspector General, Office of Evaluation and Inspections, Region III. Participating in this project were the following people:

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# CRACK BABIES

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## EXECUTIVE SUMMARY

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### PURPOSE

This report examines how crack babies are affecting the child welfare system in several major cities.

### BACKGROUND

Crack is cocaine in a smokeable form. It first appeared in the United States during the mid-1980's. Although crack is only one method of ingesting cocaine, we use the terms crack and cocaine synonymously in this report as their detection in the body does not differ.

The National Institute on Drug Abuse (NIDA) estimates that over 6 million women of child-bearing age are using illegal substances; for 1 million this means cocaine. The President's National Drug Control Strategy estimates that 100,000 cocaine exposed babies are born each year.

Prenatal cocaine exposure can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. Crack babies have a significantly higher rate of Sudden Infant Death Syndrome (SIDS) than babies who have not been prenatally drug-exposed. While most experts believe that many crack babies will suffer developmental disabilities, the full range of long-term effects of prenatal cocaine exposure is not known.

When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services, or foster care. However, these agencies are often unable to meet the needs of crack babies and their mothers.

While some State and local governments have done studies on aspects of the crack baby problem, little data is currently available at the national level. Several studies are underway at the Federal level to gain insight into this problem.

### METHODOLOGY

We conducted on-site interviews in 12 metropolitan areas during the last quarter of 1989. Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, State and local officials, and national experts.

We also reviewed numerous studies and public documents on this subject.

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## FINDINGS

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### **WE ARE ONLY SEEING PART OF THE PROBLEM**

*The scope of the problem is wide-ranging.*

Only two-thirds of the cities we visited could provide the number of crack babies reported to the child welfare system. These eight cities handled 8,974 crack baby cases during the previous year. These cities represent 20 percent of the population of U.S. cities of more than 50,000. Many crack cases are unreported. Some respondents estimate that only half of the crack babies are reported. The actual figures we obtained, coupled with the underreporting phenomenon, are consistent with President Bush's National Drug Control Strategy report which estimates 100,000 cocaine babies born per year.

We estimate the cost for hospital delivery, perinatal care, and foster care through age 5, for those children who need it, for just these 8,974 identified babies will approximate \$500 million.

Crack babies may also require other services. The Florida Department of Health and Rehabilitative Services estimates an annual cost of over \$40,000 per child to get crack babies ready for school. If other States in our study were to provide similar services for these 8,974 identified babies, the additional costs for developmental intervention, education, and health services through age 5 could be as high as \$1.5 billion.

While these calculations do not include any costs for services which may be required by some crack-exposed children after age 5, such costs will also be substantial. In Pennsylvania, for example, one year of special education in a class for a learning disabled child costs \$7,900. A year of residential treatment and special education for an emotionally disturbed child costs \$25,000 to \$47,500. The average episode of juvenile detention lasts 15 days and costs about \$2,250. If a juvenile requires residential drug treatment, costs can be \$15,000 or more.<sup>1</sup>

The NIDA is currently supporting research on the costs to communities of providing comprehensive services to addicted pregnant women and their children. Additional research is planned on costs and benefits of foster care.

*There is no typical crack baby.*

There is no typical set of signs or patterns by which to identify a cocaine-exposed infant. A Los Angeles County study found that 70 percent of crack babies are full term.<sup>2</sup> One expert suggests that because the babies appear healthy, doctors frequently do not detect the subtle signs of cocaine exposure. Therefore, some babies are discharged without being recognized as drug-exposed.

***People Are Worried About The Effects Of Prenatal Exposure To All Drugs, Not Just Crack.***

- Crack is not the only drug threat to the lives of crack mothers and their babies.
- Respondents want leadership and action.

**RECOMMENDATIONS**

***State And Local Governments Should:***

- Encourage outreach and community involvement with aggressive campaigns emphasizing the dangers of prenatal drug and alcohol exposure;
- Reduce placement barriers by reviewing and revising existing laws and policies on abandonment, termination of parental rights, and interracial placement;
- Develop guidelines and training for child welfare staff;
- Establish reporting and tracking systems;
- Expand interagency mechanisms to coordinate services and integrate funding.

***The Office Of Human Development Services Should:***

- Identify and disseminate practices considered effective in dealing with drug-exposed baby cases;
- Focus service strategies on serving the family;
- Evaluate obstacles to placement including policies on family reunification, voluntary termination of parental rights, and restrictions on foster care and adoption.

***The Office Of Human Development Services And The Public Health Service Should:***

- Coordinate Departmental activities relating to drug-exposed babies and their families;
- Conduct short- and long-term research on the effects of prenatal exposure, treatment models, and placement outcomes;

- Promote drug abuse training in medical schools, hospitals, and child welfare agencies;
- Promote prevention through public outreach and informational materials.

*The Public Health Service And The Health Care Financing Administration Should:*

- Continue to support targeted, intensive outreach and prenatal care for substance-abusing pregnant women and their babies.

**COMMENTS**

We received comments on the draft report from the Office of Human Development Services (HDS), the Public Health Service (PHS), the Health Care Financing Administration (HCFA), and the Assistant Secretary for Planning and Evaluation (ASPE). Respondents were generally supportive of our findings and recommendations. Suggestions to strengthen recommendations and a number of technical corrections have been incorporated into the report. We also expanded discussion on some issues in response to comments from all respondents. The full text of comments received appears in the appendix.

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## TABLE OF CONTENTS

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**EXECUTIVE SUMMARY**

**INTRODUCTION** .....1

**FINDINGS** .....3

**We are only seeing part of the problem** .....3

**The child welfare system struggles to cope** .....6

**Most crack babies go home,  
but many go into foster care** .....9

**People are worried about prenatal exposure  
to all drugs, not just crack** .....13

**RECOMMENDATIONS** .....15

**ENDNOTES** .....21

**AGENCY COMMENTS** .....A-1



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## INTRODUCTION

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### PURPOSE

This report examines how crack babies are affecting the child welfare system in several major cities. A companion report identifies programs and procedures considered effective in working with crack-addicted mothers and their babies.

### BACKGROUND

Crack is cocaine in a smokeable form. It first appeared in the United States during the mid-1980's. Although crack is only one method of ingesting cocaine, we use the terms crack and cocaine synonymously in this report as their detection in the body does not differ. The National Institute on Drug Abuse (NIDA) estimates that over 6 million women of child bearing age are using illegal substances; for 1 million this means cocaine. The President's National Drug Control Strategy estimates that 100,000 cocaine-exposed babies are born each year.

Prenatal cocaine exposure can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. Crack babies have a significantly higher rate of Sudden Infant Death Syndrome (SIDS) than babies who have not been prenatally drug-exposed. While most experts believe that many crack babies will suffer developmental disabilities, the full range of long-term effects of prenatal cocaine exposure is not known. Four Department of Health and Human Services agencies are directly affected by the increase in crack baby births: the Office of Human Development Services (HDS), the Public Health Service (PHS), the Health Care Financing Administration (HCFA), and the Social Security Administration (SSA). These Federal agencies fund services for crack-addicted mothers and their babies through a variety of programs, most operated at the State and local level.

When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services, or foster care. However, these agencies are often unable to meet the needs of crack babies and their mothers.

Most crack mothers are not teenagers. Most often, they are between their early 20's and 30's, with an average age of 25 to 28 years. Usually, they have between two and four other children. Crack babies reported to the child welfare system are primarily black, with a smaller number of Hispanics and even fewer whites.

While some State and local governments have studied this issue, little data is currently available at the national level. Both HDS and PHS have studies underway to gain insight into the problem. The General Accounting Office (GAO) is also studying the costs of services for this population. In addition, the Office of Inspector General (OIG) is conducting two related inspections on the termination of parental rights and laws regarding prenatal exposure to substance abuse.

## **METHODOLOGY**

We conducted on-site interviews with over 200 respondents in 12 metropolitan areas during the last quarter of 1989. The sites included: Chicago, Fort Wayne, Los Angeles, Miami, New York City, Newark, Oakland, Philadelphia, Phoenix, San Francisco, Tacoma, and Washington, D.C. We selected these sites to give a perspective on how cities of varying size and location were being affected by crack baby births.

Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, and State and local officials. We also interviewed national experts and reviewed studies and public documents on the subject.

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## FINDINGS

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### WE ARE ONLY SEEING PART OF THE PROBLEM

*The scope of the problem is wide-ranging.*

Only two-thirds of the cities we visited could provide the number of crack babies reported to the child welfare system. These eight cities handled 8,974 crack baby cases during the previous year. These cities represent 20 percent of the population of U.S. cities of more than 50,000. Many crack cases are unreported. Some respondents estimate that only half of the crack babies are reported. The actual figures we obtained, coupled with the underreporting phenomenon, are consistent with President Bush's National Drug Control Strategy report which estimates 100,000 cocaine babies born per year.

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The NIDA is currently supporting research on the costs to communities of providing comprehensive services to addicted pregnant women and their children. Additional research is planned on costs and benefits of foster care.

*There is no typical crack baby.*

There is no typical set of signs or patterns by which to identify a cocaine-exposed infant. A Los Angeles County study found that 70 percent of crack babies are full term.<sup>2</sup> One expert suggests that because the babies appear healthy, doctors frequently do not detect the subtle signs of cocaine exposure. Therefore, some babies are discharged without being recognized as cocaine exposed.

Crack babies are more likely to be born premature and to have special medical needs. Experts report that crack babies are nearly 4 times more likely to be born with low birth weights (under 2500 grams or about 5.5 pounds) than babies not exposed to drugs in utero.<sup>3</sup>

An estimated 18 percent of crack babies are born premature with complications and require extended intensive care.<sup>4</sup> One respondent told us that modern technology allows physicians to save many babies who would not have survived even a few years ago. This is especially true of the very low birth weight babies (500-1500 grams, about 1 to 3 pounds).

Some crack babies require special medical attention after hospital discharge. These children are designated as medically needy and require special services from their mothers or foster families.

### ***Most crack babies are not identified at birth.***

Inconsistent testing is one reason many crack babies are not identified at birth. According to respondents, public hospitals are the only ones testing; most private hospitals and physicians do not test. While no State visited mandates universal testing of mothers for controlled substances, Indiana does require testing if there is suspicion of drug exposure. One hospital in our sample tests all newborns.

The majority of hospitals in our survey rely on mothers to self-report drug use. At least four use this as their primary method of identification. Some respondents criticize using this method exclusively. A survey in one Florida hospital found only 27 percent of the pregnant women testing positive for drug use at labor and delivery had admitted their use.<sup>5</sup>

Five of 13 hospitals visited use specific testing protocols, and these vary in detail and scope. Testing criteria can include suspected drug use, lack of prenatal care, premature delivery, neonatal intensive care admission, and indications of a sexually transmitted disease. Some respondents are concerned that reliance on self-reporting and the absence of specific testing protocols mean that low-income and minority women are being tested while white and middle class women are not. This results in more minority and low-income babies being identified as drug-exposed.

Even when tests are conducted, they provide only limited information. Most tests can detect cocaine in the system for only 24 to 48 hours.

### ***Crack babies face future problems.***

When considering how society will deal with crack babies, some respondents emphasize that the environments in which these children are raised will play a major role in their development. In one expert's view, the real issue is how much damage is actually attributable to the child's home environment as opposed to in utero exposure to drugs.

Many respondents are concerned that drug-exposed babies will suffer long-term problems. They caution that the effects of cocaine exposure may not appear until the age of 2 or 3. These effects may include neurological and behavioral problems, attention deficits, and developmental delays.

Many respondents worry what will happen when crack babies reach school. Those who have worked with crack babies say the children will have severe learning disabilities as they grow older. We were told, "These children need special education. If they don't get that, we'll see them in juvenile court later." The Los Angeles Unified School District has developed a special curriculum for drug-exposed babies at the preschool level. A similar program exists in Chicago.

Many children are staying in foster care longer. As recently as 1985, nationwide median foster care stays ranged from 9 months, for those who had left foster care, to 1.5 years, for those who still remain. However, officials from 2 cities in our survey reported the current average length of stay as 3 years and 4.8 years respectively.

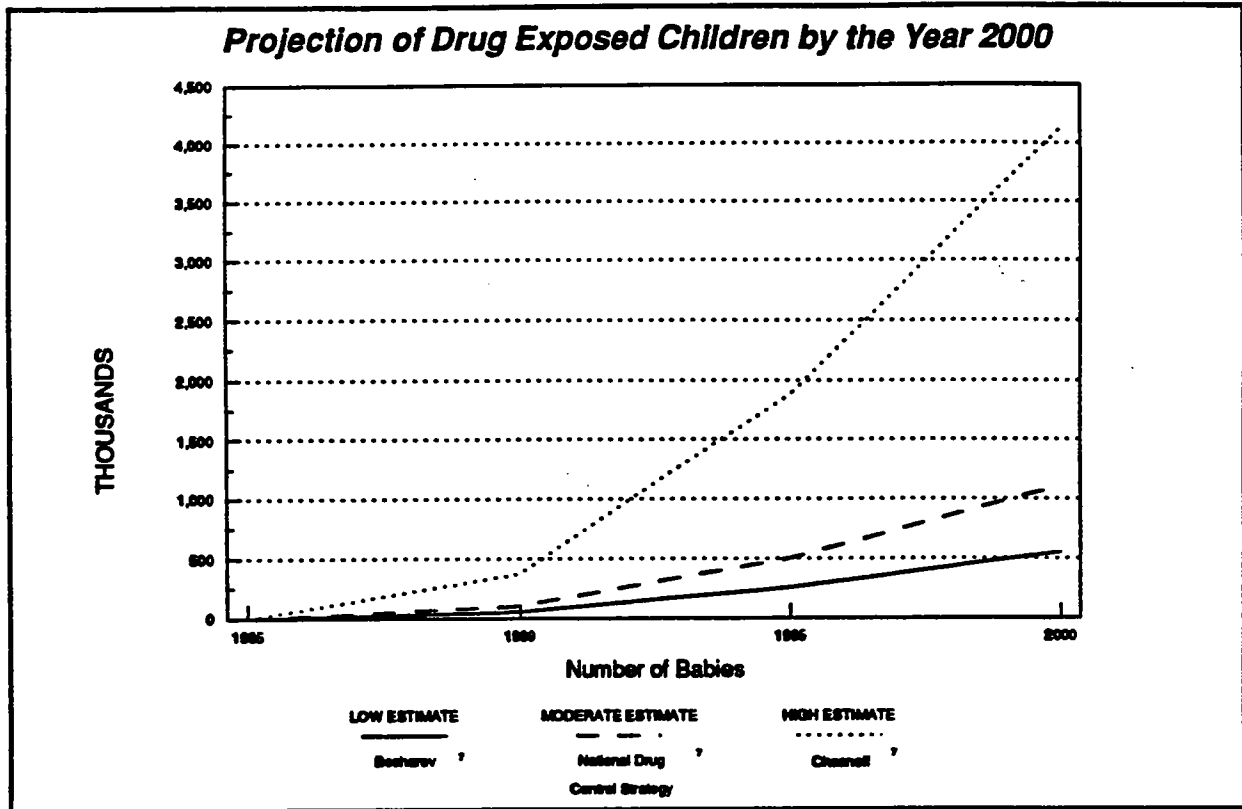
Children are also entering foster care at a younger age. According to a recent New York State report, "In 1980, only 19 percent of the foster care caseload was under 5. Today it is over 50 percent, primarily due to crack."<sup>6</sup>

According to several respondents, crack babies have more problems bonding than other babies. Researchers report that even in the care of their natural parents or a permanent foster parent, crack babies have difficulty bonding. Some researchers attribute a portion of this problem to organic damage caused by the drug exposure.

The following graph depicts the potential population of drug-exposed children born this decade, based on current annual estimates of crack-, cocaine-, and drug-exposed births.<sup>7</sup>

While the projections shown assume no change in annual drug-exposure birthrates, there are indications the number of drug-exposed births is increasing. In California, three hospitals report the number of drug-exposed births have at least doubled since 1986. One of these reports an 84 percent increase in 2 years.

Interviewees tell us the aftershocks of the crack epidemic will be felt by society for many years. As one respondent said, "Even if we stopped crack use right now, we would still be dealing with its effects in some way for the next 50 to 75 years. The ramifications are forever...it's a horrible cycle!"



**AN ALREADY OVERBURDENED CHILD WELFARE SYSTEM STRUGGLES TO COPE.**

*Crack baby cases are complicated and time-consuming.*

In most cities visited, an increasing majority of child welfare cases are drug related. The New York City Mayor's Task Force on Child Abuse and Neglect reported a 72 percent increase in child abuse related to drug dependency, primarily crack, from 1985 to 1988.

State officials contend that crack baby cases are more complex than other child welfare cases. One official said, "Crack users represent a different kind of [protective services] case. There is a lot more abandonment and violence." Crack baby cases require extensive tracking and follow-up. This can be difficult for caseworkers to provide when confronted with the realities of an already overwhelming caseload.

Drug use can supercede all other aspects of the lives of crack-addicted mothers. In the words of one caseworker, working with the mothers "is like beating your head against a brick wall...because you are dealing with someone who has no control over her life. She's worried about her next hit."

Caseworkers can spend days tracking mothers who give false addresses to hospitals and then abandon their babies. Other time-consuming activities include finding emergency placements, foster care, parental drug treatment, and services necessary for special needs children.

Child welfare casework is a dangerous job, according to several respondents. Caseworker home evaluations can involve entering hostile situations, unescorted and without radio contact. Personal danger, stress, and relatively low pay contribute to caseworker burnout or resignation. One city official reported half of the staff had been working less than 1 year. In another city, the average tenure of a child protective worker is 2 years. High turnover results in lack of service continuity and complicates legal proceedings because several caseworkers may work on a case over the years.

We found large child welfare worker caseloads in many cities. For example, one child welfare agency official reported an average caseload of 49 children for foster care and 161 for protective services. The Child Welfare League of America recommends not more than 17 active cases for workers dealing with abused or neglected children and their families.

***Prenatal exposure to drugs may not be treated as child abuse.***

Babies who test positive for controlled substances are not always reported to child welfare officials. The actions taken depend on how a State defines child abuse or neglect. These terms are not interchangeable and the distinction can be significant. The Office of Inspector General is currently conducting a study to assess how State legal definitions affect the handling of prenatal drug exposure cases.

Indiana law provides that a child born addicted to drugs can be considered abused or neglected. In Fort Wayne, the baby and any siblings are placed in protective custody pending an investigation. An Illinois law effective January 1, 1990 states that prenatal drug exposure is evidence of neglect.

Only four States visited require hospitals to report a positive toxicology to the child welfare agency or a central State registry. Some hospitals in other sites visited make referrals voluntarily. At one site, hospitals have been instructed by the child welfare agency to report cases only when the mother could not care for her child. In another city, drug exposure cases are investigated only if accompanied by other factors, such as mother self-identification or prior abuse reports.

***Several child welfare agencies are using new approaches to deal with crack baby cases.***

Some cities have organized high-risk drug baby units to provide intake and risk assessment for drug-exposed infants. The caseworkers assigned to these units are specially trained to deal with the needs of the substance-abusing mother and her child. In at least one city, caseworkers in these units have reduced caseloads.

One child welfare agency has decentralized services into zones and community districts. Caseworkers are now physically located closer to the families they serve. This enables caseworkers to provide better support for families and become more familiar with local services.

Cities are providing more caseworker training; New York City trained 1,264 new caseworkers in 1989. Many respondents felt that child welfare workers need more training to identify and assess the needs of substance abusers and their children. Other respondents said caseworkers need formal guidelines for making decisions regarding termination of parental rights.

***Hospitals are beginning to perform child welfare functions in some cities.***

Several hospital officials told us that because child welfare agencies are overwhelmed, they are taking action. They say hospitals cannot afford the financial losses that result from extended unnecessary stays. In some cities, hospitals now actively recruit foster parents, especially among their own staff. Some hospitals now make placement recommendations to child welfare.

Staff at several hospitals now locate, provide, and coordinate services for crack-addicted mothers and their babies. Other hospitals have begun to track clients after discharge.

***Interagency coordination helps child welfare agencies cope.***

Lack of coordination is the most difficult problem faced in providing services to crack babies and their families, according to many respondents. One interviewee said, "Interagency case management is the key to addressing this issue, if anything works."

Some States and private agencies are tackling the issue of coordination. Illinois has a program of collaboration among child welfare, alcoholism and substance abuse, and related programs. The coordinated effort has "reduced systems barriers to integrated services and allowed for a full complement of services to be made available to high-risk families."<sup>8</sup>

The family court division, attorney general's office, and child welfare agency in Miami coordinate services by "fast tracking" cases through the system. Fast tracking is a process where the courts agree to set aside specific times to hear dependency cases. Miami officials report that this process has allowed for more and faster placement decisions.

In many sites, governors or mayors have created task forces to address the crack baby problem. Staffed by private citizens, government officials, and medical and child development experts, the task forces identify and pull together service providers, recommend policies, and integrate monies for services to high-risk families.

***Comprehensive case management is essential in helping crack-addicted mothers and their babies.***

Case management consists of guiding families to services such as early intervention, education, health care, counseling, physical therapy, drug rehabilitation, and parenting classes. Respondents say that requiring clients to seek out supportive services on their own does not work with crack addicts. Client needs are so complex and their addiction so overwhelming that professional case management is needed.



The case manager is an advocate who leads families through the system. In the words of one respondent, it is unrealistic to expect a crack-addicted mother to meet the "demands of 8 to 10 different service providers simultaneously." A case manager can guide and motivate mothers and supervise care of the children. Case management is widely seen as the responsibility of the child welfare agency.

Successful case management requires that services be readily accessible, according to many respondents. They emphasized the need to locate services in the community and provide transportation and child care. Their most frequent comment was that central locations with multiple services work best; "one stop care," said one caseworker.

Even when services are available, however, crack mothers don't always participate. According to respondents, crack addiction results in demanding, impatient behavior. Crack mothers sometimes deny they have a problem and refuse services altogether.

### **MOST CRACK BABIES GO HOME, BUT MANY GO INTO FOSTER CARE.**

*Most babies go home with mother or a relative.*

Although few statistics are kept, respondents offered personal insights into the demographics of crack baby families. Usually 50 to 75 percent of identified crack babies go home with their mother or a relative, although the range is 50 to 95 percent at the sites visited. At two sites, a baby is put into temporary protective custody (for up to 72 hours) while the child welfare agency investigates.

Maternal grandmothers are the relative most likely to take the baby. Most child welfare workers try to place a baby with the grandmother before making any other kind of placement. Respondents at five sites say grandmothers, who often care for several children, are overwhelmed by the needs of drug-exposed babies. Officials report fathers are rarely involved with the custody of the baby.

Some relatives receive foster care reimbursements. Most child welfare agencies prefer relative to foster placements, but relatives often cannot afford to take care of the babies. New York City provides State-approved relatives with foster care reimbursements, but opinions on this approach vary. While some believe this approach is fairer and results in better monitoring, others say such programs delay reunification of mother and baby, create family antagonism, and perpetuate the baby's foster care status. At least one respondent said it creates opportunities for fraud.

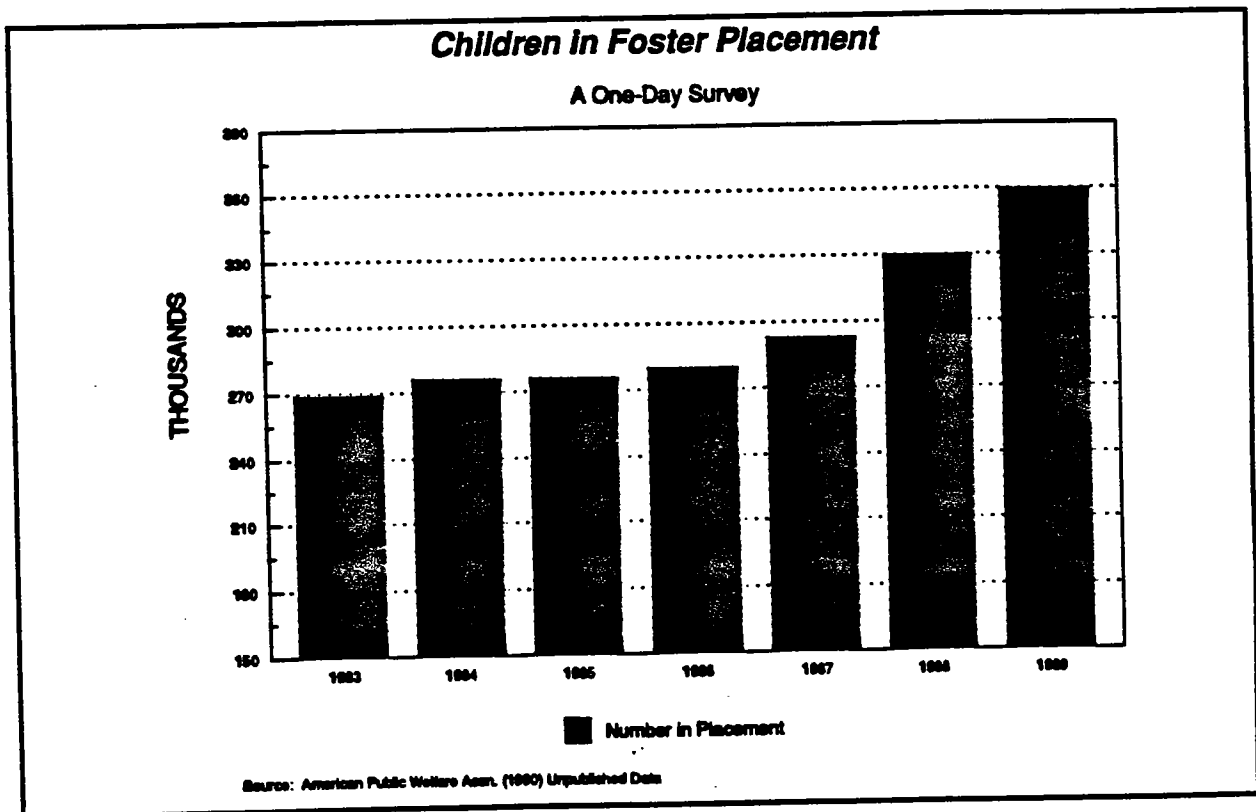
When mothers enter drug treatment centers that do not accept infants, their babies go to relatives or foster care. The restrictions against infants may be due to insurance liabilities and the traditional adult orientation of treatment programs. Some mothers must attend out-patient drug treatment programs as a condition for keeping their babies. Respondents tell us some mothers drop out of treatment or resume using drugs, but most treatment programs do not track recidivism among the mothers.

**Many babies go into foster care.**

Most officials estimate 30 to 50 percent of identified crack babies go into foster care, although a range of 5 to 50 percent was reported. According to some officials, children may be left with their natural parents because no foster placements are available.

Officials in Chicago, Newark, and Washington, D.C. report critical foster care shortages, but others are coping. Fort Wayne and Phoenix have little difficulty finding foster families. Both cities have comparatively small numbers of drug-exposed babies.

As shown in the chart below, the number of children in foster care placements has increased. On a given day in 1982, there were 262,000 children in placement; 280,000 in 1986; 293,000 in 1987; 330,000 in 1988; and an estimated 360,000 in 1989.



Respondents speculate the increase of children in foster care is due to increased parental drug abuse, but this cannot be confirmed. Data to demonstrate this connection is not collected nationwide by child welfare agencies.

Low reimbursement was the most commonly cited reason for a shortage of foster parents. Respondents say reimbursements are too low to attract full-time foster parents, especially for medically needy babies.

Rate schedules are complex and lack uniformity. Variables affecting rates include the child's age and health, the placement agency, and the services or products that qualify for reimbursement. For example, one city has eight categories of reimbursement for infants who do not require consistent medical attention and four categories for infants who do require consistent medical care. Within each category, child welfare has the flexibility to determine the exact reimbursement rate. Overall, reimbursement ranges from \$3,233 to \$30,730 annually.

Respondents also report shortages of black foster parents and homes that accept infants. In five cities respondents report a particular shortage of homes for infants with special needs. In one State that restricts interracial placements, the babies are predominantly black, but there is a shortage of black foster parents. To deal with the demand, some agencies put more children in each foster home, shift children between homes, separate siblings, and place children in group homes.

Respondents told us repeatedly that foster parents need training and support services. According to one respondent, there is a correlation between such training and a foster parent's willingness to continue. Others commented that foster parents need day care (regular and therapeutic), transportation, respite, and better access to physical and mental health services for their foster children.

In several cities, outreach efforts have produced good results. Strategies frequently incorporate newspaper stories, radio and TV talk shows, and paid advertising. Other recruitment approaches include teaming private foster care agencies with specific hospitals, offering bonuses to foster parents who recruit other foster parents, and working with local churches and community groups. Child welfare agencies and private agencies are also expanding the pool of potential foster parents by accepting singles and full-time employees.

Although outreach efforts often result in an outpouring of community response, the number who actually become foster parents is lower than the number who apply. Some applicants are disqualified while others lose interest. Respondents also say there are obstacles to increasing the pool of foster parents and keeping them. These include requirements that foster parents live within certain geographic limits and restrictions on interracial placements.

On the other hand, some respondents say that standards for foster parents have declined. According to a West Coast caseworker, applicants with "marginal" qualifications who would have been turned away a few years ago are now being accepted.

#### *A few go to other care settings.*

Crack babies are occasionally placed in other arrangements, such as emergency or congregate care. Emergency care is a temporary placement pending return to a parent or placement in foster care. Emergency care can be a small group home, a large shelter, or a foster family. When a long-term placement cannot be made, caseworkers may be forced to move babies

from one emergency placement to another. Two cities reported that they need but do not have emergency placement facilities.

Congregate care is usually a permanent group home. While used mostly for older children, some babies have been placed in such care. Officials in one city received strong public criticism of the care provided to babies in congregate care. As a result, all babies originally placed in congregate care have been placed in foster homes. Washington, D.C. is now building two group homes for infants to cope with critical foster care shortages.

We encountered strong opinions about congregate care. Of 58 respondents who commented, nearly half (27) believe congregate care can work as a substitute for foster care as long as the homes are small, keep siblings together, and are managed professionally. Twenty-one respondents think congregate care is a bad idea; 10 have mixed opinions.

A few babies go with their mothers to residential drug treatment centers. Mothers and babies stay at these centers from 6 to 24 months, depending on the program and the mother's treatment needs. Seven cities visited have at least one such center, and respondents say many more are needed.

Some babies remain in the hospital even though medically ready for discharge. Known as "boarder babies," these infants stay in the hospital due to legal complications, questions about parents' ability to care for them, or lack of care alternatives. Respondents from five cities with boarder babies say they are able to make placements in a timely manner. Four other cities report they are not able to make timely placements. The three remaining cities did not raise the issue. More information on this issue is presented in our companion report, "Boarder Babies."

#### ***Few crack babies have been adopted.***

While respondents prefer adoption to permanent foster care, opinions on adoption versus family reunification differ widely. Many respondents said the existing policy goal of family reunification is unrealistic for many crack babies and simply prolongs the adoption process. But others feel strongly that child welfare's goal of family reunification should remain.

The adoption process is long, difficult, and expensive. According to a recent report from a children's advocacy group, caseworkers guiding the process need to be more aggressive "to challenge the hurdles of the adoption process, to face a court which seems reluctant to approve adoption, ...to [confront] the parent, and to negotiate the obstacles of the agency process itself."<sup>9</sup>

Most prospective parents want babies. Officials tell us that termination of parental rights is usually contested, and although the process can theoretically be completed in 18 months, the reality is at least 3 years. By then, these children are less likely to be adopted; they are not babies anymore.

Respondents cited other hindrances to adoption. One referred to a law which requires a 72-hour waiting period for a mother to voluntarily relinquish parental rights. This respondent added that a crack mother may decide to relinquish her rights when her baby is born, then leave the hospital and disappear. Neither hospital nor child welfare staff can locate her. When this happens, the baby cannot be made available for adoption until the legal process is complete.

Another long-standing barrier to adoption is the bias against interracial placement. Some respondents say white families don't want black babies; others say States and agencies are slow to approve interracial adoptions.

Many respondents believe that even if parental rights were terminated, most crack babies would not be adopted. One caseworker frankly said there are not enough people willing to adopt "these kind of children." Prospective parents fear long-term effects of crack and potentially expensive medical, educational, or psychological needs. Adoption subsidies for hard-to-place children, available in all States, are being used in some cities visited.

### **PEOPLE ARE WORRIED ABOUT THE EFFECTS OF PRENATAL EXPOSURE TO ALL DRUGS, NOT JUST CRACK.**

*Crack is not the only drug threat to the lives of crack mothers and their babies.*

On the West Coast, the next drug crisis is already here. Child welfare agencies are preparing for babies born to users of a methamphetamine derivative called "ice." Although ice is more expensive than crack, the long-lasting high makes it attractive to drug abusers. Methamphetamine is known to produce rapid, extensive fetal damage.

Many respondents, especially on the East Coast, were concerned about the overlap of AIDS and crack. In the words of one official, "You can't separate the crack baby problem from the AIDS problem." The overlap of AIDS and drugs for these infants often means we are dealing with the same risk groups, offering the same messages, and often providing services to the same babies.

Respondents said many crack-addicted women engage in high-risk behavior and bear AIDS-infected babies. Fully 70 percent of pediatric AIDS cases are the result of drug abuse by the mother or her sexual partner. A local health official said, "AIDS is now the largest killer among young women [here]. We may not have to worry about [crack baby] mothers; they'll all be dead."

*Respondents want leadership and action.*

Respondents repeatedly called for strong leadership, accurate information, and heightened public awareness. They point out that crack addicts use so many other drugs and alcohol that it is futile to target just crack. Although there is no clear consensus on exactly what to do, people express a sense of urgency.

One suggestion by respondents was to establish a national commission on prenatal drug exposure. Many respondents point to the success of the National AIDS Commission in raising awareness and educating the public about prevention. They urged the HHS Secretary to take this proposal to the President. These respondents see a national commission as a way to galvanize public attention, promote greater participation by State and local governments and the private sector, and generate potential solutions. It was suggested that this commission be drawn from the public and private sector, and include representatives from a wide variety of disciplines, such as education, health, child welfare, substance abuse, justice, and housing.

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## RECOMMENDATIONS

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We agree with respondents that the problems of crack babies are inseparable from the larger issue of prenatal exposure to all drugs and alcohol. We also recognize that the impact of infants prenatally exposed to drugs extends beyond the purview of this Department. While we recognize that some policy issues remain unresolved, our recommendations focus on actions which we believe can be accomplished without additional authorities or significant funding.

### STATE AND LOCAL RESPONSIBILITIES

1. ***Encourage outreach and community involvement.*** State and local governments should conduct aggressive outreach to provide prenatal care for at-risk pregnant women. These efforts must emphasize the dangers of prenatal drug or alcohol exposure. Community and religious groups should be involved in identifying and helping mothers and children at risk. It is important to work with local black and Hispanic leaders.
2. ***Reduce placement barriers.*** State and local agencies should reduce barriers to placing drug-exposed infants into foster care and adoptive homes. This includes reviewing and revising existing laws and policies on abandonment, termination of parental rights, and interracial placement. Courts should establish "fast track" procedures to expedite child welfare cases involving drug abuse.
3. ***Develop guidelines and training.*** States should develop guidelines for child welfare agencies to follow in responding to drug exposure cases and in training caseworkers to handle such cases. Guidelines should cover risk assessment, family reunification, and termination of parental rights. Caseworkers should be trained in identifying substance-abuse behaviors, recording drug histories, and documenting evidence for court.
4. ***Establish reporting and tracking systems.*** States should establish criteria for identifying and reporting prenatal drug exposure as child abuse. Existing State child abuse reporting and tracking systems should be expanded and computerized. The information should be used not only for legal purposes, but also for the provision of health care and education.
5. ***Expand interagency mechanisms.*** State and local governments should develop initiatives such as task forces to coordinate services and integrate funds. These initiatives should involve courts and prosecutors to review policies and expedite legal proceedings involving drug-exposed babies and their families.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES

### Office of Human Development Services

1. ***Disseminate effective practices.*** The Office of Human Development Services (HDS) should identify practices, programs, and laws or regulations considered effective in dealing with drug-exposed baby cases and disseminate this information to State and local governments. The HDS should also undertake studies to evaluate the effectiveness of these practices.
2. ***Focus service strategies on serving the family.*** Because of the rapidly growing number of drug-exposed babies, most will be raised in their natural families. Many families already have multiple problems, which will be compounded further by having to deal with the problems faced by drug-exposed babies. In developing its service strategy for these babies, the HDS should place priority on providing needed interventions with the family, to help ensure that drug-exposed children can grow up in caring and supportive family environments.
3. ***Evaluate obstacles to placement.*** The HDS should evaluate obstacles to foster and adoptive placements, especially as they relate to drug-exposed babies. This examination should include current policies regarding family reunification, voluntary parental termination, and restrictions on foster care and adoption.

### Office of Human Development Services and the Public Health Service

1. ***Coordinate Departmental activities.*** The HDS and the Public Health Service (PHS) should coordinate Departmental activities relating to drug-exposed babies and their families. This recommendation could be achieved through the expansion of the informal interagency coordination activities of HDS and PHS. Representatives from the following HHS components should be included:
  - Office of Human Development Services
  - Public Health Service
    - National AIDS Program Office
    - PHS Panel on Women, Adolescents, and Children with HIV Infection and AIDS
    - Alcohol, Drug Abuse and Mental Health Administration
    - Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration
    - National Institute on Child Health and Human Development, National Institutes of Health



- Family Support Administration
- Health Care Financing Administration
- Social Security Administration
- Assistant Secretary for Planning and Evaluation

2. **Conduct short- and long-term research.** The HDS and the PHS should conduct both short- and long-term research on the effects of prenatal exposure to drugs, including crack cocaine, on babies and their mothers.

Specific areas for short-term research include:

- determining optimal treatment for cocaine-addicted mothers during pregnancy to ensure the birth of a minimally affected infant;
- examining the risk factors responsible for drug abuse so effective prevention can be implemented; and
- establishing a monitoring system to survey the extent of the crack epidemic, especially among women of child-bearing age.

Specific areas for long-term research include:

- studying the long-range effects of prenatal drug exposure on physical, psychological, and neurological development. Longitudinal research on these topics could conceivably take up to 15-20 years on the same subjects, with annual or semi-annual reports of findings required;
- evaluating long-term outcomes of various treatment modalities in reducing or eliminating drug use by women of child-bearing age who are addicted to crack cocaine or other drugs; and
- assessing permanent placement options and outcomes for drug-exposed babies as compared to other babies and children in the custody of child welfare agencies. The long-term resources required (staffing as well as funding) for each of these groups could also be compared.

3. **Promote drug abuse training.** The HDS and the PHS should promote drug abuse training in the following areas:

- Medical schools and hospitals - Most physicians are not trained to recognize the signs of drug use. As a result, physicians are failing to identify many pregnant women who are using drugs as well as newborns exposed in utero. Medical school

and continuing education curricula could include: identifying drug abuse behaviors, documenting drug and lifestyle histories, and recommending appropriate drug treatments.

- Child welfare agencies - Model training materials should be developed and disseminated to State and local child welfare agencies. These materials could include: techniques to recognize and assist drug-abusing families and their children and examples of successful case management techniques. Training materials should also address parallel service delivery problems such as providing prenatal care in drug treatment programs and drug treatment in prenatal care programs.

4. ***Promote prevention through public outreach and informational materials.***

Existing anti-drug messages do not sufficiently emphasize the dangers of prenatal drug exposure. A comprehensive strategy should be developed to target all women of child-bearing age, including teenagers, as well as junior high and middle school students. Model brochures (including easy to read, illustrated formats) and public service announcements are among the possible approaches.

#### **Public Health Service and the Health Care Financing Administration**

1. ***Continue to support targeted outreach and prenatal care.*** The PHS and the Health Care Financing Administration should continue to support targeted, intensive outreach intervention and prenatal care for substance abusing pregnant women and their babies. This includes identifying and disseminating practices which encourage community involvement in prenatal care outreach and education.

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## COMMENTS ON THE DRAFT REPORT

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Comments received from HDS, PHS, HCFA and ASPE were generally supportive of our findings and recommendations. All respondent comments reflected a thoughtful review of the draft and many excellent suggestions were made. Many have been incorporated into the final report. In addition, the full text of the comments received has been included in the appendix. The reader will find much additional useful information in these comments.

The HDS and ASPE requested more detail on our cost estimates for hospital delivery, perinatal care, and foster care through age 5. We will provide this information to them.

The HDS felt that while the selection of cities as the source of information for the report was reasonable, there was an implication that the problem of infants exposed to crack was an urban phenomenon. We believe that the purpose statement of the study clearly defines that we examined the affect of crack babies on the child welfare system only in several major cities.

The HDS also felt the report would be strengthened by providing further documentation. We have responded by indicating the sources of data in charts and by providing specific citations in footnotes. Since we interviewed several respondents in each city, we did not feel that an itemization of the number would add significantly to the report.

The ASPE suggested adding hospital staff to our State and local recommendation on development of guidelines and training for child welfare staff. Our recommendations to HDS and PHS already address promotion of such training in medical schools and hospitals, and we believe this is the most effective approach for addressing these areas with health professionals.

With respect to our recommendation on interagency coordination, PHS and ASPE pointed out that crack baby issues relate to public health as well as social services. We agree, and have modified our recommendation to reflect the cross-cutting nature of the problem.

The PHS suggested that the report focus on cocaine rather than just the crack form of cocaine. As stated in the report, we have used the terms crack and cocaine synonymously as their detection in the body does not differ and many respondents addressed their comments using the terms interchangeably.

Another area of PHS concern was that the report failed to discuss the availability of drug treatment programs for pregnant women. We have included descriptions of such programs and other types of services directed to the drug exposed children and families in our companion report "Crack Babies: Model Programs."

The PHS also provided several technical comments, many of which were incorporated in the report.

The HCFA suggested we reword our recommendation on expanded availability of prenatal care to at-risk mothers and their babies. We agree and have made the suggested change.

However, because of space considerations we have not included the American Bar Association's monograph *Drug Exposed Infants and Their Families: Coordination Responses of the Legal, Medical and Child Protection System* which PHS provided with its comments.

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## ENDNOTES

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1. Villanova University, Human Organization Science Institute, unpublished data, 1990.
2. D. McAllister, County of Los Angeles, Department of Health Services, Drug Abuse Program Office, *1987 Drug-Related Costs in the County of Los Angeles*, September 1988, p. 17.
3. State of New York, Senate Committee on Investigations, Taxation, and Government Operations, *Crack Babies: The Shame of New York*, December 20, 1989, p. 4.
4. (McAllister, 1988, p. 17)
5. E.S. Bandstra, B.W. Steele, G.T. Burkett, D.C. Palow, N. Levandoski, and V. Rodriguez, "Prevalence of Perinatal Cocaine Exposure in an Urban Multi-Ethnic Population," *Pediatr Res*, April 1989 as cited in the U.S. Congress, House of Representatives, Select Committee on Children, Youth and Families, *Born Hooked: Confronting the Impact of Perinatal Substance Abuse*, (Washington, D.C.: GPO, 1989), p. 6.
6. State of New York, Senate, Committee on Investigations, Taxation, and Government Operations, *Crack Babies: The Shame of New York*, December 20, 1989, p. 5.
7. D.J. Besharov, "The Children of Crack: Will We Protect Them?", *Public Welfare*, Fall 1989, p. 7.  
  
*National Drug Control Strategy*, The White House, September 1989, p. 44.  
  
LJ. Chasnoff, M.D., National Association for Perinatal Addiction Research and Education, *A First: National Hospital Incidence Survey*, 1989.
8. State of Illinois, Department of Children and Family Services, Illinois Department of Alcoholism and Substance Abuse, and the National Association for Perinatal Addiction Research and Education, *The Illinois Model: A Statewide Collaborative Program for Alcohol and Other Drug Using Pregnant Women*, p. 3.
9. Philadelphia Citizens for Children and Youth, *In Their Second Best Interest*, 1989, p. 30.

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**APPENDIX**

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***OPDIV COMMENTS ON THE DRAFT REPORT***



DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED  
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OFFICE OF INSPECTOR  
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Washington, D.C. 20201

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| IG        | _____ | ✓ |
| PDIG      | _____ | ✓ |
| DIG-AS    | _____ |   |
| DIG-EI    | _____ | ✓ |
| DIG-OI    | _____ |   |
| AIG-MP    | _____ | ✓ |
| OGC/IG    | _____ |   |
| EX SEC    | _____ | ✓ |
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MEMORANDUM

TO: Richard P. Kusserow  
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: Crack Babies Report

03-89-01540

Overall I found this report informative, supporting many of the anecdotes we have been hearing about these children. I do, however, have several comments which I note below.

**Issues not Mentioned:**

I suggest that you note somewhere that existing evidence indicates that many (though certainly not all) of these children will have long term needs. In addition, it looks as though we can help these children compensate, but cannot cure, their deficits.

Your discussion of testing and tracking these children might also mention the growing tendency by local and state officials to prosecute pregnant women. I believe this very punitive approach is counter productive because its most likely effect will be to drive drug abusing women away from prenatal care, further damaging the child.

**Regarding Specific Statements in the Report:**

On page 3, paragraph 2 you estimate the cost of caring for the children you observed through age 5 to be \$500 million. I find this figure confusing without further explanation regarding your assumptions. For example, what proportion are you assuming will be in foster care? It would also be helpful to cite a comparison figure regarding normal children.

In the final paragraph on page 3 and the first paragraphs on page 4 you note, quite appropriately, that few of these children are being identified. What you fail to point out, however, but that we find to be an important issue, is that the lack of appropriate testing guidelines seems to result in discrimination against minority and low income women. Therefore, more minority and low income children are identified.

Your discussion of identifying these children (page 3-4) might also mention that it is difficult to identify them as they grow up because of the limits of existing developmental tests.

Certainly, they cannot identify cause. In addition, most such tests are structured, catering to the strengths of these children. The deficits we are finding in these kids are primarily in their abilities to structure their own activities and emotions without help. They perform in the low normal range on structured tests. It is in unstructured activities (like play and interacting with other children and adults) that their problems show up.

On page 5 you note infant attachment problems among many of these children placed in foster care, particularly if the infant has been moved from home to home. I share your concern but note that several researchers have also found attachment problems in these children when they remain with their biological parents or a single caretaker. A portion of the problem may be organic rather than environmental, relating to the damage done by the drug.

The chart at the bottom of page 5 fails to recognize the issue which you note later (on page 13) that while crack is today's drug of choice among certain populations, "ice" or something else will soon come along to replace it. Straight line projections of the number of crack babies is therefor somewhat misleading.

**Regarding Your Recommendations:**

I would add to your recommendations of State and Local Responsibilities (page 141) the active establishment and promotion of drug use prevention and drug treatment programs. This is especially important for women of childbearing age. Most anti-drug messages are now aimed at teenagers, and as your report notes, these are not teenage mothers. In addition, few treatment programs are set up to treat pregnant women or mothers effectively. For example, few provide child care. (A recent study found that 87% of the existing drug treatment programs in New York City would not treat pregnant, Medicaid eligible crack users.)

Your State and Local Recommendation number 4 notes the need for better reporting and tracking of these children. I would also add the need for better identification of drug exposed infants, including crack and other drugs. While you note in Recommendation 3 the need for training and guidelines for child welfare workers, it is hospital staff who must first identify these mothers and children. As your report notes, only 1/3 of the hospitals you visited had testing protocols in place. As noted above, this leads to racial and socioeconomic discrimination.



You offer a list of recommendations regarding Federal activities which are needed. While it is an appropriate list, I would suggest that you also mention existing activities which address many of the needs you mention. Your staff are aware of a recent report written by my staff which outlines many of these efforts.

Your Recommendation number 4 for the Office of Human Development Services (page 15) suggests the need for interagency coordination of activities regarding these children and families. While we agree with that assessment, we are less certain to which agency the lead should be assigned. This is both a public health issue and a social services one. The lead could appropriately come from a variety of sources. In addition, I believe that the Social Security Administration should be added to your list of agencies which should be involved because of their role in funding services for these children (particularly through the SSI disabled children program).

  
Martin H. Gerry



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of  
Human Development Services

Assistant Secretary  
Washington DC 20201

APR 30 1990

**TO:** Richard P. Kusserow  
Inspector General

**FROM:** Assistant Secretary  
for Human Development Services

**SUBJECT:** Office of Inspector General Draft Report on "Crack  
Babies," OEI-03-89-01540

Thank you for the opportunity to review the draft report of the Office of Inspector General (OIG) entitled "Crack Babies."

The report provides valuable information and a good overview of the scope of the problem of infants exposed to crack cocaine and of its impact on child welfare and other systems (e.g., medical, rehabilitation, mental health, juvenile justice) either currently or projected into the future. We note that the findings are generally consistent with those being reported by other investigators on a national and regional basis. There is also agreement with the consensus of the respondents interviewed for the report that the problem of infants exposed to crack cocaine is interrelated with the larger issue of prenatal exposure to other drugs and alcohol as well as AIDS (page 13).

We do, however, have several concerns. First, page 3 of the report states that "We estimate the cost for hospital delivery and perinatal care, and foster care through age 5 for just these 8,974 identified babies approximate \$500 million." We suggest that these costs be broken down and justified so that they can be better understood. We are concerned, for example, about the five year projected length of stay in foster care. In addition, the initial draft of the OIG report factored in costs for a nine day hospital stay for healthy babies, which considerably exceeds the norm of three days or less.

Second, while the selection of cities as the source of information for the report was reasonable, the implication is that the problem of infants exposed to crack cocaine is an urban phenomenon. The

staff of the Children's Bureau are beginning to receive reports from small towns and rural areas which indicate that the problem has spread to these areas of the country. Officials in the State of Wisconsin, for example, indicate that one reason that the problem of infants exposed to crack cocaine may be underreported in such areas is that the babies are frequently referred to developmental disabilities programs, rather than to child protective services for assistance. These officials indicate, moreover, that the increase in the problem in rural areas of the State is equal to or greater than in the city of Milwaukee.

Third, the report would be strengthened by the provision of documentation. For example, the number of respondents interviewed by site should be provided, as should the sources for the information presented in the charts on pages 5 and 10. In addition, the data presented on page 9 of the text and in the chart on page 10 relate to a one day count of children in foster care, not to entry rates for the years 1983-1986, the last years for which Voluntary Cooperative Information System (VCIS) data are currently available.

Moreover, in discussing the stress being placed on the child protection system, the report did not note that the system was already overburdened, due to high caseloads and inadequate resources, prior to the advent of the phenomenon of infants exposed to crack cocaine. Although some difficulties were identified in the adoption process, adoption is a reasonable approach for infants exposed to crack cocaine with no parents or relatives. Adoption subsidies are currently available in all States.

Finally, while we recognize that the OIG's recommendations must relate to the Department, we would suggest that some mention be made of the fact that the impact of infants exposed to crack cocaine extends beyond the purview of the Department of Health and Human Services to encompass education, housing, law enforcement and other Federal, State and local agencies.

Again, thank you for the opportunity to review the report.

  
Mary Sheila Gall



## Memorandum

APR 18 1990

Date

From

Gail R. Wilensky, Ph.D. *GW*  
Administrator

Subject

OIG Draft Report - Crack Babies, OEI-03-89-01540

To

The Inspector General  
Office of the Secretary

We have reviewed the subject draft report. It examined how crack babies have affected the child welfare system in 12 metropolitan areas.

Though the report makes several recommendations to local, State and Federal agencies, only one recommendation is addressed to HCFA. The report recommends that HCFA and the Public Health Service (PHS) continue to support expanded availability of prenatal care to at-risk mothers and their babies. We believe that the wording of the recommendation is too vague. Rather than expansion, we support targeted or intensive outreach intervention and prenatal care for substance abusing pregnant women. We are already engaged in identifying and disseminating practices which encourage community involvement in prenatal care outreach and education, as this recommendation further suggests.

In addition to the drug abuse training cited on page 16, we believe Departmental efforts must also address parallel service delivery problems. Prenatal care services or linkages must be provided in drug treatment programs, and drug treatment services or linkages must be provided in prenatal care programs.

Finally, we have one technical comment. The PHS components listed on page 15 should be clarified to read:

- Bureau of Maternal and Child Health and Resources Development, Health Resources and Services Administration
- National Institute of Child Health and Human Development, National Institutes of Health

- Alcohol, Drug Abuse and Mental Health Administration
  - National Institute on Drug Abuse
  - Office of Substance Abuse Prevention
  - Office for Treatment Improvement

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position at your earliest convenience.



*Bachel*

# Memorandum

**APR 20 1990**

Date

From Assistant Secretary for Health

Subject OIG Office of Evaluation and Inspections Draft Report "Crack Babies," OEI 03-89-01540, February 1990

To Inspector General, OS

Attached are the PHS comments on the findings and recommendations contained in the subject OIG draft report. We concur with the recommendations directed to PHS to (1) conduct long-term research on prenatal exposure, treatment models, and placement outcomes; promote training in medical schools and child welfare agencies; and promote prevention through public outreach, and (2) continue to support prenatal care expansion.

*James O. Mason*  
 James O. Mason, M.D., Dr.P.H.

Attachment

|           |                        |
|-----------|------------------------|
| IG        | <u>          </u> ✓    |
| PDIG      | <u>          </u> ✓    |
| DIG-AS    | <u>          </u> ✓    |
| DIG-EI    | <u>          </u> ✓    |
| DIG-OI    | <u>          </u> ✓    |
| AIG-MP    | <u>          </u> ✓    |
| OGC/IG    | <u>          </u> ✓    |
| EX SEC    | <u>          </u> ✓    |
| DATE SENT | <u>          </u> 4/25 |

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COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF  
INSPECTOR GENERAL'S (OIG) DRAFT REPORT  
"CRACK BABIES," OEI 03-89-01540, FEBRUARY 1990

General Comments

The OIG reports that we are only seeing part of the problem. There is no typical crack baby and most are not identified at birth. We concur that tests can detect cocaine in the mother for only 24 to 48 hours after use. However, new methods are becoming available to measure cocaine in meconium and in hair. These tests, if positive, would indicate prolonged use of cocaine during pregnancy.

Although the report recognizes polydrug abuse and related problems (e.g., AIDS), the review addresses issues only in terms of crack-cocaine. Given the limitations to this narrower focus, we believe the report should concentrate on "cocaine" rather than on the "crack" form of cocaine. Although the report's title will attract attention, we believe the use of the terms "crack" and "cocaine" synonymously may lead to inaccurate and perhaps misleading statements on prevalence since there is no way to differentially identify crack cocaine use from the use of other forms of cocaine. This is because presence in the human body does not differ by form at intake.

In addition, when addressing the impact of crack-using mothers on the child welfare system, there are clinical indications that when a woman uses the rapidly and highly addicting "crack" form of cocaine, she may more rapidly become mentally incapacitated and unable to stop using it, than if she used some other form of cocaine.

Another point we wish to highlight is that the report fails to discuss the availability of drug treatment programs for pregnant women. We believe that there should be coordination among substance abuse treatment, primary and prenatal care and HIV infection prevention programs.

There is a need to address pediatric AIDS and drug-exposed babies as part of the same problem. The overlap between the problems of AIDS and drugs for these infants means we are usually dealing with the same risk groups, offering the same messages, and often providing services to the same babies.

Fully 70 percent of pediatric AIDS cases are a result of the drug abuse of the mother or her sexual partner. Recognition of this fact should be reflected in the report, particularly recommending Federal, State, and local coordination of these pediatric HIV/AIDS activities.

The Surgeon General and the Director, National AIDS Program Office co-chair a PHS Panel on Women, Adolescents, and Children with HIV Infection and AIDS. This panel is comprised of all the PHS agencies and the Office of Population Affairs, and addresses many of the same problems identified in this report. Therefore, any DHHS effort to address the problems of drug-exposed infants should include this panel.

The following are our comments on the OIG recommendations.

OIG Recommendation

**STATE AND LOCAL RESPONSIBILITIES**

*Establish reporting and tracking systems.* States should establish criteria for reporting prenatal drug exposure as child abuse.

PHS Comment

We concur. However, the recommendation only centers on legal issues and this information should be used concurrently to provide appropriate health education and care.

OIG Recommendation

**DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSIBILITIES**

*Disseminate effective practices.* The Office of Human Development Services (HDS) should identify practices, programs, and laws or regulations considered effective in dealing with drug-exposed baby cases and disseminate this information to State and local governments.

PHS Comment

We concur. However, in addition to the identification of practices considered effective, evaluation of their effectiveness must be considered at the same time.

OIG Recommendation

*Coordinate Departmental activities.* The HDS should coordinate Departmental activities relating to drug-exposed babies and their families.

PHS Comment

We believe that PHS rather than HDS should be the lead OPDIV to coordinate Department activities relating to drug-exposed babies and their families. There is a need for education and



support through family planning centers and prenatal programs. We advocate this position because drug-exposed babies and their families encounter numerous medical problems. We believe that these problems are primarily medical or public health issues, and not foster care or child abuse matters.

OIG Recommendation

*Office of Human Development Services and the Public Health Service*

1. *Conduct long-term research.* The HDS and the PHS should conduct long-term research on the effects of prenatal exposure to drugs, including crack cocaine, on babies and their mothers.

PHS Comment

We concur. In this regard, the Health Resources and Services Administration's (HRSA) Maternal and Child Health Research Grant Program permits principal investigators to submit applications for long-term research on "drug-exposed" babies. If a proposed research project in this area proves viable, it is considered for funding.

However, short-term research is also indispensable. We suggest added bullets to state:

- o short-term research should determine the optimal treatment to cocaine-addicted mothers during pregnancy to ensure the birth of a minimally affected infant.
- o research examining the risk factors responsible for drug abuse is needed if effective prevention is to be implemented.
- o national surveillance systems should exist to monitor the extent of the crack epidemic, specifically during pregnancy.

OIG Recommendation

2. *Promote drug abuse training.* The HDS and the PHS should promote drug abuse training in:

- o Medical Schools, and
- o Child welfare agencies.

PHS Comment

We concur. The following sets forth our activities in these areas.

o Medical Schools

The Bureau of Health Professions, HRSA, recently awarded a contract to the Society of Teachers of Family Medicine. The purpose of this contract is to train approximately 180 family-medicine physician faculty how to teach residents about substance abuse.

The Bureau of Health Professions also awarded a contract to sponsor a Physician Consortium on Substance Abuse Education. The Consortium is comprised of representatives from academic and professional organizations responsible for the education and training of physicians. The purpose of the consortium is to refine and implement strategies which will enhance and build on existing medical education strategies for removing barriers to prevention and early identification of substance abuse.

o Child Welfare Agencies

The Maternal and Child Health (MCH) Block Grant Program may indirectly, through the States, allocate MCH funds to child welfare agencies for drug abuse training.

OIG Recommendation

3. Promote prevention through public outreach and informational materials.

PHS Comment

We concur. However, the education should be expanded to courses in junior high schools and middle schools since prevention must begin early.

The Office of Maternal and Child Health, HRSA, is working with the Office for Substance Abuse Prevention, ADAMHA, on a joint demonstration grant program to local communities focusing on "prevention and treatment of drug use during pregnancy." To date, a total of 45 demonstration projects providing training in developing new intervention techniques in high-risk population areas have been funded.

OIG Recommendation

**Public Health Service and the Health Care Financing Administration**

Continue to support prenatal care expansion. The PHS and the Health Care Financing Administration should continue to support expanded availability of prenatal care to at risk mothers and their babies.

PHS Comment

We concur. HRSA's Office of Maternal and Child Health is working with HCFA to expand availability of prenatal care to more pregnant women, including those with "drug-exposed" children.

Technical Comments

The title of this report, "Crack Babies," is erroneous and misleading. The appropriate terminology, which is used by experts and professionals in the field, is "drug-exposed" or "drug-affected infants." It is recommended that the title be changed throughout the report to "drug-exposed babies."

Crack is only one method of ingesting the drug cocaine. It is virtually impossible to determine whether these babies were, in fact, exposed to crack, intra-nasally ingested (snorted) cocaine, or if the mother used a combination of drugs during her pregnancy. The current research available indicates that most "crack" users are poly drug users, combining cocaine with other drugs. By focusing only on "crack" babies, a narrow and inaccurate perception of the problem is created. Any references to drug use among women, such as that on page 1, "crack addicted mothers," should be changed to "drug-addicted mothers."

Pages i and 1, "BACKGROUND"

The first paragraph should be changed to read "The National Institute on Drug Abuse (NIDA) estimates that over 6 million women of child bearing age...." instead of the 5 million cited in the report. The estimate is based on data from the National Household Survey, 1988.

Page 1, Fifth Paragraph

The report's exclusive focus on crack suggests there is relatively low use of crack cocaine among teenage mothers. This "finding" could be misleading in that a clinically

significant number of teen age women are abusing many drugs, including other forms of cocaine. These young women are or soon might become pregnant and thus will endanger the lives of their yet-to-be-born children. These teenagers require a wide range of services that are designed to take into account their developmental as well as their obstetrical needs.

Page 3, "The scope of the problem is wide ranging."

In the second paragraph, OIG reports ". . . the cost for hospital delivery and perinatal care, and foster care . . . approximate \$500 million."

Although in this report the costs of foster care, hospital delivery, and short-term perinatal care have been pooled, it might be more informative to discuss hospital delivery and perinatal care apart from the cost of foster care. Information on cost to support hospital delivery and perinatal care is now available. This is in contrast to the paucity of information on the actual cost of providing quality care in foster homes over indefinite periods of time.

In response to these questions, NIDA is currently supporting research demonstration studies that soon will provide more detailed information on the cost to communities to provide effective comprehensive services, with and without case management systems in place, to addicted pregnant women and their children. Although no studies have as yet been submitted, NIDA is actively encouraging clinical investigators to design studies that will critically examine the current foster care system in terms of cost and beneficial effects.

Page 3, "There is no typical crack baby. Most are not identified at birth."

In the first sentence, OIG states that most crack babies look healthy and are therefore difficult to identify. We believe it may be more correct to state the following:

"There is no typical set of adverse signs or drug-induced pattern by which to identify either a cocaine- or a crack cocaine-fetally-exposed infant."

Several reasons account for this lack of differentially discrete pattern of effects:

- (1) Most women are polydrug abusers rather than cocaine-only, and therefore clinicians have identified many overlapping patterns.

- (2) In most cases, it is impossible to get an accurate drug use history from the mother, at least accurate enough to relate a specific neonatal clinical pattern with the mother's use of a specific drug like cocaine.
- (3) There still is too small a number of cases where accurate drug use histories do exist to form the basis upon which to make a differential diagnosis.
- (4) Very subtle signs of cocaine exposure in utero are difficult to detect at the present time because of a lack of clinical instruments and procedures.

NIDA is currently supporting studies that aim to describe the effects of cocaine exposure on the fetus, newborn, and developing child as well as research in the development of clinically sensitive and useful diagnostic instruments and procedures.

Page 5, the chart "Projection of Drug Exposed Children by the Year 2000"

The source for the data used in the projection chart is not provided.

Page 13, "PEOPLE ARE WORRIED ABOUT PRENATAL EXPOSURE TO ALL DRUGS, NOT JUST CRACK."

Further elaboration is necessary on this statement.

Page 14, "STATE AND LOCAL RESPONSIBILITIES"

"2. Reduce placement barriers." To date, many of the ideas put forth to reduce placement barriers by ". . . reviewing and revising existing laws and policies on . . . termination of parental rights. . ." have addressed the issue of unfit motherhood from the perspective of removing the baby, and perhaps the other children, from the mother. Unfortunately, termination of parental rights may result in fewer women voluntarily coming for prenatal-postnatal care or for treatment for their addiction (see attached copy of the American Bar Association's monograph Drug Exposed Infants and Their Families: Coordination Responses of the Legal, Medical and Child Protection System). Although temporary placement for children is often necessary, community efforts and resources should be directed toward methods to increase the number of addicted women of childbearing age coming into the medical, social service, and drug treatment programs that are currently available.

Page 15, "4. Coordinate Departmental activities."

Under the bullet Public Health Service, the National Institute on Drug Abuse and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) are listed as being equal organizations of PHS. NIDA is an Institute of ADAMHA. Also, there are other organizations within PHS, ADAMHA, HRSA, and the National Institutes of Health which have responsibility relating to the subject matter of this report. HRSA's Bureaus of Health Care Delivery and Assistance and Health Professions should be included along with the Office of Maternal and Child Health in the PHS representatives for the Department activities. Therefore, this part should read as follows:

- National AIDS Program Office
- PHS Panel on Women, Adolescents, and Children with HIV Infection and AIDS
- Alcohol, Drug Abuse and Mental Health Administration
  - National Institute on Drug Abuse
  - Office for Substance Abuse Prevention
  - Office for Treatment Improvement
- Health Resources and Services Administration
  - Bureau of Health Care Delivery and Assistance
  - Bureau of Health Professions
  - Office of Maternal and Child Health
- National Institute on Child Health and Human Development,
  - National Institutes of Health