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ABSTRACT

This report, which is based on the work of the Perinatal Substance Exposure Think Tanks, establishes priorities for statewide services in California to young children who are prenatally exposed to alcohol and drugs. Although the report focuses on the developmental needs of children, it also examines efforts to provide prevention and treatment services to mothers. Children prenatally exposed to alcohol and other drugs are at risk for physical, behavioral, learning and social dysfunctions that may limit their hopes and potential. The risks of maternal alcohol and drug addiction are compounded by the risks associated with poverty and because of the newborn's greater fragility and vulnerability may result in inadequate mother-child attachment. Children of alcohol and drug abusers may have as much as 10 times the average risk of becoming substance abusers themselves with all its attendant dangers. Other child development issues for these children relate to trust and their relations with their families and neighborhoods. Think Tank participants offered 21 policy and program recommendations from the perspectives of children living with families involved with chemical substances, living in foster care, and served by early education programs. The recommendations addressed: (1) terminology used to describe children of substance-abusing mothers; (2) prevention; (3) children's developmental assessment; (4) early intervention; (5) family treatment; (6) foster care; (7) family reunification; (8) prenatal, pediatric, and mental health services; (9) child care and education; (10) training for service providers; and (11) funding of services. A case study of "Tony," a child born to a substance-abusing mother, and of Tony's family, is provided. Appended materials include a description of the Child Development Programs Advisory Committee and a 10-item bibliography. (BC)

PERINATAL SUBSTANCE ABUSE

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**WHAT'S
BEST
FOR THE
CHILDREN?**

A Report of the Child Development Programs Advisory Committee
for Funding by Orangewood Children's Foundation



State of California



**CHILD DEVELOPMENT PROGRAMS
ADVISORY COMMITTEE**
915 Capitol Mall, Room 336
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Dear Friends:

The rise of alcohol and drug use in America places many of our children in jeopardy. Estimates show that twenty percent of all infants admitted to neonatal intensive care units in the state are potentially substance exposed.

While we do not yet know the ultimate outcome for children born to substance using mothers, the potential dangers of prenatal drug and alcohol use cannot be overestimated. We do know that all children born to substance using mothers face significant mental, social, developmental and medical difficulties.

In order to clarify and define the needs of this growing number of infants and children, the Child Development Programs Advisory Committee brought together thirty-seven experienced practitioners in medicine, education, child care, foster care, child development, psychology, teen counseling, chemical dependency, legislative offices and government agencies for two scheduled Think Tanks. From these meetings and from the research gathered and reviewed came *PERINATAL SUBSTANCE ABUSE: WHAT'S BEST FOR THE CHILDREN?*

In it we have provided recommendations for quality service approaches to be considered as a basis for state policy. It is our hope that this report will invite the Administration, the Legislature, each of the State Departments involved, and other state and local policy makers, as well as the private sector, to strengthen their commitment to this issue, and to continue to look for ways to improve the system that now exists.

On behalf of the Committee, we want to thank all the Think Tank participants, the staff, and the volunteers who made this report possible. A very special thanks to Marie Kanne Poulsen Ph.D., the principle author of this report, to the Orangewood Children's Foundation for sponsoring the Think Tanks and providing major funding for the report, and to Children's Institute International for their ongoing support to this project.

Sincerely,

Mary M. Emmons
Chair

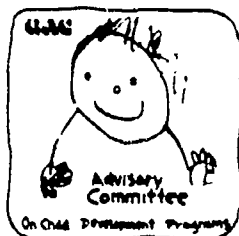
William G. Steiner
Immediate Past Chair

PERINATAL SUBSTANCE ABUSE

WHAT'S BEST FOR THE CHILDREN?

A Report by the
Child Development Programs
Advisory Committee

Principal Author
Marie Kanne Poulsen, Ph.D.



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Children's Foundation

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Photos are courtesy of Children's Institute International. To protect the confidentiality of families served, names and photos used are for illustration purposes only.

SUMMARY OF RECOMMENDATIONS

The following are the primary recommendations of the Perinatal Substance Exposure Think Tanks sponsored by the Child Development Programs Advisory Committee. An analysis discussing these recommendations is contained within the report.

TERMINOLOGY

1. Children should not be labeled, stereotyped or referred to as "crack babies" or "drug kids". These generalizations are unfair and inaccurate and serve to limit our understanding of how to meet the needs of children and their families.

PREVENTION

2. Every community should offer effective outreach to substance abusing pregnant women with immediate access to prenatal care and recovery programs. Outreach and awareness models should address the needs of both pregnant women and their service providers.

ASSESSMENT

3. Neurodevelopmental screening tools and comprehensive developmental assessment protocols must be developed and used with all at-risk children where substance abuse is suspected. Current screening tools are not sufficient to address the vulnerabilities that place these infants and children at-risk of developmental, learning and behavior problems.

EARLY INTERVENTION FOR INFANTS AT RISK

4. Developmental services for at-risk children should start in the neonatal period and should extend as needed through infancy. Most infants prenatally exposed to drugs do not currently qualify for intervention services designed for those with developmental disabilities.

FAMILY TREATMENT

5. Immediately following birth, hospitals should initiate comprehensive services for substance using mothers and their newborn infants. Too often, few attempts are made to foster a relationship with these mothers during their hospital stay, and partly because most alcohol and other drug involved women are discharged 24-36 hours after delivery.

6. Comprehensive family-centered services should be available to substance involved mothers and their infants, and all other family members. Comprehensive services require improved interagency collaboration.

7. Treatment services should address drug recovery in the context of total family needs. Treatment programs offered in isolation of meeting the individual social, emotional, medical, and physical needs of family members cannot begin to ensure family stability.



8. High-risk infants and families should receive coordinated case management and follow-up for a minimum of five years. Substance abuse is a long-term problem and long-term solutions are necessary. An effective, coordinated follow-up process by the public health or child protective services system should be developed in each community.

FOSTER CARE

9. Placement decisions for newborns should be made only after a comprehensive family risk assessment. Central to assessment is the family's capacity to provide a safe, stable, nurturing environment for the child.

10. Placement decisions should include an assessment of the receiving family's ability to meet the child's special needs, whether it is a foster family or relative. Careful matching of children's needs with the most appropriate placement resource should be a top priority. Support services should be provided when needed to ensure that the child's special needs are met.

11. Multiple placements should be avoided. Multiple placements and inconsistent multiple caregivers place most young children at equal or greater risk than does the prenatal exposure to drugs. Foster care support systems and reimbursement rates should be modified to ensure continuity and stability of placements.

12. Sibling separation should be avoided in foster care placement. The maintenance of sibling contacts with each other, even those of tiny babies, are critical to effective treatment of children and families. Existing

law should be amended to place a priority on placement of all siblings within one foster care setting, or at least addressing the issue of maintaining sibling contact.

13. Training and recruitment of foster families for at-risk infants should be clearly defined and intensified. Almost 70% of all California counties have identified a need for additional foster parents who have been trained to cope with the needs of at-risk children.

FAMILY REUNIFICATION

14. When children are returned to family custody, support and monitoring should be intensified, not discontinued. When infants are removed, they may return to their families as strangers. All transitions as well as the family reunification process should address the emotional experience of the child and family.

HEALTH SERVICES

15. Prenatal and pediatric health care providers should increase attention to conditions related to substance exposure.

MENTAL HEALTH SERVICES

16. Mental Health services for infants and their families should be significantly increased. Services that focus on the development of the mother-infant bond are the essential components of early intervention for high-risk infants and high-risk parents.



CHILD CARE & EDUCATION

17. Trained child development specialists should be involved in services for children established in drug recovery programs. Only by addressing the recovery needs of the parent and the developmental needs of the child can a balance be achieved.

18. Therapeutic day care programs should be provided to infants and young children in all communities. Child care is an effective vehicle for the delivery of service. However, child care providers need training to meet the special developmental, learning, emotional and social needs of high-risk children, and to work effectively with high-need families.

19. Child care, preschool and school-age educational programs should develop the capability to serve at-risk children who do not qualify for special education. Programs need to provide the child at-risk with opportunities to learn how to cope with and how to compensate for his neurodevelopmental immaturities that compound the normal stresses of his daily living activities, including large group situations, peer interactions, teacher expectations, classroom routines and mastery of developmental tasks.

TRAINING

20. All service providers for substance involved families should receive training necessary to deliver family-centered, interagency collaborative services. Most professionals working with children and families have been trained as specialists. In order to effectively work together on interagency collaborative approaches, these professionals should receive cross-training on issues that affect quality care to children prenatally exposed to alcohol and other drugs.

FISCAL

21. Funding guidelines across the state departments should be restructured to promote delivery of family-centered, coordinated services and program continuity. The administrative burden and lack of program continuity caused by the diverse funding streams currently supporting treatment of an infant and his family is a great barrier to quality coordinated service. Existing funding streams for family services should be evaluated and recommendations made for restructuring the existing funding system to provide "seamless" and "braided" family-centered services.

PERINATAL SUBSTANCE ABUSE: WHAT'S BEST FOR THE CHILDREN?

PURPOSE

The CHILD DEVELOPMENT PROGRAMS ADVISORY COMMITTEE¹ sponsored the Perinatal Substance Abuse Think Tank to identify and establish priorities for statewide services to young children prenatally exposed to alcohol and other drugs. Thirty-seven experienced practitioners in medicine, education, child care, foster care, child development, psychology, teen counseling, chemical dependency, legislative offices and government agencies convened to define and clarify the needs of these infants and young children. The experts then formulated policy and program recommendations to address the developmental issues facing the growing number of California children.

Children prenatally exposed to alcohol and other drugs are at-risk for physical, behavioral, learning and social dysfunctions that may limit their hopes and potential. Their capacity for leading happy, productive and successful lives may hinge upon how social service, health, and education agencies respond to their diverse needs and those of their families.

The newly recognized problem of perinatal substance abuse has begun to be addressed by both the Legislative and Executive branches of state government. Previous reports have focused on:

1. Survey data from counties on infants referred to child protective services;
2. Legal issues surrounding drug testing and reporting of infants and mothers;
3. State and local interagency coordination strategies;
4. Detailed documentation of the effects and costs of perinatal substance abuse.

This report by the CDPAC adds to prior information by reviewing the special developmental needs of children prenatally substance exposed and by providing recommendations for quality service approaches to be considered as a basis for state policy.

Comprehensive drug recovery and prevention programs for pregnant and parenting women are generally viewed as the most effective means of prevention of perinatal substance exposure of children. Postpartum drug and alcohol treatment and family focused health and social services following delivery are also crucial. However, until the various approaches being piloted have demonstrated their effectiveness and are available to all who need them, we must address how the health care, child development, foster care and education communities can best meet the needs of children already exposed perinatally to alcohol and drugs.

Until now, the major California policy initiatives have been focused on the health care and drug treatment needs of pregnant and parenting substance abusers. The Think Tank sponsored by the CDPAC - titled "Perinatal Substance Abuse: What's Best for the Children?" - sought a more detailed examination of issues from the perspective of children's needs. This was done with the recognition that the needs of children are closely intertwined with the needs of



Without a network of support for recovering mothers, children will be left with little hope for a parent free of substance abuse.

¹ See Appendix A: Child Development Programs Advisory Committee, A History



All children born to substance using mothers are at-risk for psychosocial, developmental, learning and behavioral vulnerabilities. Some will have significant medical conditions.

mothers, other family members, and the community in which they live.

While the focus of this report is on the developmental needs of children, Think Tank participants strongly recognized and supported efforts to provide prevention and treatment to mothers. Without a network of support for recovering mothers, children will be left with little hope for a parent free of substance abuse. Without an effective and coordinated community response system, children and their families will continue to receive too little, too late.

Though it is difficult to separate out one component of the perinatal substance abuse issue without addressing how it fits: supports and meshes with others, such as a site review must occur to understand how best to approach one of the biggest challenges facing California—successfully meeting the special needs of hundreds of thousands of children prenatally exposed to alcohol and other dangerous drugs.

CHILDREN PRENATALLY EXPOSED TO ALCOHOL AND OTHER DRUGS

How Many?

The rise of alcohol and drug use in America places many of our children in jeopardy. Thousands of children are at-risk for developmental, behavioral and learning difficulties. The Department of Alcohol and Drug Programs estimates that between 72,000 and 85,000 of the 570,366 live births in California during 1989 involved prenatal drug and alcohol exposure. The Department estimates that 810,400 women of child-bearing age in California use illicit drugs and 900,000 abuse alcohol. The Department of Health Services estimates that some 20

percent of all infants admitted to neonatal intensive care units in the state are drug exposed.

The seriousness of the drug problem has sparked media attention. Images of tiny babies writhing in their bassinets and the haunting cries of infants who will not be comforted are imprinted on our nation's consciousness.

Increased Risk

Although there is no predetermined outcome for children born to substance using mothers, the potential dangers of prenatal drug and alcohol use cannot be overestimated. All children born to substance using mothers are at-risk for psychosocial, developmental, learning and behavioral vulnerabilities. Some will have significant medical conditions.

Drug use crosses all racial and socioeconomic lines. However, substance abusing mothers who are identified in our society tend to be women of poverty and women of color. According to The Department of Alcohol and Drug Programs, a black woman is 9.58 times more likely than a white woman to be reported for alcohol and drug abuse during pregnancy even though black women comprise less than 19 percent of the women in drug treatment programs.²

Poverty

The experienced clinicians and researchers participating in the Think Tank emphasized the danger of a policy focusing on drugs as the only culprit. The linkage of drug and alcohol addiction to the risks associated with poverty, such as poor maternal nutrition and lack of prenatal care, compound the risk for negative pregnancy outcome. Poverty exacerbates the risks of low birth weight,

prematurity, intrauterine failure to thrive, and sexually transmitted diseases.

For children born into poverty, the negative effects of prenatal substance exposure are compounded by the role poverty plays in their family's capacity to provide safe, secure nurturance—including housing, nutrition, health care, employment, racial non-discrimination, social supports and parental self-esteem.

Maternal Attachment

The impact of alcohol and drugs, prematurity and low birth weight on the development of the newborn can be considerable. The infant may evidence a constellation of early behaviors that influence how he learns about and responds to the persons, objects and events in his world. This, in turn, affects the development of attachment to his caregivers. The newborn period is the most vulnerable time because the parent-infant bond still is in the process of formation, and parents and other caregivers may be overwhelmed with their new responsibilities.

The at-risk infant's response to caregiving may be considerably different from those a mother would expect. The infant may not calm down when held, accept food, look at her mother's face or smile readily. She may tense when held and arch her body away instead of cuddling when her mother holds her close.

These behaviors are a result of known and unknown factors, including fetal hypoxia secondary to the effect of drugs and alcohol upon the maternal vascular systems, placental function and fetal vascular and hormonal systems. The infant's at-risk behaviors may also be a consequence of maternal malnutrition or infection during pregnancy.

Regardless of the cause of the deviations in the infant's behavior, it can prove difficult for even the most experienced mother. When the mother is insecure in her role as parent, it can be devastating. Without appropriate help, the development of attachment between infant and parent can be seriously impaired and further jeopardize that infant's healthy development.

Other Risks

Many of the children identified at-risk will experience learning and attention difficulties. For these children, the question is, "Do mild dysfunctions of learning and attention become educational challenges, or do they become handicapping conditions with serious emotional and behavioral repercussions?" The answer will depend on how the child is helped to cope with the added stresses caused by learning and attention problems.

Children of alcohol and drug abusers may have as much as ten times the risk of becoming substance abusers themselves. The challenge is how to protect an at-risk child from becoming an at-risk adolescent, who is more prone to be a substance abuser, a high school drop-out, a teen parent, a juvenile offender or an unemployed adult. The most critical challenges, thus, center on how to break the intergenerational cycle of substance abuse and how to improve the overall quality of life for hundreds of thousands of our most vulnerable children.

UNDERSTANDING CHILD DEVELOPMENT ISSUES

Research into the long-term effects of perinatal substance exposure is only beginning. The early research is limited in size and scope, making it premature to



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Children need environments that nourish their emotional, social and spiritual well-being.

generalize from the findings. Additionally, researchers have the difficult task of separating the effects of prenatal drug exposure from other pre- and postnatal influences such as poor health care and unstable caregiving environments. However, a strong, well-established body of general child development research, combined with knowledge from early studies and clinical practice relating specifically to prenatal substance exposure, does provide guidelines for policies defining quality care.

Child development research indicates that universal sequences of growth and change occur during the early years of each child's life. Each child, however, exhibits an individual pattern of growth, behavior, learning, and personality development. Within the normal range, there are enormous differences in individual development.

The Child's Environment

Infants who are born exposed to alcohol and drugs appear to show a wide range of consequences. While many children evidence no negative effects, there are infants who are born medically fragile and require specialized health care and developmental services. There are also thousands of infants who demonstrate a range of neonatal behaviors that place their future development at-risk. It is generally understood that for medically fragile children, the developmental periods of infancy and early childhood are critically important and require early intervention. What is less understood is that the early developmental periods are of equal critical importance to infants born with neurodevelopmental vulnerabilities. The quality of the at-risk infant's environment and caregiving can influence his development to a significant degree.

All children deserve safe, secure environments that provide for their physical needs for nourishment, sleep, cleanliness, stability and shelter. Equally important, however, children need environments that nourish their emotional, social and spiritual well-being.

Learning to Trust

In infancy, a primary developmental task for the newborn child is to establish trust in himself, in people and in the world in general. For infants, trust develops over time as a result of consistent and loving caregiving. Responsive caregiving, in which an infant's needs determine the adult's response, is particularly critical; it teaches the infant that the significant people in his life will respond when needed, at the infant's request. Thus the child learns to trust in the responsiveness, safety and predictability of the environment.

This sense of trust provides the growing child with the emotional security he needs to initiate, to explore, to discover and to learn about the world and himself. It also provides the child with the skills he needs to persist in difficult tasks, to pursue goals not immediately attainable, and to handle internal frustration and external stresses.

Infants and young children learn to trust the world and themselves when they are provided with:

- Consistent, loving, responsive caregivers.
- Family-centered rituals of daily living experiences.
- Protection from becoming overexcited or overfatigued.
- Consistent expectations of behavior.
- Acceptance of expressions of feelings.
- Responses to their requests for care.

recognition of achievement, comfort, and praise.

- Support when separated from primary caregivers.
- Opportunity for experiences with peers.
- Opportunity for independence in daily living activities.
- Opportunity to make choices.
- Opportunity for new experiences that allow them to discover and to learn.

A Child's Community

Children are influenced not only by the family environment in which they live, but also by the well-being of their neighborhood. Environments rife with drugs, crime and the stresses of poverty place these children at added risk. The Erikson Institute studied how children learn to cope in stressful environments. The three elements critical in order for children to cope with extreme stress are: (a) parent-child attachment; (b) parental self-esteem; and (c) stability in shelter, food and medical care.³ This study underscores the need of the community to support the attachment between parent and child and the infrastructure of family life. A child can cope with a difficult environment only to the extent to which his mother is not stressed beyond her own capacity to manage.

Policies to achieve optimum development of children must support environments and caregiving styles that support these principles of healthy child development.

Understanding Family Recovery Issues

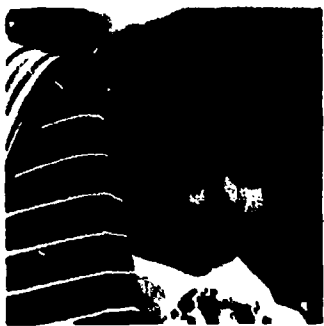
The dynamics of chemical dependency on family life have a major impact on the growth and development of children. Substance dependency is a chronic and progressive disease that affects every member of the family. Recovery is a long, complex process. The recovering family member goes through several phases which may last two years or more. During this time, the addicted person may experience intense cravings, confusion and turmoil. Behavior may fluctuate and relapse may occur. The recovering mother needs considerable support in dealing with her anxiety, guilt and depression. She needs to focus on her own recovery and may need major assistance to meet the needs of her child as well.⁴



Children are influenced not only by the family environment in which they live, but also by the well-being of their neighborhood.

³ Gabarino, J., Durbrow, N., and Kostelny, K., Progress Report, Erikson's Institute, 1989

⁴ California's Perinatal Substance Abuse Project, Health and Welfare Agency, January 1991; and California's Drug-Exposed Babies/Undiscovered, Unreported, Underserved, July 1990, pg. 21



It is exceedingly important that children at-risk due to prenatal substance exposure are not labeled, stereotyped or segregated.

RECOMMENDATIONS FOR QUALITY CARE POLICIES FOR CHILDREN

To help clarify issues that influence positive child development outcomes, Think Tank participants addressed policy and program recommendations from three perspectives:

1. Children living within substance involved families;
2. Children who are in or have experienced foster care; and
3. Children served by child care, early intervention and education programs.

Recommendations address service delivery, training, research, policy, and legislation. Throughout the work groups, participants from all areas of practice emphasized the wide variation in children and families affected by substance abuse. In all cases, recommendations for services should be tailored to meet individual needs and the sociocultural values of the community.

TERMINOLOGY

1. CHILDREN SHOULD NOT BE LABELED, STEREOTYPED OR REFERRED TO AS "CRACK BABIES" OR "DRUG KIDS."

A real danger lies in the expectations we have for those who are too often referred to as "crack babies." To a great extent, the community's expectations of children prenatally exposed to drugs have been formed by the media. The press has had a lot to say about these children including:

"Born to Lose ..." (Wall Street Journal, July 18, 1989)

"... turning up in first and second grade classrooms wreaking havoc on themselves and others"
(Washington Post, September 17, 1989)

"A generation of sociopaths ..."
(The Oakland Tribune, May 25, 1989)

In fact, children born to drug-using mothers demonstrate a continuum of possible developmental outcomes, ranging from seriously compromised, developmentally disabled children, to those with milder dysfunction, to those who are healthy, intact children. It is exceedingly important that children at-risk due to prenatal substance exposure are not labeled, stereotyped or segregated. Most children prenatally exposed to alcohol and other drugs have the capacity to develop into healthy children and become responsible members of the community with appropriate early intervention.

State agencies should ensure that their policy, educational, and public awareness materials utilize appropriate language and information. State officials should seek to extend this understanding to all state funded programs operating throughout California. Government officials, researchers, clinicians and service providers at all levels should attempt to educate the public and the media on the inappropriateness of using labels such as "crack babies" and "drug kids" to define children. Public awareness efforts should explain that these generalizations are unfair and stigmatizing to children. Further, they are inaccurate and serve to limit our understanding of how to meet the needs of children and their families.

PREVENTION

2. EVERY COMMUNITY SHOULD OFFER EFFECTIVE OUTREACH TO SUBSTANCE ABUSING PREGNANT WOMEN WITH IMMEDIATE ACCESS TO PRENATAL CARE AND RECOVERY PROGRAMS.

Pregnant women and their unborn infants cannot wait for treatment. Funding to community-based groups must include adequate support to clear existing treatment waiting list problems and to establish effective outreach to this population (for whom there are many barriers to using existing resources.)

Risks from prematurity, low birth weight and prenatal substance exposure can be lessened by a mother's reduction of alcohol and other drug usage during pregnancy and by obtaining health care. The developmental outcome of infants born to substance using women can be significantly improved by the availability and timely utilization of prenatal medical care and recovery programs. Since many substance using pregnant women do not seek prenatal care, culturally sensitive, community based outreach programs will be necessary in order to reach this underserved population.

The Advisory Committee recommends that various outreach models and methods be the focus of the October 1992 meeting of its Child Protection and Special Needs Subcommittee. Some of the participants from the prior Think Tank as well as specialists within the State Departments of Health Services, Social Services, and Drug and Alcohol Programs should be included. Outreach and awareness models should address awareness needs of both pregnant women and their service providers.

ASSESSMENT


3. NEURODEVELOPMENTAL SCREENING TOOLS AND COMPREHENSIVE DEVELOPMENTAL ASSESSMENT PROTOCOLS MUST BE DEvised AND USED WITH ALL AT-RISK CHILDREN WHERE SUBSTANCE ABUSE IS SUSPECTED.

Many of the deviations or immaturities in neurodevelopmental behaviors which place infants at-risk are not obvious to the parent, social worker or foster parent. Clinicians and researchers experienced with infants also caution that current screening tools are not sufficient to identify the vulnerabilities these children show.

Formal assessment must include a broad base of child observation, caregiver interview, and an analysis of strategies used by the child to accomplish tasks. Protocols for the assessment and monitoring of a child's social and emotional development need to be established. Current use of standardized assessment tools provides valuable information about a child's capacity to respond on a one-to-one basis in a structured situation. However, spuriously high psychometric scores may belie the vulnerability of a child's spontaneous adaptive functioning and coping mechanisms, and may not reflect the qualitative aspects of a child's development that hinder learning in family or large group settings.

New screening tools, comprehensive assessment protocols, and professional training programs must be developed that capture the neurodevelopmental vulnerabilities that place infants and young children at-risk for developmental, learning and behavior problems.

The Model Needs Assessment Protocol developed by the Health and Welfare Agency pursuant to implementation of SB 2669



The developmental outcome of infants born to substance using women can be significantly improved by the availability and timely utilization of prenatal medical care and recovery programs.



Monitoring infants and young children until problems become severe enough for services is an inappropriate model of service delivery.

(Chapter 1603, Statutes of 1990 Health and Safety Code Section 10900) provides for assessment of risk and service needs of infants and their families to be completed prior to the infant's release from the hospital. This early assessment should be followed after the infant leaves the hospital by a more comprehensive evaluation to fully identify any psychosocial and developmental needs of all at-risk infants where substance abuse is suspected.

The State Department of Developmental Services, the Department of Mental Health, and the State Department of Education should convene a workgroup of experienced specialists to assist in the development of appropriate screening tools, comprehensive assessment protocols, and professional training programs.

**EARLY INTERVENTION
FOR INFANTS AT RISK**

4. DEVELOPMENTAL SERVICES FOR AT-RISK CHILDREN SHOULD START IN THE NEONATAL PERIOD.

- Currently available intervention services for infants are generally limited to those children with identified developmental disabilities. California has not yet adopted a comprehensive model for extending services to infants in the at-risk category as defined in P.L. 99-457.
- As a result, most infants prenatally exposed to drugs will not qualify for intervention services designed for those with developmental disabilities. However, a high percentage of these infants will evidence deviations in their neurodevelopmental patterns that place them at-risk for developmental learning, behavioral and psychosocial difficulties.

At-risk behaviors may also stem from conditions other than prenatal drug exposure, including multiple placements, homelessness, poverty, prematurity and other perinatal biological insults. If these risk behaviors are not appropriately addressed in a timely manner, the child remains at-risk for later school failure and behavioral problems.

- The present practice of monitoring infants and young children until problems become severe enough for services is an inappropriate model of service delivery. Services need to be available for those children who evidence behaviors that place them at-risk for future learning or behavior problems.
- All infants born to substance involved women should receive an early evaluation to assess their special psychosocial and developmental needs. Immediate access to early developmental services should be available for infants of substance involved women who show either neurodevelopmental deviations, immaturities or developmental disabilities.

Children at biological risk are more vulnerable to inadequate environments than non-risk children, particularly in the development of attachment, organization of behavior, self-esteem and the coping mechanisms needed to handle the stresses of daily living. Inadequate environments are those that cannot meet the special needs of the high-risk child. Child care at two, Head Start at three or four, and education at five come too late for these children. Overwhelmed or inexperienced mothers and foster parents cannot provide the special needs child with protective, predictable and constant responsive caregiving without special intervention support.

Birth and foster parents and high-risk infants benefit from programs that stress quality transactions between mother and child, rather than only focusing on the development of motor, language skills and daily living skills in the child. Intervention needs to include a flexible combination of "hands on" developmental guidance, infant/parent interactions, emotional support and practical guidance. The particular intervention plan should depend on the clinical needs of the family.

At-risk infants need developmental enrichment in whatever setting they are placed. If parents are unable to participate, alternative opportunities must be provided for the child. These may include enriched or therapeutic day care and shared parenting models.

The State Department of Developmental Services should work with the P.L. 99-457 Local Planning Areas to extend services to infants in the at-risk category. These services should be coordinated with the Department of Social Services and County Child Welfare Departments to ensure that children in temporary or long-term foster care are included.

The Child Development Division of the California Department of Education should develop models for enriched or therapeutic infant day care, and utilize a portion of the expanded funding available from the federal block grant to implement these models.


In addition, the Advisory Committee recommends that one time carry over funds from the Federal Child Care and Development Block Grant should be used to develop a training video on enriched or therapeutic infant day care. The video can be made available to all providers and center staff.

FAMILY TREATMENT

5. IMMEDIATELY FOLLOWING BIRTH, HOSPITALS SHOULD INITIATE COMPREHENSIVE SERVICES FOR SUBSTANCE USING MOTHERS AND THEIR NEWBORN INFANTS.

The immediate postpartum period may be a time when mothers are particularly responsive to intervention. Too often, few attempts are made to foster a relationship with these mothers during their hospital stay. Social services are available at most major hospitals, yet these services are rarely targeted to alcohol and other drug involved mothers except to initiate proceedings to remove the child from the mother's care. Part of the difficulty in initiating a relationship with the mother during this period is due to restrictions that exist in Medi-Cal funding for the delivery of an infant. Most alcohol and other drug involved women are discharged 24 to 36 hours after delivery. This is too short a time. The birth of a baby is one of the few times that many of these women will come in contact with professional staff who can provide help and support. Existing hospital services should be mobilized in an effort to address the drug recovery, health, and social service needs of women during their hospital stay.

In addition, many other community services currently exist for families with limited income, such as the Women, Infants and Children (WIC) food supplement program and voucher programs for temporary housing. Few drug involved women are aware of these programs. Many of these mothers are unprepared to negotiate the social service system. As a result, they often fail to take advantage of existing programs, including visiting nurses programs, free medical programs and Head Start. Although much of the information could be disseminated by



The immediate postpartum period may be a time when mothers are particularly responsive to intervention.



Services to all family members contribute to overall family stability which allows for a break in the intergenerational cycle of substance abuse.

hospital staff, *there should be a close alliance between hospital staff and outside drug recovery, health, and social service agencies so that support and help continue to be provided to these women subsequent to their hospital stay.*

Current Options for Recovery Pilot Projects⁵ have initiated hospital-based services as well as follow-up case managers to attempt to ensure that families receive appropriate services. These new services which are pilot and permissive in nature should be encouraged and expanded.

In addition, to utilize this critical postpartum period effectively, current restrictions on Medi-Cal funding should be extended when authorized as part of a substance abuse treatment plan. Current Medi-Cal funding allows a hospital stay of 48 hours. Because the postpartum period provides both a critical time for infant bonding and for the marshalling and coordination of services to the infant and mother, the 48 hour limit is viewed as too short. By extending the time allowed, and by using the additional time to develop a plan of treatment for the infant and the infant's family and to begin the education and treatment of the mother, long-term costs of treatment may be reduced. The postpartum period is a key window of opportunity that is currently not being used effectively.

Existing Medi-Cal policy allows for extended hospital stays for medically significant events. *A positive tox screen from a newborn infant should be viewed as a medically significant event for both the newborn infant and the mother, thereby allowing the mother to remain in the hospital with the infant for extended treatment and initiation of recovery services.*

6. COMPREHENSIVE FAMILY-CENTERED SERVICES SHOULD BE AVAILABLE TO SUBSTANCE INVOLVED MOTHERS AND THEIR INFANTS, AND ALL OTHER FAMILY MEMBERS. COMPREHENSIVE SERVICES REQUIRE IMPROVED INTERAGENCY COLLABORATION.

High-risk, substance involved families have extensive and complicated service needs. Although it is recognized that not all birth mothers will be able to raise their children, the placement of choice for every child is with the birth family. Every opportunity must be offered to enable the family to provide a sober, safe, nurturing environment for its children.

Child care and transportation are critical elements in service delivery accessibility. The community based "one-stop shop" model has proved to be the most effective means serving high-need families. Substance involved families differ in terms of their individual service delivery needs. Communities must provide an array of services, including mother-children residential programs, center-based day treatment programs, and home-based services. Decision making should be based on needs of the family, rather than on the availability of services.

It is important to address service needs for the entire household, including father, siblings, and extended family members. All children living in a substance involved family are at greater risk for negative developmental outcome, including teenage substance abuse, school failure, emotional disorders and delinquency. Services to all family members contribute to overall family stability which allows for a break in the intergenerational cycle of substance abuse.

The current Options for Recovery pilot program, which coordinates services across

⁵ California's Perinatal Substance Abuse Project, Health and Welfare Agency, January 1991

bureaucratic boundary lines, is an important first step toward providing a central marshalling of services. Though recently expanded, the program unfortunately remains a pilot. Interagency collaboration is urgently needed in every community.

The Child Development Programs Advisory Committee should be included in the review of the effectiveness of the pilot program. The Committee is uniquely qualified to assess the programs impact on the child care and development community. The Committee is also prepared to work with the pilots on meeting the foster care, day care, early childhood development, and before and afterschool care needs of infants and children.

7. TREATMENT SERVICES SHOULD ADDRESS DRUG RECOVERY IN THE CONTEXT OF TOTAL FAMILY NEEDS, NOT IN ISOLATION.

Many substance involved families face problems beyond the role that alcohol and other drugs play in their lives, including homelessness, poverty, lack of health care, poor nutrition, unemployment, lack of literacy/education, and rapid cycles of repetitive pregnancy. A high percentage of identified substance using mothers also have personal histories that include sexual and physical abuse, loss of other children to child protective services, domestic violence, incarceration of self and significant others, and dysfunctional family experiences. Their effectiveness as parents and the ability to respond emotionally to the needs of their children will be influenced by the extent to which they have addressed and resolved their own issues of self and parental self-esteem. Drug recovery programs offered in isolation of meeting the individual social, emotional, medical, and physical needs of family members cannot begin to ensure family stability.


It is clear that success in addressing perinatal substance abuse and the need for care of at-risk children is inexorably linked to success in responding to many other areas of social need. In a real sense, perinatal substance exposure is a symptom of the much larger problem this nation faces. *For the children, it is imperative that we act immediately to treat the symptom "perinatal substance exposure"; but in the long-term, we must find ways to impact on the underlying problems.*

8. HIGH-RISK INFANTS AND FAMILIES SHOULD RECEIVE COORDINATED CASE MANAGEMENT AND FOLLOW-UP FOR A MINIMUM OF FIVE YEARS.

Substance involved mothers may have difficulty finding and availing themselves of the medical, recovery, and developmental follow-up services needed for themselves and their children. To ensure that at-risk children are adequately assessed and receive the necessary services, an effective, coordinated follow-up process by the public health or child protective services system should be developed in each community.

Short-term family support and monitoring programs (e.g., six-month drug recovery programs, 14-week parenting classes, and six-month family maintenance contracts) are not an effective means of ensuring long-term stability for high-need substance involved families. The recovery process takes at least two years.

The protection and long-term welfare of the infant must be the primary goal of the family-centered approach. There must be recognition that substance abuse is a long-term problem and long-term solutions are necessary. Addiction and recovery are lifelong processes. Ongoing family supports must balance the progressive degenerative nature of addiction, the uneven and unpredictable



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Comprehensive risk assessment procedures avoid careless, arbitrary or biased decision making.

course of recovery, and the critical need of every child for a secure and nurturing environment.

The service delivery system is crowded with recidivist cases. The short-term treatment approaches have not only failed to recognize the actual recovery period, but have also failed to recognize the long-term familial and economic benefit of continued long-term follow-up. A planned five-year program would realistically provide for both recovery and for intervention at critical developmental junctures. It would also contribute to breaking current intergenerational cycles and begin removing recidivists from service delivery systems.

The State Department of Social Services and the Department of Alcohol and Drug Programs should develop models for family support services which recognize the realities of drug and alcohol treatment and recovery, and develop treatment plans extending over a five year period.

FOSTER CARE

9. PLACEMENT DECISIONS FOR NEWBORNS SHOULD BE MADE ONLY AFTER A COMPREHENSIVE FAMILY RISK ASSESSMENT.

The initial placement decision after a newborn is identified as prenatally exposed to substance abuse is critically important. cursory evaluations can lead to mistakes in judgments, resulting in the child being exposed to a heightened risk of abuse, neglect or abandonment, or suffering unnecessary separation from his family because appropriate services were not offered to the birth family. Comprehensive risk assessment procedures avoid careless, arbitrary or biased decision making. Central to assessment is the family's capacity to provide a safe, s*

nurturing environment for the child.

The Model Needs Assessment Protocol developed by the Health and Welfare Agency pursuant to implementation of SB 2669 (Health and Safety Code Section 10900, 1990) provides for assessment of risk and service needs of infants and their families to be completed prior to the infant's release from the hospital. In many cases, this initial assessment may not provide enough time or information to make the kind of comprehensive family risk assessment necessary for this critical decision. While home visits are permissible as part of this hospital assessment, they are not required and are unlikely to be implemented in most cases. The code allows a wide range of health practitioners, including dental hygienists, to conduct these in-hospital assessments.

The needs assessment prescribed by Health and Safety Code Section 10900 is an important first step in identifying service needs of substance involved mothers and their newborns. *This initial hospital-based assessment should be followed by an in-home assessment by a child welfare or public health worker trained to assess risk in substance involved families before placement decisions are completed.*

10. PLACEMENT DECISIONS SHOULD INCLUDE AN ASSESSMENT OF THE RECEIVING (FOSTER OR RELATIVE) FAMILY'S ABILITY TO MEET THE CHILD'S SPECIAL NEEDS.

When a child cannot safely remain with his birth parents, relative placement is often the first option considered. Issues of assessment, a resources, intergenerational conflict a social assistance can complicate an a complex situation and undermine the aional support to the child.

The current demand for foster family care is high. The demand for qualified foster care for children with special needs is even higher. Foster care placement decisions jeopardize the development of children when their developmental and emotional needs are not given priority. Many foster parents are receiving too many at-risk children and are not able to meet their special developmental needs. Many children are being placed in small group homes (6-12 children), often characterized by high caregiver turnover and lack of needed specialized services. These factors place children at added risk.

The placement decision for children is critical. There is a general perception that given current workloads, children are often "put" rather than "placed". This distinction can be critical to the long-term well-being of children. Careful matching of children's needs with the most appropriate placement resource should be a top priority.

All communities should have a Court Appointed Special Advocates (CASA) program available to assist in decision making when appropriate.

Child development specialists should develop caregiver assessment protocols for placement of special needs children, protocols that address quality of care issues such as:

- Consistency of caregiving;
- Level of stress in environment;
- Cultural/linguistic/religious similarity;
- Ability to deal with special developmental, behavioral or familial problems associated with substance abuse;
- Ability to accept all siblings;
- Ability to promote a healthy attachment between the child and birth mother;
- Ability to access health, mental health and social services for the children;
- Commitment of the family to keep

child/children until relinquishment or reunification; and,

- Proximity of out-of-home placement to birth parents.

When children are placed with relatives, support services should be provided when needed to ensure that the child's special needs are met.

The Department of Social Services is developing assessment protocols for matching a dependent child and his or her family with the services provided at various levels of group home foster care (Welfare Institutions Code Section 11467). Currently this excludes young children. This process should be extended to include the needs of the infants and toddlers. *Developmentally appropriate standards of care should be established for infants and young children who are placed in any form of out-of-home care.*

The Advisory Committee's representative from the Department of Social Services should be requested to keep the Committee informed of the progress of the development of the protocol. Further, the Department representative will convey to the staff preparing the protocol the Committee's eagerness to render whatever assistance possible to ensure the needs of infants and children are adequately met. The Advisory Committee should facilitate a public forum on expanding the protocol to meet the needs of infants and children who have been exposed to substance abuse

11. MULTIPLE PLACEMENTS SHOULD BE AVOIDED.

One of the concerns most strongly voiced by participants in the Think Tank was the alarming number of different placements and new caregivers experienced by infants and toddlers in foster care. The factors creating this situation are numerous and complex. The dramatic growth in the number of children in



The foster placement decision for children is critical.



Multiple placements and inconsistent multiple caregivers place young children at-risk.

foster care has led to shortages of traditional foster care resources. Many of these infants are medically fragile and difficult to care for. These factors, as well as issues of licensing restrictions, reimbursement rates, lack of support to relative caregivers, and often premature or abortive attempts at family reunification contribute to the high rate of multiple placements.

Multiple placements and inconsistent multiple caregivers place most young children at equal or greater risk than does the prenatal exposure to drugs. Infants and young children always experience a profound sense of loss when moved from place to place. They may express their feelings by becoming lethargic, withdrawn, overactive and/or irritable. Sleeping or feeding problems may develop. The loss a child experiences can damage a child's capacity to trust and form new relationships, resulting in serious psychosocial problems as he is growing up.

Several strategies will reduce the damage caused by multiple placements:

- Training must be made available to providers to enable them to cope effectively with the emotional, behavioral, and social complications that go along with the care of a child who has been separated from his family.
- At-risk/special needs children and foster families should receive enough community support to maintain a stable placement until family reunification or adoption.
- Licensing that restricts foster parents to specific age groups can be detrimental to the child if it means another move within the system for that child. Licensing policies should be modified to ensure

children are not moved because of age.

- Respite care for foster parents helps maintain stable placements. The Options for Recovery Pilot Program provides an average of 48 hours of respite care a month for foster families.⁶
- Foster care reimbursement rates and policies should be modified to ensure continuity and stability of placements. Under the current rate structure, a child must "remain qualified" to stay in a specialized foster home. This may result in rate reductions to foster care providers of recovering, stronger children. To maintain the original reimbursement rate, which they may depend on for the household income, they must demonstrate a continuing disability for the child.

The Department of Social Services in combination with child development specialists and foster care providers should review current foster care licensing and rates policy to analyze how it affects continuity and stability of placements and provide recommendations for administrative and legislative improvements to the Senate Select Committee on Children and Youth.

Training of foster care providers should be strengthened as outlined in Recommendation 13.

12. SIBLING SEPARATION SHOULD BE AVOIDED IN FOSTER CARE PLACEMENT.

Under California Civil Code Section 275, foster care placements with family members receive a priority. Existing law does not, however, address the issue of maintaining sibling contact nor does it place a priority upon placement of all siblings within one foster care setting.

⁶ California's Perinatal Substance Abuse Project, Health and Welfare Agency, January 1991

In SB 2669, the Legislature clearly expressed its intent to view perinatal substance exposure as a family problem to be treated with a family-centered approach. The maintenance of sibling contacts with each other, even those of tiny babies, are critical to effective treatment of children and families. Civil Code Section 275 should be amended to reflect a priority for maintaining familial integrity and the unity of siblings in foster care placement.

The Committee recommends adding Section 275.05 to the Civil Code to read:

- *Diligent effort shall be made in all foster care placements, including those with relatives, to maintain sibling togetherness and contact. Separation of siblings is to be avoided unless such separation is determined to be in the best interests of the child separated from other siblings.*
- *When maintaining sibling togetherness is not possible, diligent effort shall be made, and a plan of care prepared, which provides for on-going and frequent interaction among siblings until family reunification is achieved or parental rights are terminated. If sibling interaction is determined to be detrimental to a child or children, the reasons for the determination shall be noted on the plan of care, and interaction may be suspended.*
- *When sibling interaction is suspended, periodic review of the reasons for such suspense, occurring at least every 90 days, shall take place. When sibling interaction can be safely resumed, the plan of care shall be amended to provide for interaction.*
- *Each sibling, his or her guardian ad litem, or designated representative, shall be able to comment on the plan of care's provisions for*

interaction. When interaction is suspended, each sibling shall be provided with an opportunity to review the findings of fact associated with the suspension determination and to appeal the suspension of interaction when factual error is present in the determination.

13. TRAINING AND RECRUITMENT OF FOSTER FAMILIES FOR AT-RISK INFANTS SHOULD BE CLEARLY DEFINED AND INTENSIFIED.

In a 1989 survey of county welfare agencies, the Senate Office of Research reported 69 percent of the counties identified a need for more trained foster parents to cope with the growing caseloads of infants and young children.⁷ In addition to the need for more foster parents, Think Tank participants believe the changing role of foster parents in the treatment of at-risk children requires further definition and study.

Foster parents of infants are receiving and caring for these high-risk children during a time in their early lives when appropriate medical and developmental intervention is critical. Foster care providers need a strong understanding of the emotional and internal process of the child. Foster parents need to preserve family history and allow children to maintain quality memories. There needs to be a respect for children's connections to their families, parents and siblings.

Foster parents should receive training which includes:

- *Special developmental needs of children at-risk due to prenatal exposure to alcohol/drugs and other related factors;*
- *Strategies to meet the special needs of children at-risk from substance abuse and other related factors;*
- *Treatment needs of families in recovery.*
- *Impact of out-of-home placement on*



The maintenance of sibling contacts with each other, even those of tiny babies, are critical.

⁷ California's Drug-Exposed Babies/Undiscovered, Unreported, Underserved, pg. 21, A Special Report Prepared for Senator Diane Watson by the Senate Office of Research, July 1990



Family reunification must address the emotional experience of the child.

- children and all family members;*
- *Strategies to meet needs of children experiencing out-of-home placement;*
 - *Issues of mothers (women) in recovery;*
 - *Access to community resources; and,*
 - *Interagency collaboration skills.*
 - *Strategies for helping foster children cope with the sense of loss and separation from siblings and other family members (including a sense of loss when removed from other foster care settings).*
 - *Strategies for assisting in the maintenance of maternal-child ties.*
 - *Methods of maintaining safety and resolving conflict when interacting with families with a substance abuse history.*

Currently, Chapter 5.3 of Welfare and Institutions Code Section 16525 (et seq) provides for Pilot Projects which include specialized foster care of children at-risk of substance exposure and HIV positive children. These projects currently provide specialized training to foster parents to meet the health needs of the children. *This training should be expanded to address the special developmental and emotional needs of at-risk children as well. A minimum level of training should be mandated. Because of the critical statewide need for well-qualified foster families to care for children, the foster parent recruitment and training component of these pilot projects should be implemented on a statewide basis.*

FAMILY REUNIFICATION

14. WHEN CHILDREN ARE RETURNED TO FAMILY CUSTODY, SUPPORT AND MONITORING SHOULD BE CONTINUED.

Current planning and methods for assisting children's return to their parents are often inadequate. When children are returned to family custody, support should be intensified,

not discontinued. Children who have experienced out-of-home placement usually have many unresolved issues of prior loss and separations. When infants are removed, they may return to their families as strangers. Family and individual support systems must be available to all family members experiencing these transitions.

All transitions and the family reunification process must address the emotional experience of the child. A single consistent person who has established a relationship with the child should represent the child's perspective in all transitions and reunification plans and help interpret the process to the child. This person may be either a social worker or a Court Appointed Special Advocate depending on the needs of the community.

The Committee recommends Section 16507 (et seq) of the Welfare and Institutions Code be amended to ease the current restrictions on family reunification services to provide procedures for supporting and monitoring reunified families for a period of time specified in the family treatment plans. This section should also be amended to reflect legislative intent to provide ongoing follow-up and case review in order to ensure the success of the reunification process and the continued well-being of the child.

HEALTH SERVICES

15. PRENATAL AND PEDIATRIC HEALTH CARE PROVIDERS SHOULD INCREASE ATTENTION TO CONDITIONS RELATED TO SUBSTANCE EXPOSURE.

Seventy-nine percent of women with AIDS are of reproductive age. Fifty-two percent have a history of IV drug use. The national annual number of new HIV infections in newborns due to drug exposure is between

1,500 and 2,000. Sixty-five percent of mothers who are HIV positive will pass it on to their offspring. The rate varies because of different patterns of drug use in different communities. Statistics report the growing estimates of HIV positive in newborns—one in every 1,200 births in California. If antibodies are present after 18 months, then almost surely the virus is present. This occurs in 30 to 49 percent of the cases.

The Center for Disease Control (CDC) reports there is a new silent epidemic of sexually transmitted diseases throughout the U.S., falling hardest on the young, the poor, and the drug user. And now, many inner city neighborhoods have become permeated with syphilis. An estimated 30,000 infants will die or suffer birth defects every year as a result of sexually transmitted diseases.

Untreated mothers may deliver offspring who may manifest no clinical abnormality for weeks or even months and thus remain unidentified and untreated. Instead, general symptoms of fever, poor weight gain and restlessness compound an already compromised newborn who may not be treated for syphilis. Later clinical manifestations of untreated congenital syphilis can result in blindness, neurological disease, and abnormalities of the bone.

The CDC attributes the increase in syphilis to drug use and lack of access to health care. It has been reported that 25 percent of inner city mothers who have a positive toxic screening for drugs have syphilis. Congenital syphilis can be prevented if diagnosed early in a woman's pregnancy, and it can be treated if the newborn is tested.

There is an increase in numbers of failure to thrive infants among drug exposed babies, due to gastrointestinal vulnerability, the

difficulty the infant may have in developing a relationship with his mother, and the potential lack of maternal emotional availability. The postnatal social environment is of great significance.

The Department of Health Services reports that all branches within the Family Health Division are continuously facilitating communication and networking between state and local entities. In 1989 the Department, in cooperation with the Department of Alcohol and Drug Programs, Developmental Services and Social Services, worked on the development of local systems of health care for women and children utilizing comprehensive case management services in each of the five pilot sites. Prior to implementing these services, training needs assessments were completed for all participants in the pilot projects. Based on these findings, a minimum of eighty hours of training was developed for each site. This training was conducted jointly by the Department and the School of Nursing at the University of California, San Francisco. Training modules and materials were developed for this program. Due to budget cuts, the program was transferred from the Department of Health Services to the Department of Alcohol and Drug Programs in 1991.

Health Services has two programs underway targeted at outreach to health care providers. One is a manual for obstetric providers, and the other is a proposed outreach to family planning agencies.

The Department of Health Services should be encouraged to continue developing strategies for communication, outreach and professional training to ensure that health practitioners statewide are aware of the increase of these serious conditions related to perinatal substance exposure.



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Services that focus on the development of the mother-infant bond are the essential components of early intervention

The Committee specifically recommends use of Federal Child Care and Development Block Grant Funding for the development and distribution of a broadcast quality training video for health care professionals. The Block Grant has provisions for both health education and quality improvement, and either category would encompass the development of such a video. Further, cable systems currently have community access, educational consortium, and/or health information channels to which such a video could be distributed.

MENTAL HEALTH SERVICES

16. MENTAL HEALTH SERVICES FOR INFANTS AND THEIR FAMILIES SHOULD BE SIGNIFICANTLY INCREASED.

Recent National Institute of Mental Health studies indicate that one of three people with mental disorders are substance abusers. These people are often not accepted by traditional mental health or substance recovery programs, and thus fall through the cracks in a community's service delivery plan. Two-thirds of individuals in the nation's jails and prisons have a history of mental disorders and substance abuse. A significant drug abuse preventative strategy for any community should be to identify early and to treat anxiety and depression in children and adolescents. Children and adult family members need mental health services as individuals and as members of the family unit.

The California Department of Mental Health recognizes that children, especially in the 0-3 and 12-13 year old range are an underserved population in the state's mental health care delivery system.⁸ Mental health service providers should become more involved in providing services to infants who have had substance exposure and to their

families. Services that focus on the development of the mother-infant bond are the essential components of early intervention for high-risk infants and high-risk parents.

CHILD CARE & EDUCATION

17. TRAINED CHILD DEVELOPMENT SPECIALISTS SHOULD BE INVOLVED IN SERVICES FOR CHILDREN ESTABLISHED IN DRUG RECOVERY PROGRAMS.

The current focus of drug recovery programs is on the substance abuser. The large number of problems faced by a recovering parent and an infant require a balanced approach to recovery for both parent and child *in order to encourage all facets of the recovery process to progress.* Much of the parent's recovery will be linked to the ability to interact "normally" with the child. Yet, much of both the parent's and the child's responses to the environmental and interactive stimulus will be anything but "normal."

A recovery program narrowly focused on the parent, or even more broadly tailored to encompass the parent's interaction with the child, would still lack the balanced approach necessary to establish normal familial relationships. Only by addressing the recovery needs of the parent and the developmental needs of the child can a balance be achieved.

18. THERAPEUTIC DAY CARE PROGRAMS SHOULD BE PROVIDED TO INFANTS AND YOUNG CHILDREN IN ALL COMMUNITIES.

Child care has been demonstrated to be an effective vehicle for the delivery of service. When enriched, it can serve to meet the special needs of children. Child care while a parent is recovering is essential. At-risk birth

parents need child care services in order to work, to manage their lives, and/or for respite. Foster parents need child care services so that more working parents will be encouraged to become foster parents. At-risk children may need enriched child care to promote their development.

Child care providers need training to meet the special developmental, learning, emotional and social needs of high-risk children, and to work effectively with high-need families. Along with additional training, child care providers may need lower adult/child ratios, consultation from child specialists, and a support system that will help them replenish from the frequently excessive amounts of time and energy expended to help a high-need child and his family.

Recently the Governor signed Senate Bill 668 by Senator Russell which requires the Department of Education to design a professional staff development and training system for all child development staff serving children at-risk due to substance exposure who are placed in infant, toddler, preschool and school-age programs. The new law is broad in its scope and requires:

- Compiling factual information on the conditions and behaviors of children at-risk due to substance exposure;
- Establishing a group of trained professionals to identify children at-risk and train staff in specialized teaching and caregiving methods;
- Identifying and reviewing training materials;
- Performing local and regional staff development activities; and
- Providing ongoing reinforcement and support to trained professionals.

The bill specified that funding for the

project's activities was to come from the Federal Block Grant.


The Committee encourages the California Department of Education (CDE) to complete development of this training system as early as possible, and recommends that the Department report to Senator Russell and to the Committee by September 30, 1992. If necessary, the Committee through its Subcommittee structure should assist CDE by obtaining input from a multidisciplinary group of health and education professionals.

Once training materials have been developed, the Advisory Committee recommends broad distribution to providers through state and local organizations including family day care associations, provider organizations, Resource and Referral Agencies, city and county coordinators, the California Department of Education, and the Licensing Division of the State Department of Social Services.

19. CHILD CARE, PRESCHOOL AND SCHOOL-AGE EDUCATIONAL PROGRAMS SHOULD DEVELOP CAPABILITY TO SERVE AT-RISK CHILDREN WHO DO NOT QUALIFY FOR SPECIAL EDUCATION.

At-risk children may have special behavioral and learning needs that must be addressed within a general education setting. Programs should address both attachment issues and the disorganization of behavior that result when a child with neurodevelopmental immaturity is raised in a high stress environment that can't meet his special developmental needs.

Programs need to provide the child at-risk with opportunities to learn how to cope with and how to compensate for his neurodevelopmental immaturities that compound the normal stresses of his daily living activities, including large group



At-risk children may have special needs that must be addressed within a general education setting.



Professionals need cross training on issues that affect quality care to children.

situations, peer interactions, teacher expectations, classroom routines and developmental task mastery.

Curriculum, classroom and program modifications, interdisciplinary team approaches, and home-school partnerships are helpful. Additional training and consultation from child development specialists, special educators, social workers, psychologists and communication disorder specialists, and the availability of support systems may be required to enable general education teachers to work effectively with high-need children and families. Pre-service training also needs to prepare teachers to work effectively with families from diverse sociocultural, racial and ethnic communities.

The Advisory Committee encourages the California Department of Education (CDE) to incorporate the special behavioral and learning needs of these at-risk children within their existing training program and to explore possibilities for providing specific curriculum materials and training opportunities for child care. The Advisory Committee should assist CDE in this effort by 1.) collecting models for child care, preschool and school-age educational programs which address the needs of at-risk children, and 2.) sponsoring public forums and training workshops which showcase appropriate models and curriculums.

TRAINING

20. ALL SERVICE PROVIDERS FOR SUBSTANCE INVOLVED FAMILIES SHOULD RECEIVE TRAINING NECESSARY TO DELIVER FAMILY-CENTERED, INTERAGENCY COLLABORATIVE SERVICES.

Staff of public and private service delivery agencies including health, mental health,

developmental services, education, child welfare, child care, drug and alcohol recovery, and probation need extensive training on attitudes, knowledge and skills that affect service delivery to substance using families and at-risk children.

Most professionals working with children and families have been trained as specialists. In order to effectively work together on interagency collaborative approaches, these professionals should receive cross-training on issues that affect quality care to children pre-natally exposed to alcohol and other drugs.

Existing statutes require training for health care providers, child welfare workers, drug and alcohol recovery workers, teachers, child care staff, and other children's services professionals.⁹ The California Department of Education should be instructed to work together with the Department of Social Services and other agencies to deliver interagency training. *Training on methods of coping with the special needs of infants and young children should be incorporated into this statutory and regulatory scheme.* In order to develop appropriate training models, the Advisory Committee encourages CDE to bring together specialists from multiple disciplines to look at the issue and formulate training protocol which addresses the many facets of developmental issues facing these at-risk children. Financial support for release time and training program development is essential for effective training of these service providers who work under extreme pressure.

⁹ e.g., Health and Safety Code §1597.056 which sets day care teacher qualifications.


21. FUNDING GUIDELINES ACROSS ALL STATE DEPARTMENTS SHOULD BE RESTRUCTURED TO PROMOTE DELIVERY OF FAMILY-CENTERED, COORDINATED SERVICES AND PROGRAM CONTINUITY.

The administrative burden and lack of program continuity caused by the diverse funding streams currently supporting treatment of an infant and his family is a great barrier to quality coordinated service. Different funding streams often carry different eligibility criteria, making it difficult, and many times impossible, to provide services to all members of a family or to maintain program continuity. Success in one area of treatment or rehabilitation may lead to lack of program eligibility. In other cases, eligibility is time limited, rather than related to the client's condition. Denying services in one category often leads to the necessity of providing more expensive services in another category of funding.

In addition, a significant barrier to interagency collaboration is that the time needed for effective coordination is not financially supported in most service delivery systems. The initial planning for a family is critical, and the time and money spent early in the process speeds recovery. Agencies need time to set up effective interagency communication networks for family centered decision making.

The Legislature should direct the Department of Finance and Legislative Analyst's Office (in coordination with the Interagency Coordinating Council, the Secretary of Child Development and Education, the Secretary of the Health and Welfare Agency, the Superintendent of Public Instruction, and CDPAC) to evaluate existing funding streams for family services and report to the Legislature their findings and

recommendations for restructuring the existing funding system to provide "seamless" and "braided" family-centered services. Special attention should be given to coordination of eligibility criteria, interagency services, linkage with private and non-profit services, and a preventive approach to managing family social services needs. The funding of early assessment and prevention services, in addition to coordinated follow-up monitoring, should be evaluated to determine whether service enhancements and program cost reductions can be achieved.



A significant barrier to interagency collaboration is that effective coordination is not financially supported.



He was overly sensitive to being uncovered, touched, held, or cuddled.

THE STORY OF SHERRY'S FAMILY

This is the story of one of many families in the State who are receiving services.

The names have been changed to protect the confidentiality of the family.

Tony came to the shelter care nursery at a couple weeks of age. He came directly from the County Hospital as a ward of the Dependency Court because he had a positive tox screen for cocaine and alcohol, and because his mother was considered a high-risk parent with no visible means of support. Tony was born prematurely, underweight and undernourished—a result that cocaine can have on the unborn child. (Like 80 to 90 percent of babies born at county hospitals, his mother received minimal prenatal care.)

Tony had a difficult time during his first few weeks. He was overly sensitive to being uncovered, touched, held, or cuddled. Tony did not respond to our usual ways of comforting babies—stroking, patting, cuddling, rocking—instead he responded with haunting, high-pitched cries and was difficult to soothe. He had irregular, restless sleep patterns, seldom calming down to sound sleep but not coming to alert wakefulness, and he had difficulty sucking, taking an inordinate time to feed. Tony was extremely jittery, startled easily, and arched away instead of cuddling. Most importantly, he did not show the precious few minutes of calm alertness we see even in early infancy that allows the baby to engage with a loving, mothering caregiver. Added to an already shaky start, Tony had a positive screen for syphilis, which was being treated. This contributed to his increased restlessness and poor weight gain. (Tony's mom was one of the 25% of inner city drug using pregnant women with syphilis that was not identified and treated because she received no prenatal care.)

Sherry, Tony's mother, showed up two weeks after he arrived at the shelter care nursery. She had not known where her baby was placed because Child Protective Services did not know where to contact her. Like many mothers whose babies are removed at birth, Sherry was part of the uncounted homeless, staying with friends, acquaintances and/or family until she wore out her welcome. Tony's father was in jail on drug-related charges. Sherry had no means of support.

Sherry was an extremely thin young woman of 26 with a certain flair and style. She had five boys, ranging in age from 2 to 10 years, who had been removed from her custody and placed in foster care. Sherry had grown up in Los Angeles. Her own mother had serious psychiatric problems and Sherry helped raise her siblings until age 15 when she left home with "the love of her life"—a 16 year old who was unwilling to take responsibility when she became pregnant.

A relationship with another man held early promise for security, and resulted in three more children. Then he was killed in a street drug scene. Through Aid to Families With Dependent Children, Sherry kept her family together. She used cocaine socially as "part of the scene". She reported she did not like it at first, but then it clicked. She became what she called a "strawberry"—traded sex for drugs—a clear distinction she made from being a street walker. A neighbor reported her prolonged absences to Child Protective Services because she was tired of caring for the kids when Sherry went on her one to

two-day binges. The children were removed. The four children were split and sent to homes 40 miles apart. Sherry had no transportation. She became increasingly depressed.

She soon became pregnant and reported, "I could feel my baby kicking inside of me, but I couldn't put my pipe down . . . the highs were so high." Her fifth son, Frankie, was born with a seizure disorder and cerebral palsy. He was medically fragile and was immediately placed in a foster home. Though very bonded to her other sons, Sherry reported she never really got to know Frankie, who now calls someone else "Mommy."

But after Tony (her sixth son) was born and removed, something happened! Sherry immediately enrolled in a drug recovery program, and tracked down her new baby. Once she found him, she visited him daily. (Of the 1,000 babies going in and out the doors of the shelter in the last five years, Tony's mother was one of the few who visited every day.) When asked, "Why now?," Sherry responded, "There isn't enough cocaine in the world to keep me happy. It's all or nothing. If I don't stop now, I'll be dead before I'm 30."

Sherry spent three days deciding on just the right name for Tony. Like many of our mothers, she ended up naming her child after a character she knew on television, in this case, from the Hill Street Blues series. The role models offered by television are often the only ones available to our mothers.

Sherry's first four sons were born relatively drug free. When Frankie was removed and placed in foster care 40 miles away, she saw him only sporadically. Sherry was determined to know Tony and make up for all that Frankie did not get. During the first six

months she bought him five pairs of tennis shoes "so he can be proud." (She also bought NIKE'S for all her boys, because she did not like the cheap shoes the foster mothers were sending the kids to school in.)

Sherry moved in with her sister a few miles from the center and enrolled in the center's programs. Project Interact: Baby and Me Program, was designed to support mother-child relationships for drug using mothers, inexperienced in parenting, and to develop opportunities for relationship when a mother loses her baby to the system.

In Project Interact: Baby and Me Program, her stated goal was to give Tony "all the love my mother never showed me". Growing up, Sherry never once heard the words, "I love you" and was never praised for anything she did. Sherry intended to turn a new leaf and become the perfect parent. But because of Tony's prematurity, low birth weight and drug exposure, he showed many of the vulnerabilities we see in at-risk babies. When Sherry tried to cuddle him close to her body, he pushed away. He did not smile readily or look at her intently. When he cried, she would rock him and sing to him saying, "This will work!"

But Tony became increasingly active, cried louder, longer and refused to be comforted. Sherry would dissolve into tears. What worked with her first four children did not work with Tony. She knew he was "falling out" because he was "mad" at her for her drug use. You could almost see what was left of her parental self-esteem melt away.

Through the program, Sherry learned different ways of approaching, handling, and positioning a very, very sensitive baby. She learned how to notice and respond to his more muted smiles, and how to wait for him



Through the program, Sherry learned different ways of approaching, handling, and positioning a very, very sensitive baby.



They were readjusting to reunification and needed to rebuild a relationship of trust.

to look to her rather than moving in too quickly and vigorously. She learned that it's all right for babies to put things in their mouths, be messy, and not want to play when mom wants to. She learned it's all right to feel upset or frustrated when her baby has a "bad day" and still be a "good mother".

After six months of being drug free, Sherry regained custody of three of her boys. The other three remained in foster care because she could only afford a one-bedroom apartment and needed a larger dwelling before her other children would be returned.

Tony's father was released from jail. He offered some financial support, but he was still using, which added a stress to Sherry's life. One day she came to the parent group with a swollen wrist. The night before, one of her young children was sick and crying all night. She craved respite from his crying and craved cocaine, but could not call anyone because all of her friends would help by offering her some crack. Instead she put her hand through the wall. She wore her bandage as a "badge of courage" and proudly announced she had made it through the night.

Through it all, Sherry never missed coming to the program. Tony was still living at the center. Transportation was provided by an available van or bus passes. She brought her three boys with her in the summer. Child care was provided. The boys had been in several placements. They were readjusting to reunification and needed to rebuild a relationship of trust. Sherry had her hands full and was often very stressed, but she really took everything she learned and tried to apply it at home. After mealtime rituals were discussed as being central to quality child development, she created her own family ritual which consisted of a cloth on the floor with everyone having a designated place. She

even composed a grace before meals. They had never eaten together because there were never enough chairs. Her pride in her parenting was evident.

After a year, Sherry had custody of five of her six children. Sherry struggles from day to day. The children continue to have problems adjusting at home and at school. Sherry has her good days and bad days, but she is drug free.

Demonstration project funds that helped offer support, school advocacy, child care, and transportation are no longer available. Her children desperately need counseling, but Medi-Cal does not adequately cover mental health services. Sherry's success is holding on by a thread. All of her children remain at-risk. The question is, will the intergenerational cycle of substance abuse and hurting families be broken at last for Sherry and her children?

APPENDIX A

CHILD DEVELOPMENT PROGRAMS ADVISORY COMMITTEE



The Child Development Programs Advisory Committee is a citizen's review board comprised of appointed members — parents, public members, family day care and child care center operators — and representatives of state departments. The Committee meets monthly and operates through two forums:

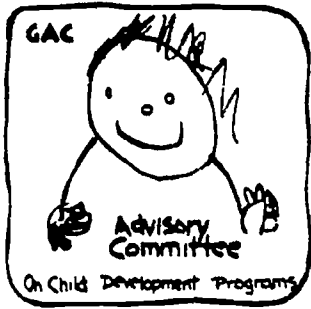
- Meetings of the Whole, which are open to the public;
- Subcommittee Meetings, which are open to participation by anyone interested. Currently, there are four subcommittees: Regulations, Public Resources, Special Needs, and Child Protection.

The Child Development Programs Advisory Committee is California's chief forum for issues of concern to young children. The Committee's twenty-two Governor's appointees represent all major facets of the child care and child development community. Its five ex-officio members represent the key state agencies providing services, programs, and protection to children. The Committee's outreach efforts have attracted an impressive and growing list of Liaison participants. These Liaisons represent major state and local organizations serving children as well as the major professional and educational associations in the fields of child care and child development.

Mandated by state statute, the Committee advises and supports a comprehensive services system for the children of California in child care and development. The Committee provides public policy recommendations to the Governor, Legislature, Superintendent of Public Instruction, the Secretary for Child Development and other relevant state agencies. Through its regular meetings, task forces, public forums, and subcommittee meetings, the Committee has explored issues facing California's children and the adults who provide them with care and learning. Its four subcommittees are Special Needs, Child Protection, Regulations and Resources.

Committee's Legislative Mandates

- *Provide public policy recommendations to the Governor, the Legislature, the Secretary of Child Development and Education and the Superintendent of Public Instruction concerning child care and development.*
- *Advise and assist the State Department of Education in developing a State Plan for child care and development programs.*
- *Coordinate the development of local planning council guidelines.*



- *Maintain expertise on employer supported child care and provide information on employer child care tax credits.*
- *Advise the Department of Social Services on the Ombudsman Program for Community Care Licensing.*

Created in 1965, the Committee has been the one continuing point of contact between the child care and development communities and state policy makers. The widely distributed minutes of Committee meetings provide those who work in child care in all parts of the state with a window on state activities. The Committee's reports, issue and briefing papers are used and respected by decision makers and policy analysts in both state and local government.

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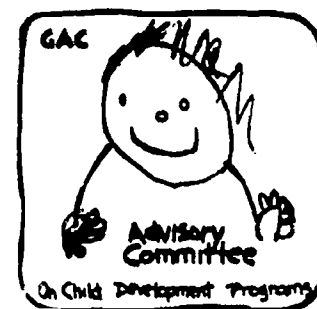
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PERINATAL SUBSTANCE ABUSE: WHAT'S BEST FOR THE CHILDREN?

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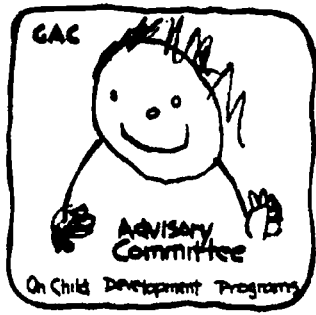
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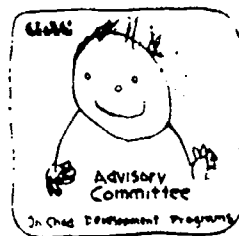
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