Children with Prenatal Drug and/or Alcohol Exposure

Contents

- Background
- Health Conditions of Drug-exposed Infants
- Developmental Outcomes
- Developmental Patterns in Children
- Exposed Prenatally to Drugs
- Techniques in Working with Drug-exposed Infants
- Behavior Descriptions and Suggested Strategies
- Parent Involvement
- Summary
- Resources
- References

This factsheet is available as a printed document in Adobe PDF Format

Background

The drug epidemic that swept this country during the 1980’s has had a devastating effect on families, and particularly on the children who have been the silent victims of prenatal exposure to drugs. The number of children born each year exposed to drugs and/or alcohol is estimated to be between 550,000 and 750,000. In addition to the biological risk that prenatal alcohol or drug exposure poses to these children, they are at an increased risk of child abuse and neglect by parents whose need for drugs takes priority over the care of their infants and children. As a result of these factors, there has been a sharp increase in the number of drug exposed children in out-of-home placements, including respite and crisis care programs.

Health Conditions of Drug-exposed Infants

Birth weight
Birth weight is an important factor associated with children’s overall health and development. Children who weigh under five-and-one-half pounds at birth are more likely to have serious medical problems and to exhibit developmental delays. Drug-exposed infants often do not exhibit normal development.

Prematurity
The risk of prematurity (birth at less than thirty-seven weeks) is higher in drug-exposed infants. Other complications can include an increase in acute medical problems following birth, and extended periods of hospitalization. Birth weight under three pounds has been associated with poor physical growth and poor general health status at school age. Low Birth weight infants also have an increased risk of neurosensory deficits, behavioral and attention deficits, psychiatric problems, and poor school performance. Premature infants may have experienced bleeding of the brain tissue, hydrocephalus, bronchial problems, eye disease, and interferences with the normal ability to feed.

Small for Gestational Age (SGA)
This term is used to describe infants whose Birth weight is below the third percentile for their gestational age (i.e., 97% of infants the same age are heavier than the SGA infant). It is common for women who abuse cocaine to experience decreased appetite and provide inadequate nutrition for themselves and their baby.

Failure to Thrive (FTT)
Infants who were exposed to alcohol and/or drugs may exhibit this disorder, which is characterized by a loss of weight, or slowing of weight gain, and a failure to reach developmental milestones. This can be due to medical and/or environmental factors. The infant’s behavior includes poor sucking, difficulty in swallowing, and distractibility. Many of these children live in chronically dysfunctional families which places them at greater risk of parental neglect.
Neurobehavioral symptoms
Within seventy-two hours after birth, many infants who were exposed prenatally to drugs experience withdrawal symptoms, including tremors and irritability. Their skin may be red and dry; they may have a fever, sweating, diarrhea, excessive vomiting, and even seizures. Such infants may require medication for calming. Other infants exposed to stimulants show a pattern of lethargy during the first few days after birth, are easily overstimulated, and may go from sleep to loud crying within seconds. These behaviors usually decrease over time and subside in toddlerhood.

Infectious diseases
Infants with prenatal drug exposure may be exposed prenatally or postnatally to infectious and/or sexually transmitted diseases contracted by their mothers. The most common infectious diseases seen in infants are chlamydia, syphilis, gonorrhea, hepatitis B, HIV, and AIDS.

Sudden Infant Death Syndrome (SIDS)
Children who have been exposed prenatally to alcohol and/or drugs have an increased risk of dying from sudden infant death syndrome. The causes of SIDS are unknown and its occurrence is almost impossible to predict. Apnea/cardiac monitoring is recommended for these infants.

Fetal Alcohol Syndrome
Mothers who consume large quantities of alcohol during pregnancy may have babies who are born with Fetal Alcohol Syndrome (or FAS). A diagnosis of FAS is based on three factors: 1) prenatal and postnatal growth retardation; 2) central nervous system abnormalities, and, 3) abnormalities of the face. Many of these children display significant disabilities, learning disorders, and emotional problems as they mature.

Each of the above conditions associated with prematurity or drug exposure has programmatic implications for caregivers; the children who exhibit these conditions are often referred to as “medically fragile”.

Developmental Outcomes
There are many unknowns involved in trying to predict the outcomes of infants and children exposed to drugs. While we know that there are certain physical problems that may remain with the child, in a structured and nurturing environment, many of these children are able to grow and develop quite normally. A small percentage of children have been found to have moderate to severe developmental problems.

But regardless of their health status, all children who have a history of prenatal substance exposure should receive developmental evaluations on a regular basis: at least once during the first six months; at twelve months; and at least every year thereafter until school age. Early identification of social, language, cognitive, and motor development problems is essential.

Developmental Patterns in Children Exposed Prenatally to Drugs

Birth to fifteen months
- Unpredictable sleeping patterns
- Feeding difficulties
- Irritability
- Atypical social interactions
- Delayed language development
- Poor fine motor development

Toddlers from sixteen months to thirty-six months
- Atypical social interactions
- Minimal play strategies

Preschool children from age three to five
While average preschoolers are beginning to share and take turns, demonstrate language skills, and increase their attention spans in a group setting, the drug-exposed toddler may be hyperactive, have a short attention span, lose control easily, have mood swings and problems moving from one activity to another. These children may also experience difficulties processing auditory or visual information/instructions.

School and teenage years
There has not been sufficient research into the long-term biological effects of drug exposure on older children and teenagers, however, we do know that children with the behaviors described above are at greater risk of abuse and neglect, learning disabilities, and behavioral problems. Obviously, it becomes imperative to identify these problems at a very early age, access the necessary resources for the child, and build a team of professionals who regularly monitor the progress of each child.

Supporting a drug-exposed child in the course of his life may require advocating vigorously for specialized educational services; providing recreational and employment opportunities that allow a measure of success; educating parents; and providing counseling.

**Techniques in Working with Drug-exposed Infants and Young Children**

Respite and crisis care programs working with drug-exposed infants and children may not know the exact drugs to which each child was exposed. A combination of substances, including alcohol and tobacco, may be involved. There are a few techniques, however, which can be used in a general plan of care that may be individualized to meet the specific problems of each child:

1. Provide a calm environment: low lighting; soft voices; slow transition from one activity to another.
2. Be aware of signs of escalated behavior and frantic distress states before they occur, e.g., increased yawns, hiccoughs, sneezes, increased muscle tone and flailing, irritability, disorganized sucking, and crying.
3. Use calming and special care techniques on a regular basis, such as
   - swaddling blankets tightly around the infant
   - using a pacifier even when the infant is not organized enough to maintain a regular suck
   - rocking, holding, or placing the infant in a swing, or Snuggly™ carrier
   - massaging the child
   - bathing in a warm bath, followed by a soothing application of lotion
   - rubbing ointment on diaper area to prevent skin breakdown
4. Encourage developmental abilities when the infant is calm and receptive using only one stimulus at a time. Look for signs of infant distress and discontinue the activity if this occurs.
5. Gradually increase the amount and time of daily developmental activities; encourage the child to develop self-calming behaviors and self control of his own body movements.

**Behavior Descriptions and Suggested Strategies**

**Feeding problems**
Feed the baby more often; feed smaller amounts at one time; allow the infant to rest frequently during feeding. Place the infant upright for feeding; after feeding, place the child on his side or stomach to prevent choking; if vomiting occurs, clean the skin immediately to prevent irritation.

**Irritability/unresponsive to caregiver**
Reduce noise in the environment; turn down lights; swaddle the infant: wrap snugly in a blanket with arms bound close to the body. Hold the infant closely; put the infant in a bunting-type wrapper and carry it close to your body. Rock the infant slowly and rhythmically, either horizontally or with its head supported vertically, whichever soothes. Place the child in a front-pack carrier; walk with the infant; offer the infant a pacifier or place it in an infant swing.

**Goes from one adult to another, showing no preference for a particular adult**
Respond to specific needs of child with predictability and regularity.

**May have poor inner controls/frequent temper tantrums**
Use books, pictures, doll play, and conversation to help the child explore and express a range of feelings.

**Ignores verbal/gestural limit setting**
Talk the child through to the consequence of the action.

**Shows decreased compliance with simple, routine commands**
Provide the child with explicitly consistent limits of behavior.

**Exhibits tremors when stacking or reaching**
Observe the child and note the onset of tremors, their duration, and how the child compensates for them;
provide a variety of materials to enhance development and refinement of small motor skills, e.g., blocks, stacking toys, large Leggos™, and puzzles with large pieces. Sand and water play are soothing and appropriate.

Unable to end or let go of preferred object or activity
Provide attention and time to children who are behaving appropriately; provide child with an opportunity to take turns with peers and adults.

Delayed receptive and expressive language
Create a stable environment where the child feels safe to express feelings, wants, and needs; use stories/records/songs; use hands-on activities to reinforce the child’s language abilities.

Expresses wants, needs, and fears by having frequent temper tantrums
Remove and help calm the child; redirect the child’s attention; verbalize the expected behavior; reflect the child’s feelings. Praise attempts toward adaptive behavior. Set consistent limits.

Difficulty with gross motor skills (e.g. swinging, climbing, throwing, catching, jumping, running, and balancing)
Provide appropriate motor activities through play, songs, and equipment. Offer guidance, modeling, and verbal cues as needed.

Over-reacts to separation of primary caregiver
Offer verbal reassurance; be consistent, and help the child learn to trust adults.

Withdraws and seems to daydream or not be there
Provide opportunities for contact; move close to the child, make eye contact, use verbal reassurance; allow, identify, and react to the child’s expressions of emotions.

Frequent temper tantrums
Understand that a tantrum is usually a healthy release of rage and frustration; protect the child from harm; remove objects from the child’s path if he is rolling on floor. Some children do not want to be held during a tantrum and doing so can cause more frustration. Remain calm, using a soothing voice; anger will only escalate the child’s frustration. Do not shout or threaten to spank the child–the adult needs to be in control. Help the child to use words to describe emotions. Read stories about feelings. Help the child gain control by making eye contact, sitting next to the child, giving verbal reassurance, and offering physical comfort (rubbing back, etc.). Note the circumstances that provoked the tantrum, and try to avoid such confrontations when possible. Provide a neutral area for the child to work through the tantrum, (e.g., a large cushion or bean bag chair). Some children want to work through a tantrum alone; keep the child in sight, but do not interact until he is calm.

Parent Involvement

It is critical to the success of the drug-exposed infant that the eventual caregiver (parent, relative, foster parent, respite provider, adoptive parent) learn the care routine, control techniques, and background of the children for whom they will be providing care. Understanding the etiology of drug-exposure, the types of medical problems that arise, the developmental patterns, and the techniques for handling drug-exposed infants and toddlers is imperative.

Program social workers, case managers, child care staff, and nursing staff must all work together with the caregiver to offer parent education ("hands-on" opportunities to provide care under the guidance of professionals), and encouragement for families who undertake the care of a drug-exposed infant. The caregiver’s understanding of the child’s behavior, physical "cues," and developmental problems, goes a long way in helping the drug-exposed infant, toddler, and teen succeed. It also assists the caregiver in setting realistic expectations for children who enter the world battling the the effects of their parent’s addiction.

Many children who were prenatally exposed to drugs will grow and develop without unusual problems. However, for those infants who have physical indicators, the respite and crisis care provider can make a difference by providing, perhaps, the first stable, nurturing environment. Here, the child can be observed, positive routines for care can be established, and parents can receive the critically necessary education and support to enable them to care for an alcohol or drug-exposed child.

Summary

Staff training, caregiver training, and parent education are all critical elements of any program that will be successful with these children. Physical elements of the environment (lighting, noise, and space) may need to be adjusted to accommodate their care. The inclusion of medical support, i.e., nurses and physicians who are familiar with the problems of these children, is essential. In summary, the care of alcohol and drug-exposed children is a team effort that requires coordination, case management, special care techniques, and education to be successful in any respite or crisis care situation. With these components in place, agencies and families can witness the positive growth and development of children who have been greatly at risk.

About the Author: Jeanne Landdeck-Sisco, MSW, is the Executive Director of Casa de los Niños in Tucson, Arizona, which was the first crisis nursery in the U.S., established in 1973. Ms. Landdeck-Sisco served as the first President of the ARCH National Advisory Committee for Respite and Crisis Care Programs from 1991-93 and remained on the committee until 1996.

Resources

Center for Substance Abuse Prevention National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs, 9302 Lee Highway, Fairfax, VA 22031, (800) 354-8824.


References


Special acknowledgment is given to Rosemarie Dyer, R.N., Nursing Supervisor at Casa de los Niños, who has developed the agency’s program for drug- and alcohol-exposed infants and from whose training material many of the techniques and caregiver responses have been drawn; and to Anna Binkiewicz, M.D., Casa de los Niños Board Member and Medical Director, who has provided on-site medical treatment of Casa’s medically fragile children.

ARCH Factsheet Number 49, April, 1997

This factsheet was produced by the ARCH National Resource Center for Respite and Crisis Care Services funded by the U.S. Department of Health and Human Services, Administration on Children and Families, Administration on Children, Youth and Families, Children's Bureau—Cooperative Agreement No. 90-CN-0178 under contract with the North Carolina Department of Human Resources, Division of Mental Health/Developmental Disabilities/Substance Abuse Services, Child and Family Services Branch, Raleigh, North Carolina. The contents of this publication do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers are encouraged to copy and share it, but please credit the ARCH National Resource Center.