Children today

Crack Children in Foster Care: Re-examining the Balance between Children's Rights and Parent's Rights

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The problem of fatally-exposed babies, called "crack-babies," spread 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 Dr. Ira Chasnoff, director of the Perinatal Center for Chemical Dependence at Chicago's Northwestern Medical School. In 1988, he surveyed 40 hospitals, of which 36 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, and the low 0.4 percent.) Dr. Chasnoff took this 11 percent average and simply multiplied it against all live births in the country that year (3,809,394)[1] to arrive at the much quoted statement that: "as many as 375,000 infants may be affected each year."[2]

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, and 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, its approximately 1,500 drug-exposed babies in 1988[3] comprise only 7.5 percent of live births in the District and 15 percent of live births by District residents.[4] 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 another 14 percent in 1989-to 4,875 drug-related births a year.[5] But these 4,875 drug-related births represent only 4 percent of all live births in the city.[6]

Thus, a national total of 1 or 2 percent of all live births, or forty to eighty thousand crack babies, seems a more realistic figure. Exaggerating the size of this terrible problem only makes it seem more unmanageable than it already is. These numbers are, however, large enough to make crack babies a national concern. Even 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.[7]

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 9 in 1985 to 56 in 1987.[8] Dr. Richard S. Guy, co-chairman of the D.C. Mayor's Advisory

Committee on Maternal and Infant Health, has said that D.C.'s infant mortality rate is "going to go up" because of the "tremendous increase in the number of mothers abusing drugs."[9]

Although other drugs have plagued our society, most users have been men. Crack, a derivative of cocaine, has changed this pattern. For the first time, there are large numbers of female addicts, many of whom have children or are pregnant.

Crack is a different kind of drug, too: it is a mean drug that induces some parents to incredible violence. In one widely reported 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 his legs were fractured; he had eight other broken bones, and bruises covered his body.

Children who are not physically assaulted may be victims of their parent's neglect. "People who start using have got to find that money. Children aren't being fed," says 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." In one case, a 10-month old died after being left overnight in an overheated room-the temperature reached 110 degrees--while his mother visited her boyfriend.

There are many levels of drug use and, media coverage notwithstanding, some drug-using mothers can care for their children adequately, at least with social service support. In recent years, we have learned a great deal about working with abusive and neglectful parents; programs across the country are helping many thousands of parents, including those who use drugs, to take better care of their children.

Unfortunately, nationwide, there is a severe shortage of drug treatment programs, especially for women; most programs have long waiting lists, and many do not accept pregnant women or mothers. These conditions have led to calls for an expansion of treatment programs for drug-using mothers and women in general, which is certainly needed. However, expanded treatment, no matter how richly funded, will not be the total solution to the problem. Even the best programs have only modest success treating hard-core addiction.

What we cannot do for crack addicts in general, we cannot do for addicts who happen to be mothers. Hard-core 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," explains Edwin Delattre of Boston University. "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, makes successful treatment almost impossible for many addicts."

Years of effort have yielded no widely applicable therapeutic program for treating heroin addicts. The only practical treatment for large numbers of these addicts is methadone maintenance. No similar "blocking" agent for cocaine has been found, although there have been some initially promising experiments with anti-depressants.

Years of work, however, will be necessary to see whether these drugs, or some new approach, will work. “Crack is new enough that no one has yet figured out an effective treatment, “ according to Peter Reuter, a Rand Corporation expert on drugs.

Thus, for the foreseeable future, we must be prepared for the reality that agencies will have little or no success in treating heavily addicted parents. And we must likewise be prepared for the reality that the children of these parents -- again, not all children of drug-using parents, but those of parents with serious and debilitating problems--must be placed in foster care.

Concerned about the impact of substance abuse on the child protective and foster care programs, the American Enterprise Institute, the American Public Welfare Association, and Abt Associates obtained funds from the U.S. National Institute of Justice to conduct a nationwide survey of state child welfare agencies.

Our survey of all 50 state child welfare agencies revealed an unprecedented surge in the number of children removed from their parents and placed in foster care. APWA estimates that, in June 1987, there were about 280,000 children in foster care; by June of 1990 the number is projected to increase to 360,000. That is a 29 percent increase in just 36 months-and the numbers are still rising. (See Tables 2 and 3.)

Between 1986 and 1989, an estimated 80,000 children were added to the foster care population. However, the increases have been quite uneven, as you can see from Table 1.[10] The communities hardest hit by crack addiction have experienced startling increases. Two states (California and New York) were together responsible for 55 percent of the increase. California’s foster care population rose 41 percent during this period, from 47,327 in 1986 to 66,763 in 1989. In New York there was an increase of 98 percent, from 27,504 children in 1986 to 54,326 in 1989.[11] (The increase includes about 18,318 children placed with relatives.)[12]

Today one out of three foster children comes from either California or New York, although fewer than one out of five American children lives in these two states. In 1986, the ten states with the largest foster care populations accounted for 55 percent of the national foster care population. Now roughly 66 percent of all foster care children reside in these ten states: California, Florida, Georgia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, and Pennsylvania. Georgia’s foster care population rose by 43 percent between 1986 and 1989. Illinois, Massachusetts, and New Jersey also experienced large increases in their foster care populations.

Despite the conventional wisdom about the foster care crisis, the vast majority of children in the system receive good physical care, often substantially better care than their parents can provide. The problem lies in foster care’s emotional impact. Children who stay in foster care for more than a short time, especially if they are older, tend to be shifted through an unsettling series of ill-suited foster homes, denying them the consistent support and nurturing that they desperately need. These problems are magnified for the children of addicts.

Because their home conditions are usually so bad and treatment has only limited effect on their parents, once placed in foster care, these children of crack tend to stay there. In New York City,

at one time, 60 percent of the babies discharged from hospitals to foster care--mostly crack babies--were still in foster homes three years later. Of those in foster care, more than half (56 percent) had been in two or more foster homes; 20 percent had been in three or more homes. One child had been in eight homes.

Foster care was designed to be a temporary remedy used only until parents are able to care properly for their children. Today, foster care procedures are still designed to reunite families as soon as possible. This important goal can be taken to extremes, however: in one case, an infant who was discharged from a six-month foster care placement and returned to her mother and grandmother was found four months later to have serious burns on her back, possibly made by a clothes 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 symptoms of cocaine addiction. Yet the agency's goal was still to return the girl, by then almost three years old, along with her newborn sibling, to their mother.

Many judges and caseworkers would place more children of addicts in foster care, but they believe that the emotional limbo of foster care can be as harmful to these children as living at home with their drug-using parents. They reason that many children, after years of unsettling foster care, will end up back at home with those same parents. In effect, these professionals are choosing between two harmful situations and deciding that many children would be better off in the care of addicts. But there are other options.

Increased adoptions by loving adults is one route out of foster care limbo. Unfortunately, current legal rules and agency policies make it exceedingly difficult and time-consuming to terminate parental rights. As a result, fewer than 10 percent of the children in foster care are placed for adoption.

Even in the most alarming cases, few children are quickly made available for adoption. One crack baby was placed in foster care after his father killed the boy's baby sister. The mother, who was frequently beaten by her husband, was in touch with the foster care agency only sporadically. Three years later when she gave birth to yet another cocaine-exposed child, the first youngster still lived in a temporary foster home.

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.[13] Hundreds of others suffered injuries short of death.

The growing foster care population of crack children is forcing a fundamental re-examination of state adoption laws. Most people seem to agree that adoption laws need to be changed to reflect the realities of drug addiction, to make adoption a real option for children whose drug-addicted parents, usually mothers, cannot care for them and show little prospect for improvement. The question for legislators is: Where to draw the line?

Making it too easy to terminate parental rights would be as harmful as current policy and would

face legitimate opposition. What if, for example, a drug-addicted parent is willing to accept help but the help available is ineffective? Or worse, what if there simply is no treatment at all?

Many of these mothers are barely more than children themselves. Usually poor and seeing little prospect for the future, they are, in a sense, also victims of extremely difficult circumstances. It is discomforting to take such harsh action against those young mothers who are trying-albeit unsuccessfully-to improve their troubled lives.

Moreover, even though there are many more potential adoptive parents than casual observers believe (there are waiting lists to adopt spine bifida and Down's syndrome babies, for example), some foster children --usually older, disabled, or with behavior problems-are not readily adopted. For these children, terminating parental rights is not freeing them for adoption but. instead, cutting the last tie to their biological families. This is particularly troubling because, in time, some parents will conquer their drug problems.

The issue of race also heightens our unease. Drugs, and especially crack, take their greatest toll on those least able to bear the burden--members of disadvantaged minorities. In California, for example, for the first time in that state's history, the absolute number of black children in foster care exceeds the number of whites, even though less than 10 percent of the state's children are black. A tough policy for taking children away from their parents that falls most heavily on minority communities should make everyone think twice.

These considerations are largely mitigated when a parent is offered a reasonable program of treatment and flatly refuses to accept help. Thus, it seems appropriate to amend state laws to encourage adoption in such cases--especially for young children. Whether more ambiguous situations will also be made grounds for terminating rights will be determined after a spirited debate about the rights of children versus the rights of parents.

Even under the most liberal adoption law conceivable, many children of addicts will continue to live in foster care for long periods, so we should also be working to give them as normal a life as possible. Foster care must be restructured so that it can provide the kind of nurturing care children need. This means stable care over the long term.

Some commentators have called for a return of the orphanage. For some older children, some sort of small congregate care arrangement, like a group home, makes a great deal of sense. For infants and younger children, living in a home and family setting is best, and it ought to be our goal.

The first priority must be to have the highest quality foster parents. Most agencies, however, are having difficulty recruiting high-quality foster parents and have been forced to modify their recruitment criteria. Many, for example, now allow single women who work full-time to be foster parents--even though they have to hire others (usually without agency supervision) to care for infants and toddlers.

Although the worsening physical and behavioral problems of foster children partly explain why it is so hard to attract new foster parents, simple economics is a more serious obstacle, and one

more amenable to solution. In many places, payments to foster parents have not kept pace with the inflation of the last decade. Even when they have, agencies must compete against the marketplace for the mothers who were once their prime source of foster parents and who are now increasingly in the paid labor force. If we want to attract better foster parents, we will have to pay them more than $4,000 per child per year, the approximate national average.

Giving long-term foster children a sense of constancy must be the second priority. One idea being considered by many states is called “permanent guardianship.” In this arrangement, the child is placed with an individual willing to accept permanent responsibility for the child’s upbringing. This new guardian has all the legal rights of a parent (the agency is no longer involved) but the parents are able to maintain contact with the child. This has proven to be especially helpful in cases where the child is older and the placement is with a relative or a long-term foster parent who has developed a relationship with the parents.

When on-going support from the agency is needed, perhaps because the child has severe handicaps, some states allow the child to be placed in a status called “permanent foster care.” This gives the child a constant and secure home but allows the agency to stay involved.

Placing children with relatives, sometimes called ‘’kinship care,’‘ is another solution to the shortage of good foster parents being tried. In New York City, slightly more than one in three foster children are in the formal care of relatives, who are receiving full foster care payments.[14]

The advantage of all these new arrangements is that they avoid a complete break in family ties. But that is also their most serious disadvantage. Non-relative foster parents sometimes refuse “permanent guardianship” arrangements because they do not like the idea of having a drug addict involved in their lives.

In kinship care, relatives sometimes return children to their parents without telling the agency, either out of fear or solicitude. Permanency planning is also more difficult. When relatives receive foster payments rather than AFDC payments, as is increasingly the case, the entire family may have an incentive to maintain the children in their foster care status, because the foster care payments are so much higher than AFDC ones. In New York City, for example, foster care payments for children under five years old are two and one-half times higher than AFDC payments would be for the same child.

The reforms that I have proposed will not be easy to achieve. Making it easier to terminate parental rights is sure to be controversial, and may come only with the active support of the disadvantaged communities most affected. Similarly, the restructuring of foster care into a long-term, supportive environment will require a level of administrative commitment and capability that has too often eluded foster care agencies. But if we are to meet the needs of crack children, we cannot avoid these challenges.

Table 1
CHILDREN IN FOSTER CARE
1985-1989[12]
(Based on the last day of the reporting period)

State	FY 86	FY 87	FY 88	FY 89
Alabama	4,337	4,390	4,417	--
Alaska	1,232	--	--	--
Arizona	2,434	2,641	3,008	--
Arkansas	1,321	1,032	1,077	--
California	47,327	51,821	62,514	66,763
Colorado	3,100	--	--	--
Connecticut	3,530	3,370	3,631	--
Delaware	763	696	698	--
Dist. Columbia	--	2,120	2,210	--
Florida	6,802	7,017	7,725	7,544
Georgia	9,311	10,356	11,597	13,325
Guam	--	37	39	--
Hawaii	1,267	1,423	1,400	--
Idaho	756	1,307	770	--
Illinois	14,472	15,829	17,425	19,296
Indiana	4,730	5,207	6,043	--
Iowa	3,579	3,856	4,012	--
Kansas	4,203	4,277	4,443	--
Kentucky	2,863	3,235	3,232	--
Louisiana	6,717	6,717	6,097	--
Maine	1,855	1,855	1,815	--
Maryland	5,198	5,470	5,868	--
Massachusetts	7,546	8,814	9,588	10,284
Michigan	8,566	9,791	11,302	--
Minnesota	5,616	5,924	5,900	--
Mississippi	2,219	2,587	2,702	--
Missouri	6,354	6,515	6,902	--
Montana	--	--	--	--
Nebraska	2,438	2,432	2,296	--
Nevada	1,876	1,264	1,590	--
New Hampshire	--	1,264	1,445	--
New Jersey	6,597	8,681	8,542	8,798
New Mexico	2,062	2,088	2,195	--
New York	27,504	29,197	45,746	52,189
North Carolina	6,254	6,124	6,126	--
North Dakota	587	540	589	--
Ohio	11,263	11,263	12,539	14,200
Oklahoma	2,075	2,048	2,217	--
Oregon	3,250	3,623	3,885	--
Pennsylvania	14,685	13,433	14,636	15,416
Puerto Rico	2,252	--	--	--
Rhode Island	2,085	2,293	2,569	--
South Carolina	3,692	3,563	3,583	--
South Dakota	547	461	446	--
Tennessee	4,409	4,590	5,077	--
Texas	4,727	4,769	5,449	--
Utah	1,132	1,176	1,118	--
Vermont	1,025	987	1,025	--
Virginia	5,902	5,898	6,011	--
Virgin Islands	--	--	--	--
Washington	5,789	5,632	5,725	--
West Virginia	--	1,955	--	--
Wisconsin	4,833	4,826	5,018	--
Wyoming	595	608	762	--
Totals	272,380	285,032	323,004	207,815

Source: American Public Welfare Association, “Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States,” Final Report submitted to American Enterprise Institute (Washington, D.C., February, 1990), p. 61.

Table 2
ESTIMATED YEARLY INCREASES
FY 1986-1989

Year	Estimate	% Increase from FY 86
FY 86	280,000	--
FY 87	293,000	+ 4.6%
FY 88	330,000	+ 17.9%
FY 89	360,000	+ 28.6%

Table 3
ESTIMATED INCREASES IN SELECTED STATES
FY 1986-1989

State	% Increase
California	41%
Florida	11%
Georgia	43%
Illinois	33%
Massachusetts	36%
New Jersey	33%
New York	90%
Ohio	19%
Pennsylvania	5%

(*) Source: American Public Welfare Association, "Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States, "Final Report submitted to American Enterprise Institute (Washington, D.C., February, 1990), p. 56 & 58.

Endnotes:

1.U.S. National Center for Health Statistics, Advance Report of Final Natality Statistics. 1987, U.S. Department of Health and Human Services, Vol.38, No.3, Supplement, June 29, 1989, p. I.

2.Press Release, National Association for Perinatal Addiction Research and Education, August 28, 1988. Data from survey funded by Office of Substance Abuse Prevention and the March of Dimes Birth Defects Foundation.

3.Young, Michal, M.D., D.C. General Hospital, Washington, D.C., telephone conversation, April 12, 1989.

4.Telephone conversation with Stephanie Ventura, U.S. National Center for Health Statistics, August 14, 1989: 20,529 live births in the District. of which 10,208 were by District residents.

5.New York City HRA Office of Management Analysis, January 31, 1990. For Fiscal Year 1990, a decrease of 5% is projected, which would bring the number of drug exposed infants down to 3.8 % of all live births in New York City.

6.The number of live births in New York City in 1987 was 122,800. Source: Stephanie Ventura, U. S. National Center for Health Statistics.

7.See e. g. The Children of Addicts: Unrecognized and UnProtected, Study Report no. 3, Select Committee on Child Abuse (New York State), October 1972.

8.Clement, Douglas. “Babies in Trouble,” Minnesota Monthly (March 1989), pp.47-51, p. 48.

9.Abramowitz, Michael, “Mothers’ Drug Addictions Imperil Newborn’s Lives,” Washington Post, B1, p.5., February 22, 1989.

10.State foster care populations for fiscal years 1986, 1987, 1988, & 1989 based on VCIS data collected by the American Public Welfare Association.

11.American Public,Welfare Association, “Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States, “ Final Report submitted to American Enterprise Institute (Washington, D.C., February, 1990), p. 51. The 1989 figure is higher than that in Table I because it relates to the number of Chicago children in foster care in September.

12.Ibid.

13.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.

14.American Public Welfare Association, “Children of Substance Abusing/Alcoholic Parents Referred to the Public Child Welfare System: Summaries of Key Statistical Data Obtained from States,”supra n. 10, at p.51.