

CHILD WELFARE SOCIAL WORKERS & CHILDREN WITH PRENATAL SUBSTANCE EXPOSURE: Current Needs & Potential Solutions



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prevalence of FASDs among children and youth in child welfare to be 17 percent (Lange, Shield, Rehm, & Popova, 2013), a figure well above that for the general population. There are also reasons to believe that FASDs are under-identified in child welfare. A 2015 study explored this idea among a population of foster and adopted youth who were referred to a children's mental health center. More than 85 percent of youth with FASDs had never been diagnosed or had been misdiagnosed (Chasnoff, Wells, & King, 2015).

Children with prenatal alcohol exposure tend to be more difficult to parent due to a range of challenges, such as difficulty controlling emotions, problems communicating and socializing, and impulsivity (Hagan et al., 2016), which can be frustrating to parents and can place these children at an increased risk of neglect or abuse. This risk increases with parental substance use and/or poor parenting skills.

In school, these children often have difficulty with peer relationships (Pomeroy et al., 2016), which can lead to bullying. Teachers not being able

to identify FASD might ignore such children and their specific needs. Also, a child may be suspended by a school mistakenly for bad behavior because the school lacks FASD awareness (Pomeroy et al., 2016).

Often children with FASDs are misdiagnosed because their behavior resembles that of other conditions, such as attention deficit/hyperactivity disorder (ADHD; Chasnoff, Wells, & King, 2015). This puts these children at an increased risk of being prescribed inappropriate and unnecessary medications. FASD impairments are rooted in brain damage; although some medications prescribed for other neurobehavioral disorders might help children with FASD behavioral issues, many do not (Frankel, Paley, Marquardt, & O'Connor, 2006). This is a significant issue for children in child welfare, where misdiagnosis is a particular concern (Chasnoff et al., 2015).

The inadequate response to children with FASDs is largely an invisible problem in which children are either untreated or mistreated. Of course, many children are prenatally exposed to both alcohol and other drugs, which can complicate

It is estimated that prenatal exposure to illicit drugs and alcohol (prenatal substance exposure, or PSE) affects

400,000 newborns annually in the United States (Young et al., 2009). Most of the concern regarding maternal substance use focuses on drugs such as methamphetamine, crack cocaine, and, recently, opioids. Although alcohol is the "primary cause of intellectual and developmental disorders worldwide" with lifelong consequences (Pomeroy, Parrish, Nonaka, & Anderson, 2016), it has mostly been excluded from the discussion on substances that can harm the developing fetus. This article presents information on the effects, legislation, and current efforts on prenatal alcohol exposure and the child welfare system. There is a special focus

on the current needs and potential solutions for child welfare social workers, children, and their families.

FETAL ALCOHOL SPECTRUM DISORDERS

Fetal alcohol spectrum disorders (FASDs)—the general term for the range of adverse effects associated with prenatal alcohol exposure—include a range of diagnoses, with associated mental, behavioral, developmental, adaptive, and, in some instances, physical signs that vary from mild to severe (Hagan et al., 2016; Williams & Smith, 2015). Community-based studies of the general population estimate that 2–5 percent of children may have an FASD (May et al., 2009). That percentage is even higher among child welfare populations: One international meta-analysis found the pooled

and confuse the identification of disorders, diagnosis, and treatment.

PRENATAL SUBSTANCE EXPOSURE LEGISLATION

The system for identifying children with PSE and responding to their needs is fragmented (Young et al., 2009). The federal Child Abuse Prevention and Treatment Act (CAPTA) requires states to implement policies and procedures to address the needs of newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure (Young et al., 2009). Despite these requirements there is wide variation among states in terms of PSE policies and practices.

In 2016, the Comprehensive Addiction and Recovery Act (CARA) refined CAPTA, and the term *illegal* was removed. The updated legislation requires the secretary of health and human services to provide information to states about best practices related to safe care plans for infants born and identified as affected by substance abuse, withdrawal symptoms, or an FASD. CARA also requires states to develop policies and procedures to address the needs of infants affected by PSE. CARA further requires states to report the number of infants with PSE in the National Child Abuse and Neglect Data System. States are still determining how to best implement CARA, but the data system could be used to better understand the prevalence of PSE among children in child welfare and to identify children who need referral to appropriate care and services.

NASW standards maintain that care by well-prepared, knowledgeable social work professionals is associated with better outcomes for children and families in child welfare (NASW, 2013). Therefore, understanding the impact of alcohol and other drugs could help child welfare social workers to translate child welfare policy into practices that are responsive to the needs of children and families.

CURRENT EFFORTS

The Centers for Disease Control and Prevention (CDC) and the Administration for Children and Families (ACF) are working together to improve the identification and care of children with PSE in child welfare. CDC and ACF conducted an exploratory study within an urban child welfare agency to assess staff knowledge, attitudes, policies, and practices regarding PSE. A qualitative methodological approach was designed to best address the broad, exploratory nature of this project. Semi-structured interviews were conducted with several respondent groups (nine administrators, seven clinical/investigative caseworkers, eight permanency social workers, seven trainers, three data staff members, three medical professionals, and seven caregivers). Each interview followed the same overall pattern and included questions on educational background training received, level of understanding, professional development, and training needs regarding PSE; acceptability of substance use among pregnant women; and position-specific questions about agency policies, perceptions of the prevalence of PSE, data collection procedures,

and provision of services. This initial study revealed a lack of formal agency policies and a need for additional clinical training.

AGENCY PROCEDURES AND POLICIES

- Many participants reported that there was no established policy for how social workers are supposed to identify PSE.
- Although permanency social workers have a required list of questions (including items about the mother's pregnancy and complications at birth), targeted questions about PSE were not included.
- There were no formal processes for sharing records between medical professionals and child welfare staff.
- Several staff stressed the importance of capturing all information and services throughout case management. However, responses revealed the lack of a system to record data and inconsistency in capturing this information across cases.
- A few participants also said they were not aware of any policy regarding documenting PSE.

CLINICAL TRAINING

Children in child welfare can benefit if staff have knowledge on PSE, particularly on FASDs. Proper identification of FASDs can help parents, educators, social workers, and others understand how to best care for, treat, and support children and families (Williams & Smith, 2015). Nevertheless, the exploratory study found the following:

- The majority of staff said they received no training or workshops (offered by the agency or other professional organizations) focused on

PSE. Several staff commented that "it wasn't something on my radar."

- Most of the study participants said they gained their knowledge of PSE through "on-the-job" learning and case examples, which can lead to approaches that are not based on current research or best practices.
- Social workers struggled to distinguish PSE from other possible diagnoses, such as ADHD. An administrator noted that social workers who lack awareness about PSE are likely to suspect ADHD or other conditions because the behavioral indicators and symptoms are similar, but knowledge of PSE is important for determining best treatment.
- Every staff member interviewed stressed the need for training and education on PSE.

CDC and ACF are currently expanding this work through a large-scale, multisite project to capture the full scope of policies, practices, and needs of children with PSE in child welfare.

CHALLENGES AND OPPORTUNITIES

Establishing agency-level guidance for obtaining and documenting information on PSE may be beneficial because parental alcohol and drug abuse is often a major factor in bringing children to the attention of child welfare authorities (Osterling & Austin, 2008). For example, widespread concurrent alcohol and drug use (Singer & Minnes, 2011) implies that any child found to be prenatally exposed to other drugs is at serious risk for prenatal alcohol exposure, even if alcohol is not detected in the infant at the time of birth. Considering prenatal

alcohol exposure in addition to prenatal drug exposure is important because (1) alcohol is metabolized very quickly by the mother and unlikely to be detected through a newborn toxicology screen, and (2) alcohol is “the substance most commonly found in postnatal maternal drug tests” (Hackler, 2011).

PSE educational requirements for social workers could be useful to ensure knowledge of current understanding and best practices regarding children with PSE and their families. Considering the limited to nonexistent formal training of staff that was found in the exploratory study, and taking into account the CARA legislation, child welfare agencies could consider offering PSE training with a special focus on alcohol. This could help equip agencies to better meet the medical, educational, and psychosocial needs of this vulnerable population. Generally, well-informed approaches on PSE could help guide social workers to provide services that lead to positive outcomes for children and families.

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