

## NON-RETURN INFORMATION PACKET



*Assisting families on their lifelong journey*

# *Parenting Children Who Have Been Exposed to Methamphetamine*

**A Brief Guide for  
Adoptive, Guardianship, and Foster Parents**

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A BRIEF GUIDE FOR ADOPTIVE, GUARDIANSHIP AND FOSTER PARENTS**

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**Introduction**

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This Information Packet begins with a brief overview of current knowledge regarding the abuse of methamphetamine— what it is, how it effects the user, and how addiction is treated.

Part Two contains information about the known and suspected effects on the children of methamphetamine users. It includes both prenatal exposure effects and environmental exposure effects.

Part Three offers suggestions for adoptive, guardianship, and foster parents who care for the children from meth abusing homes.

Part Four contains reprints of several articles on the topic, written specifically for foster and adoptive parents.

Appendix A is a list of recommended resources for more information.

The scientific community is continually discovering more about the effects of this illicit drug on the children of its users, with new interventions continually explored and recommended. Although the ORPARC staff will attempt to update this packet from time to time, it does not fall within the scope of this program to be a continuing source of the latest medical and scientific information. Readers are encouraged to visit the websites on the Resource List. Many of these, such as the NIH and SAMSHA, will post new findings as soon as they are available.

*In terms of damage to children and to our society, meth is now the most dangerous drug in America.*

U.S. Attorney General Alberto Gonzales

## **Part I: Methamphetamine: An Overview**

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### **What is meth?**

Methamphetamine, or “meth,” is a strong, highly addictive central nervous system stimulant. It differs from other illicit stimulants such as cocaine or heroine in that it is synthetically processed, using toxic and flammable chemicals. Meth can be injected, snorted, smoked, or swallowed.

The highly addictive nature of meth is attributed to its powerful and immediate release of “dopamine” into the brain of the user. Dopamine is a chemical that creates feelings of well being. You may be familiar with the effects of dopamine if you have experienced the strong emotional satisfaction that follows a vigorous physical workout.

The dopamine released into the brain after physical exertion is just a tiny fraction of the amount released in response to meth. The exorbitant amount and the almost immediate release of dopamine in response to meth creates extreme feelings of omnipotence and euphoria. In its August 2005 expose, Newsweek stated that meth seduces its users “with a euphoric rush of confidence, hyperalertness, and sexiness that lasts for hours on end.” Meth is stronger and cheaper than cocaine. Researchers tell us that the amount of dopamine released by meth use is *three times* that released through cocaine use, and *four times* that released through morphine use.

### **What are its effects on the user?**

Meth creates a short but intense “rush” when it first enters the body. Users experience increased activity, decreased appetite, and strong feelings of well being, energy, and power, lasting from 20 minutes to 12 hours. As the effects wear off, the drug leaves the user feeling “drained, helpless, and deeply depressed,”<sup>1</sup> and craving the drug again.

Meth brings to its users serious physical, psychological, and cognitive effects.

#### **Short term physical effects:**

Strong and quick addition	Insomnia
Increased pulse, blood pressure, respiration	Decreased reaction time

#### **Large doses can cause:**

Convulsions	Stroke
Overheating	Heart Attack
Death	

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<sup>1</sup> America’s Most Dangerous Drug. *Newsweek*. Aug 8, ’05. p.46.

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**Long term physical effects:**

Weakness, tremors, seizures	Dental decay
Weight loss; anorexia	Coughing, dry mouth
Rapid facial aging	Brain damage
Kidney damage	Liver damage
Heart damage	Skin sores and infection
Increased risk of stroke	Increased risk of HIV and hepatitis

**Cognitive Effects Include Decreased Ability to:**

Recognize and recall words and pictures	Make inferences
Manipulate information	Learn from experience
Ignore irrelevant information	

**Short term psychological effects:**

Increased confidence	Increased alertness
Increased good mood	Increased sex drive
Increased talkativeness	Decreased boredom, loneliness

The brain damage caused by chronic meth use can also lead to:

**Long term psychological effects:**

Insomnia	Aggression
Anxiety	Confusion
Mood disorders	Psychotic behavior: which may include hallucinations, delusions, paranoia, homicidal or suicidal thoughts

**A few observations on these effects:**

The appeal of meth might be understandable in light of its short term psychological effects. Persons who are socially isolated, or who suffer from shyness or low self esteem, may be particularly vulnerable as they perceive increased confidence as a result of meth use. But meth is an equal opportunity drug. Its users include those on all rungs of the socioeconomic ladder and all races and backgrounds.

The damage to the brain by chronic meth use is detectable even months after usage. Scientists have found the brain damage caused by meth to be similar to the damage caused by Alzheimer's disease, stroke, and epilepsy. Brain scans performed on users after ten years of meth use show destruction in the Limbic brain system, which regulates emotion, and in the Hippocampus, which aids memory. Experts believe the limbic system damage leads to long term depression and anxiety, while the hippocampus damage leads to symptoms similar to early Alzheimer's disease.

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### Some Societal Effects:

- Increase in (violent) criminal activity
- Increase in domestic violence
- Increase in child abuse and neglect
- Increase in identity theft
- Endangerment due to chemical exposure
- Burns, maiming or death from volatile toxic chemicals, fires, lab explosions
- Pollution of air and ground due to toxic chemicals and vapors

### Withdrawal symptoms include:

Depression

Anxiety

Fatigue

Paranoia

Aggression

Intense cravings

### How prevalent is meth use?

A 2005 White House Drug Policy paper calls methamphetamine “the most prevalent synthetic drug manufactured in the United States,” and attributes both its highly addictive nature and the ease in which it can be manufactured to its increased usage nationwide.<sup>2</sup>

Two recent national surveys on methamphetamine usage report these findings:

### 2004 National Survey on Drug Use and Health<sup>3</sup>

	<b>Lifetime</b> (used at least once)	<b>Annual</b> (used in past year)	<b>Monthly</b> (used in past 30 Days)
US residents ages 12+	4.9%	0.6%	0.2%

### High School Students Reporting Methamphetamine Use, 2004<sup>4</sup>

<b>Grade</b>	<b>Lifetime</b> (used at least once)	<b>Annual</b> (used in past year)	<b>Monthly</b> (used in past 30 Days)
<b>8<sup>th</sup></b>	2.5%	1.5%	0.6%
<b>10<sup>th</sup></b>	5.3%	3.0%	1.3%
<b>12<sup>th</sup></b>	6.2%	3.4 %	1.4%

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<sup>2</sup> *Methamphetamines*. Drug Facts 2005. Office of National Drug Control Policy. p.1.

<sup>3</sup> *Results from the 2004 National Survey of Drug Use and Health: National Findings*. Substance Abuse and Mental Health Services Administration., Sept 2005.

<sup>4</sup> *Monitoring the Future 2004 Data From In-School Surveys of 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> Grade Students*. National Institute on Drug Abuse and University of Michigan. Dec 2004.

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Note the disconcerting frequency of use among 10th and 12th graders compared to the usage for all persons over age 12. However, meth use among high schoolers has decreased over the past two years.

The rate of usage among high schoolers in 2004 was slightly lower than a similar 2003 survey, in which the percentage of students who used meth at least once was 7.6% for all high school grades combined. That survey also yielded demographic information about who uses meth:

- Male students (8.3%) were more likely than female students (6.8%) to report lifetime methamphetamine use.
- Hispanic (8.3%) and white (8.1%) students were more likely than black (3.1%) students to use methamphetamine within their lifetime.<sup>5</sup>

A 2003 survey of meth use among college students and non-college young adults yielded these statistics:

<b>Ages/grades</b>	<b>Lifetime (used at least once)</b>	<b>Annual (used in past year)</b>	<b>Monthly (used in past 30 Days)</b>
<b>College students</b>	5.8%	2.6%	0.6%
<b>Young adults (19-28)</b>	8.9%	2.7%	0.7%

Meth use started in rural areas and on the West Coast, but it has spread across the states; it has reached epidemic proportions in most large urban areas and it is seeping steadily into the suburbs. Nationwide, law enforcement officers rank meth as the top drug they battle. Meth usage seems to know no demographic boundaries.

A tablet form of meth is gaining popularity as a “club drug,” perhaps replacing the drug “ecstasy” in popularity with young adults on the “rave scene.”

Woman of varied ages have succumbed to meth’s lure of assured weight loss. Young women in particular may also turn to meth to handle depression.

Suburban housewives as well as professionals, businesspersons and executives of both sexes have been arrested for meth possession or production.

Many American communities have suffered the embarrassment of the arrest of prominent citizens for meth use.

Gay community leaders are urging homosexual men to practice “safe sex” in light of the clear link between meth use and the increase in AIDS.

Men (both gay and straight) and women use meth to increase their sexual abilities. (But meth can actually cause impotence.)

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<sup>5</sup> *Youth Risk Behavior Surveillance – United States, 2003*. Centers for Disease Control and Prevention. May 2004.

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## **How is meth addiction treated?**

Meth addiction is so very difficult to overcome because the drug causes the brain to lose its ability to process dopamine, leaving the user less and less able to feel any enjoyment when not using the drug. Furthermore, withdrawal from the drug creates “a depression so crushing that the alternative - more meth - seems preferable.”<sup>6</sup> Time and patience are needed before the user sees a reversal of meth’s effects. The recovery rates are associated with the severity and length of usage. Studies have shown improved cognitive abilities after three months of abstinence, full recovery of attention, memory, learning, and executive function, and motor function after four years. One study showed highly successful recovery rates for users able to remain drug free for nine months.

Research is underway to develop medications for treating methamphetamine addiction and to find antidotes to treat overdose. Readers might want to refer to the National Institute on Drug Abuse website for the current status on such research ([www.drugabuse.gov](http://www.drugabuse.gov), select “Methamphetamine”).

Cognitive/Behavioral therapy is the current treatment for meth addiction recovery. The goal is to help patients to modify their thinking and behavioral patterns, and to learn new and more effective skills for coping with life stresses. Antidepressants may be prescribed to help the patient cope with the depressive states that accompany withdrawal.

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<sup>6</sup> *Your Brain on Meth.* [www.sciencecentral.com](http://www.sciencecentral.com). p. 2

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## Part II: Meth's Effects on Children

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The National Center on Substance Abuse and Child Welfare warns:

*Although meth is not the most heavily used drug in the U.S., it is drawing the most attention, ... its risks to children pose new challenges not raised by other drugs.”<sup>7</sup>*

### What are the prenatal effects of exposure?

Both born and unborn children are in danger due to the increase in meth use among women of child bearing ages. Whereas the male to female ratio of persons who enter treatment for alcohol and other drugs is 2:1 (2 men for every woman) the rates for meth treatment are closer to 1:1. (In 2003, 47% of drug admission treatments for meth users were women.) Treatment admission data also shows an increase in meth usage among young women. (In 2003, 70% of the 12 to 14-year-old female drug treatment admissions and 58% of the 15 to 17-year-old female admissions were related to meth usage.)

A child in the womb of a drug or alcohol abusing mother is exposed to the harmful substances that cross the placenta. Some of the known risks of meth to the fetus are:

- Birth defects
- Growth retardation
- Premature birth
- Low birth rate
- Brain lesions

But there are many unknowns, and exact effects of prenatal exposure are difficult to predict. Variations can depend upon the mother's frequency and intensity of usage, her nutrition and overall health, her prenatal care, and whether she also uses alcohol or other harmful substances.

In addition to the exposure to the harmful substances of meth, the fetus of the meth user is often subjected to irregular nutrition and inadequate prenatal maternal health. Users, even pregnant ones, often go on meth “binges” without eating or sleeping for several days.

What happens to a baby after birth has great impact on the child's development. The home environment is critical in the child's outcome, as consequences of exposure during pregnancy can be mediated through many available interventions.”<sup>8</sup>

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<sup>7</sup> [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov) (National Center on Substance Abuse and Child Welfare)

<sup>8</sup> Amatetti, Sharon. Administration for Children and Families, Children's Bureau. Keynote speech, national conference, Washington DC. Fall 2005.

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### **What are the postnatal effects of prenatal exposure?**

Newborns exposed prenatally to meth may exhibit any or all of these problems:

- Difficulty sucking or swallowing
- Hypersensitivity to touch
- Extreme muscle tension
- Respiratory problems

These young children are at risk for such future problems as:

- Failure to thrive
- Growth retardation
- Developmental delays or disorders
- Neurological abnormalities
- Cognitive impairments
- Learning disabilities

In addition, babies may experience addiction withdrawal symptoms which can continue for months. Symptoms vary depending upon what other drugs have been used. (It is likely that meth exposed babies have been exposed to alcohol or other drugs also.)

Withdrawal symptoms may include:

- Difficulty with transitions or changes in the environment
- Discomfort with body sensations, (bowel movements, being undressed, being bathed)

Their extreme sensitivity, neurological impairment, and difficulty being comforted render these babies difficult to care for.

### **What are the environmental effects?**

*The drug has seduced whole families and turned them into ‘zombies.’  
a police officer<sup>9</sup>*

Whether or not they have been prenatally exposed to harmful substances, children who live in substance abusing homes are subjected to physical and emotional dangers. The lack of appropriate stimulation in early life denies their brain and neurology the chance to develop as they should, leaving them with academic difficulties and delays. The lack of consistent interaction and care in their early years impacts their ability to trust others and to form relationships.

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<sup>9</sup> Op. Cit. *Newsweek*. p. 47

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The U.S. Department of Justice posts this synopsis of the risks of Child Abuse and Neglect:

*Parents and caregivers who are meth dependent typically become careless, irritable, and violent, often losing their capacity to nurture their children. In these situations, the failure of parents to protect their children's safety and to provide for essential food, dental and medical care (including immunizations, proper hygiene, and grooming), and appropriate sleeping conditions is the norm. Older siblings in these homes often assume the role of caretaker. Some addicted parents fall into a deep sleep for days and cannot be awakened, further increasing the likelihood that their children will be exposed to toxic chemicals in their environment and to abusive acts committed by the other drug-using individuals who are present. Children living at meth lab sites may experience the added trauma of witnessing violence, being forced to participate in violence, caring for an incapacitated or injured parent or sibling, or watching the police arrest and remove a parent.<sup>10</sup>*

The National Center on Substance Abuse and Child Welfare and the US Department of Justice cite these additional harmful situations for children:

*Parent manufactures meth –*

*Children living at methamphetamine laboratories are at increased risk from severe neglect and are more likely to be physically and sexually abused by members of their own family and known individuals at the site. Many children who live in meth homes are exposed to pornographic materials or overt sexual activity. A home lab carries the added risks of exposure to both immediate dangers and ongoing effects of chemical contamination, toxic fumes, fire, or explosion. The child may inhale or swallow toxic substances, or absorb toxic substances through the skin. Exposure to low levels of some meth ingredients may produce headache, nausea, dizziness, and fatigue; exposure to high levels can produce shortness of breath, coughing, chest pain, dizziness, lack of coordination, eye and tissue irritation, chemical burns (to the skin, eyes, mouth, and nose), and death. The solvents and corrosive substances used in meth production can cause skin or respiratory tract irritations, or central nervous system damage. Chronic exposure may cause cancer, damage to vital organs, and brain damage. Normal cleaning will not remove methamphetamine and some of the chemicals used to produce it. They may remain on eating utensils, floors, countertops. Toxic byproducts are often improperly disposed outdoors, endangering children and others in the area.<sup>11</sup>*

*Parent is involved in trafficking meth –*

*The children may be exposed to additional dangers, including the presence of weapons, violence, physical or sexual abuse by parents or by outsiders visiting the home. Explosive devices and booby traps have been found at some meth lab sites. Loaded guns and other weapons are usually present and often found in easy-to-reach locations.*

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<sup>10</sup> *Dangers to Children Living at Meth Labs.* [www.ojp.gov/ovc/publications/bulletins/children/pg5.html](http://www.ojp.gov/ovc/publications/bulletins/children/pg5.html)

<sup>11</sup> *Ibid and Op. Cit, Amatetti – condensed and summarized from both sources.*

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*Dangerous animals trained to protect illegal meth labs pose added physical and sanitation hazards. Code violations and substandard housing structures may also endanger children.*

*In addition to physical and health endangerment, the chaos associated with meth use and meth production creates great stresses and trauma for children, impacting their social, psychological, and emotional development. Their school attendance may be sporadic. They may feel shame and have low self esteem. A lack of appropriate role models may leave them with poor personal boundaries and social skills. Shame and embarrassment over their home situation may leave them unable to form friendships. Parental neglect during the early years may leave the child with an impaired ability to form attachments. The lack of strong advocates and role models may render them vulnerable to engaging in substance abuse or criminal activity themselves.*

*Children from these environments require developmental and mental health interventions, along with stable, nurturing caregivers.*

*Fortunately, access to healthcare, adequate nutrition, and a nurturing environment do make a difference in the outcome of these children.<sup>12</sup>*

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<sup>12</sup> Huff-Slankard, Janie. Methamphetamine Abuse and its Effects. *Family Matters*. 9/2004. p. 7

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## **Part III: Parenting Meth-Exposed Children**

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Due to the relative newness of meth abuse, and the lack of longitudinal studies of its effects on children, no exact prescriptions exist for parenting children who have been prenatally or environmentally exposed to this dangerous substance. However, much of what we now know about the needs and the development of children who have been prenatally exposed to alcohol and cocaine will be applicable.

A nurturing, calm, patient, parenting style is especially crucial for drug exposed children, whose sensory and neurological impairments and potential learning disabilities do not match well with loud, controlling, punitive, distracted, or non-empathetic parents. Parents will also need to address the on-going issues that all adoptive and foster children face – grief and loss, identity and role confusion, and the challenges of forming new attachments and integrating into a new family system. Children who have spent time in a substance abusing household have witnessed warped family and social values. Your job as their parent is to re-educate them about appropriate interactions – in the home, at school, and in the community. And finally, for the children coming out of the chaotic and unsafe environments of meth homes, a home with clear, predictable rules and routines is best suited to reassure children that they will be safe and their needs will be met.

Many excellent resources exist on parenting adopted children (see Appendix A: Recommended Resources.) The goal of this packet is not to repeat those, but to add to them. Brush up on general adoptive parenting skills. A special needs pre-adoption class or seminar might also be in order.

This section includes both guiding principles which will apply to parents raising drug exposed children of all ages, as well as some specific suggestions which may warrant review with your pediatrician, occupational therapist, special education coordinator, and the like, to determine their appropriateness for your child.

### **Guiding principles:**

*Develop a team of helping professionals.*

The last sentence in the previous paragraph hints at this first guiding principle. You will need the involvement of knowledgeable professionals to help determine your child's needs. If you accept the challenge of raising a meth exposed child, you must be willing to incorporate these "outsiders" into your life.

*Develop a support system.*

In addition to your team of professionals, you will need persons you can turn to for encouragement and support. Although friends, neighbors and extended family can be wonderful resources, find an adoptive or foster parent mentor or a support group, where you can communicate with others who are raising children with similar challenges.

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*Avoid labels, stereotypes and self fulfilling prophecies.*

Can you imagine the crushing blow to a newly placed nine-year-old upon hearing a neighbor child state, “You must have been one of those drug babies!” Children repeat what they hear – and they live up to, or down to, labels. So watch what you say and ask your family and friends to avoid negative labels, descriptions, or predictions. Coach your family members and extended support persons on responses to those who question the reason for the adoption, guardianship, or foster placement. Teach children that they need not share their entire life histories, and work with them on a “cover story” – a concise explanation of their situation. Teach them to respond to intrusive questions with phrases like, “That’s private,” or “I don’t want to talk about that.”

Help your child develop positive self esteem by avoiding negative stereotypes. While children exposed to alcohol and drugs often have learning disabilities, many can succeed in spite of their limitations. A twenty-three year old college graduate, who has fetal alcohol spectrum disorder, stated of her grade school through high school placement in advance math classes, “I didn’t know FAS kids were supposed to be bad in math!” Children do live up to or down to the labels and predictions assigned to them. Avoid labels and description such as “a walking time bomb” in reference to drug exposed children.

*Respect your child’s privacy.*

Adoptive parents often struggle with the question of what and how much to share with school personnel about their child. A good rule of thumb is to give information on an “as needed” basis. For example, the teacher will need to know that your child has a particular learning style or challenge, but not necessarily its cause. If your child has been sexualized, you may want to tell the teacher that this child should not be left unsupervised with younger children; but it is not necessary to disclose details of the child’s abuse. Use the same “need to know” rule with neighbors, youth group leaders, and the like.

*Establish predictable routines.*

To convince children from chaotic backgrounds of the continued care and safety they will encounter in your home, provide an extra large dose of predictability. Develop patterns of regular meals, bedtime routines, and consistent family rituals. The spontaneity and surprises that many families enjoy will not work well for these children. One little girl who was removed from a meth home took great joy in describing to her caseworker the routines she and her brother had learned to depend upon in their foster home:

*We play outside after school until 5:00; then we come inside to do homework. We have dinner at 6:00. After dinner the girls clear and the boys sweep the floor.*

*Then we finish our homework. Dad looks it over with us at 7:30. At 8:00 we take baths. We wash our hair on Wednesdays and Saturdays. We have to be in our beds at 8:30 but we are allowed to read until 9:00.*

These mundane routines mean so much to a child coming from a background of deprivation and unpredictability. Establish and follow patterns and vary them only upon necessity and with forewarning. Surprises such as “Pack your bags, we leave for Disneyland at daybreak!” do not

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work well with these children. Inform them well in advance and provide reminders of any changes in routines, even pleasant ones such as company or vacations.

### *Nurture in physical and emotional ways.*

We know that drug or alcohol exposed babies may have difficulty with physical closeness, touching and eye contact. Even older children with sensitive neurology or impaired nervous systems may respond differently to physical affection. Gently find ways to initiate hugs, touching, and eye contact - even if at a reduced frequency and level than you would like. Oregon families can request the ORPARC “Attachment Information Packet” for a summary of suggested techniques. Review Deborah Gray’s excellent book, *Attaching in Adoption*, and study the sections that describe attachment building techniques for varied ages.

### *Advocate for your child’s educational needs.*

Children prenatally and/or environmentally exposed to meth or to the toxins involved in its manufacture are at increased risk for learning disabilities. Parents must learn what services their child is entitled to, and how to advocate to assure the child receives appropriate educational services. Your partners in this endeavor are:

1. The Oregon Parent Training and Information Center (OrPTI). They offer a toll free Help Line, an IEP Partner program, and excellent trainings throughout the state. Help Line: 1-888-891-6784; IEP Partners: (503) 581-8156 ext. 212 or 1-888-505-2673 ext. 212; [www.orpti.org](http://www.orpti.org)
2. Wrightslaw offers excellent online information and can give a more in-depth look at the recent changes to IDEA law. [www.wrightslaw.com](http://www.wrightslaw.com) or [www.wrightslaw.com/idea/osep.statute.htm](http://www.wrightslaw.com/idea/osep.statute.htm)
3. Oregon Advocacy Center has produced several short, readable articles on issues affecting persons with disabilities. Their booklet, “Special Education: A Guide for Parents and Advocates” is available in both English and Spanish. (503) 243-2081 or 1-800-452-1694; [www.oradvocacy.org](http://www.oradvocacy.org)

### *Help your child to achieve success in at least one area.*

The literature on adolescents and young adults with prenatal fetal alcohol exposure points to the development of a talent or interest as a “protective factor.” Prenatally exposed children have excelled in the arts, physical activities, and sports. With appropriate accommodations, some have completed higher educations. Many have excelled at jobs in areas related to their interest and talent – child care, pet grooming, gymnastics instruction.

Help your child explore activities outside of school and especially promote those which seem to interest the child or for which the child shows aptitude.

### *Maintain a realistic yet positive attitude.*

Parents of meth exposed children must accept that there may be underlying biological issues that no amount of good parenting can correct. The parents’ role becomes that of encourager and advocate. You encourage the child’s fulfillment of his/her highest possible potential. You advocate to assure that the child receives all entitled services. As an advocate for your child, you also become the “teacher” who educates others about how to work with the child. As parents of

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children with developmental disabilities, you must learn to celebrate the tiniest of accomplishments, and not allow yourself to become discouraged.

Charlene Sabin, M.D., a developmental pediatrician, explains:

*Scientists now believe that the “pathways” for a child to develop interpersonal relationships are laid down in the early years of life. Inattentive or consistent care may impact the child’s ability to attach. To ameliorate impaired attachment, adoptive parents will need more patience, more understanding, and more therapeutic parenting approaches.*

*Learn tolerance for the unknown.*

As a recent study and literature review on this topic point out,

*...there are likely to be adverse developmental effects for children exposed prenatally to methamphetamine ...either because of the drug per se, or because of the environment in which these children are raised. At present, we do not know specifically what those effects will be.<sup>13</sup>*

This same article states, “... the jury is still out on the effects of methamphetamine...”

Consistent, nurturing care can ameliorate the effects of exposure to some extent, but the child may still have some long term impairments and delays. In drug exposed children, the development of many different parts of the brain is interrupted; some parts are recoverable and some are not. Each child’s situation is different. Learn to accept the many unknowns, and to take one day at a time. Don’t put undue pressure on anyone in the family – yourself, your partner, or the child.

This textbook excerpt from a section entitled *Understanding – and Misunderstanding – Parenting Influences*, might be helpful:

*In the end, research shows that parenting does matter to children’s development. At the same time, developmental scientists are increasingly recognizing the need to consider the influence of a child’s heredity characteristics as moderators of parental influence, and to incorporate into their research designs attention to hereditary factors. As a result, a new generation of parenting research is emerging that more thoughtfully illustrates the developmental integration of nature and nurture in the family environment.<sup>14</sup>*

*Take care of yourself.*

Caring for drug exposed children is demanding and exhausting. Parental burnout is a risk. Pay attention to your own needs. Take breaks, nurture yourself, continue with some interest or

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<sup>13</sup> Maternal Methamphetamine Use During Pregnancy and Child Outcome: What Do We Know? *The New Zealand Medical Journal*. Nov 26, 2004.

<sup>14</sup> *From Neurons to Neighborhoods*. The National Academy of Sciences. p. 49.

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activity outside of the family. Special needs children can take a toll on a marriage or partnership. Pay close attention to your partner's needs and nurture your relationship.

### **Age-specific suggestions:**

#### *For all ages:*

Any age child removed from a meth-abusing home should receive a medical evaluation prior to being placed in substitute care. If you are the first caretaker, ascertain that this has been done and ask for a summary of the report. Monitor the child closely and get immediate medical attention for the following symptoms of toxic chemical exposure: respiratory distress (difficulty breathing, shortness of breath, excessive coughing) or changes in mental status (confusion, excessive sleepiness or lethargy, excessive hyperactivity.)

Prior to the first placement, children will have been “decontaminated” – their clothing and possessions destroyed, their bodies and hair thoroughly washed. Verify that this has been done. Then demonstrate your empathy for children that have had to leave all of their possessions behind – no familiar clothing, no favorite blanket or stuffed animal for comfort. Provide substitute items the child might find acceptable. Find an age appropriate way to communicate your compassion for the child's losses and sadness.

#### *Newborns and babies:*

Caretakers of prenatally exposed babies must balance a calm, quiet environment that soothes the baby, with interactive times that help lay the groundwork for the baby's neurological and social development.

Prenatally exposed babies seem to vacillate between too much sleep and not enough sleep. They are usually very sleepy in the first weeks of life, and they will need to be awakened for feedings. Parents should use a feeding schedule rather than wait for the baby to wake up on its own to be fed. And by all means offer the baby a pacifier during non-feeding times- experts believe this “non- nutritive sucking” strengthens the baby's feeding abilities. After the initial sleepiness, these babies often become excessively irritable and jittery. During this phase they need a calm, quiet environment without a lot of stimulation.

Learn to recognize your baby's stress signals. These might include: changes in breathing, heart rate or temperature; stiffened arms or legs; shaking; and if the stress is not alleviated the symptoms may escalate to inconsolable screaming, vomiting, or breath-holding until the baby turns blue. When stress symptoms first emerge, move the baby to a warm, quiet environment with low lighting. Experiment with soft music, swaddling in a blanket, gentle rocking or swaying, – to determine what best calms your baby.

Soon after birth, babies need to learn the skills which lay the groundwork for social emotional, cognitive, and behavioral development. They need to partake in activities that help with their sensory and neurological organization. Think about all the tasks babies undertake in the first six months of life: – they watch people's faces; they react to voices, lights, sounds, and facial expressions; they demonstrate an interest in their surroundings.

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The drug exposed infant may need extra encouragement with these undertakings. Parents can assist by taking advantage of the baby's alert times to talk to and sing to the baby, hold the baby, rock and sway to soft music, touch and wiggle the baby's fingers and toes, massage the baby's body. Be gently persistent even with a baby who turns away from visual contact or objects. "Providing opportunities for physical contact, visual regard, and verbal interaction becomes an integral part of social development in the early stages of life."<sup>15</sup> These interactions set the stage for the development of a healthy parent/child attachment.

Work closely with your pediatrician during the child's early month and years. Babies need to be evaluated and treated for drug withdrawal, feeding problems, and respiratory distresses. Keep a journal in which you record your child's activities and behaviors. Your observations will be helpful to the pediatrician who evaluates and treats the baby.

Stick to the schedule of "well baby" check-ups and bring your notes to share any changes, progress, or regression you have noted. It is crucial that meth exposed babies receive intervention and treatment for any physical, neurological, developmental delay or regression.

Any drug exposed baby should be referred for an educational assessment. Contact your local public school or your school district's Educational Service Center to make arrangements. If your baby qualifies, he/she can receive Early Intervention Services (ages 0-3) which are free of charge and available at every public school district. Follow the recommendations of the intervention specialist, who may prescribe home routines of interacting with your baby to help in his or her development.

Once past the fragile newborn stage, an older baby is ready for "floor time" – a designated daily time when the parent gets on the floor with the child to play. The one-to-one interactions and undivided attention help the child "climb the developmental ladder" through playful activities that involve parent and baby, lots of eye contact, vocal interactions, smiling, touching, and perhaps a few simple toys. Refer to Section Two of the book, *The Child With Special Needs* for instructions and information about "floor time."

### *Toddlers and pre-schoolers:*

Work closely with a knowledgeable pediatrician during these years. The MD can be your first line of defense in recognizing latent drug exposure effects and in seeking appropriate interventions. Keep a journal of your child's illnesses, medications, activities and behaviors, and especially note any changes. Bring it along to all of your child's medical appointments.

Many meth exposed children exhibit high degrees of anxiety, from toddlerhood on up through the school years. A consistent, calm, and highly predictable environment works best for these youngsters. Be sure to discuss with the pediatrician or mental health provider any signs of anxiety you observe in your child.

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<sup>15</sup> Coehlo, Deborah Padgett, RN, PhD. *Care for Kids Exposed to Drugs*. Handout from DHS training 10-05. Used with permission of author.

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*The bulk of evidence to date about the problems these infants face points to learning disabilities and higher brain function impairment. While a meth-exposed infant may be relatively symptom free, the toddler, preschooler, and school age child need to be evaluated for cognitive function.<sup>16</sup>*

This statement indicates the need for an educational evaluation, whether the child is new to your home or has been with you since babyhood. If the toddler or preschooler qualifies for special educational services, begin them as soon as possible. These services are free and available through all public school districts. Speech therapy may be included as a part of these services, and you may be asked to undertake a home routine as well. Remember - the child does *not* have to be of school age to receive special educational services. Refer to the helpful resources previously listed under *Advocate for your child's educational needs*.

Initiate “floor time” activities described under *Newborns and babies* - add more age appropriate interactions and toys. Continue with your “floor time” throughout the toddler and preschool years. Allow the child to direct the play and follow the child’s lead.

### *School-aged children:*

Continue with regular medical, vision, and dental check ups. Follow up in a timely manner with any recommended treatments.

Establish and continue to enforce consistent rules and routines.

Meth exposed children often have difficulty going to school due to their anxiety. They may have trouble leaving the security of home or separating from parents. Work with both your pediatrician and your child’s mental health provider on these concerns, and solicit the assistance of school personnel.

Remember that one of the long term effects of prenatal drug exposure is learning disabilities, in particular, challenges in the areas of attention and abstract thinking. Many drug exposed children function acceptably in the early grades, but as the work becomes more abstract (around the 4<sup>th</sup> grade), they may begin to fall behind their peers academically. If not addressed via appropriate educational interventions, this may lead to problems in self esteem, social skills, and behaviors. Parents who can keep abreast of their child’s learning needs are often able to avoid or minimize the emotional and behavioral challenges that may accompany drug exposed children into their later childhood and adolescent years. Continue to seek educational evaluations and interventions. Learn the laws regarding eligibility and know your rights as a parent. Refer to the previously listed resources for special education advocacy.

Many of the principles espoused in the research on children with fetal alcohol exposure may apply to meth exposed grade schoolers. Read Diane Malbin’s booklet “*Trying Differently Rather Than Harder.*” Your job as your child’s advocate is to figure out how your child learns best, so that you can:

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<sup>16</sup> Op. Cit. Huff-Slankard, p. 7

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1. provide appropriate nurturing and discipline in the home, and
2. educate teachers, child care providers, youth group leaders, and the like, about the most successful types of environments and interventions for your child.

The grade school years are a good time for adoptive, guardianship and foster parents to initiate drug and alcohol abuse prevention education. Find out when your child's school is teaching a unit on this topic, and coordinate efforts at home with the school's schedule.

Refer to the website: "Parents: The Anti Drug" at [www.theantidrug.com](http://www.theantidrug.com). This website contains very helpful information on the effects of meth and helpful resources for parents.

If your child has a "lifestory book," review it together, and use it as a tool to discuss the damaging effects of illegal substances. If the lifestory book is non-existent or substandard, work with your child to create or update it. (ORPARC has several lifestory book resources for this purpose and sometimes offers classes on this topic.)

Enhance your child's understanding of the reasons for removal from birth family. A book you might find helpful is *Telling the Truth to Your Adopted or Foster Child*.

Adoptive and foster parents are sometimes so angry over the harm inflicted by substance-abusing birth parents that they are unable to speak of the birth family in an empathetic or kind manner. But one of the greatest gifts you can give your child, one that will go a long way in furthering the child's attachment to you, is to do just that. Practice saying, with sincerity, statements like: "Your mom had such a pretty smile – I can see where you got your good looks," or "Your dad was a very good man before he fell victim to drug abuse." If such statements are true, they are a positive way to honor birth family members, and they will enhance your child's attachment to you.

Teach children that they are not destined to repeat their birth parents' mistakes, and that they do have control and choices in the outcomes of their lives.

### *Pre-teens and teens:*

Continue to advocate for your child's educational needs, as learning disabilities are common among meth exposed children at all ages. If the child is new to your home or has not been recently evaluated for learning disabilities, request such an assessment from your local public school. Remember that special educational services are available in the public schools for qualified youth through age 21. These services can include preparation for life after high school.

Children in their pre-teens and teens really do benefit from learning more about their own histories. At all developmental stages they will need to review their history with increased information. In adolescence they will be trying to understand their history with new eyes and deeper insight. So even if you have explained their stories to them in the past, initiate new conversations and give more information. Pre-teens and teens need a continual review of their histories because their capacity to understand their stories in different ways increases as they grow older. Follow the guidelines in the previous section regarding compassion and respect for the birth family.

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These are important years for parents to initiate or increase their efforts at substance abuse prevention. In a matter-of-fact and non-judgmental manner, inform them that scientists believe they may be “genetically more at risk” for addictions. Teenagers need to know this information about themselves. You might solicit the help of a trusted family doctor or a mental health provider to assist in this educational effort. Even if your teen seems aloof or the information does not sink in at first, they need to keep hearing it.

Remember that every child matures at his or her own rate, and that the developmental timelines for meth exposed children are delayed. Gear your interactions and information to the child’s level of maturity rather than his or her chronological age.

Meth exposed children may not reach the developmental milestones at the same time as their peers. They will likely need the structure and parental supervision you would provide for a much younger child. Don’t overburden them with the kinds of responsibilities they are not yet mature enough to handle. Decisions about dating, curfews, learning to drive, and the like must be made with the child’s developmental level (and learning challenges) in mind. Do not expect your child to emancipate from home when other kids do so. They may need to live at home well into their 20’s and they will need a slow transition to independent living. For those who are able to undertake college work, living at home and attending the local community college is a good choice.

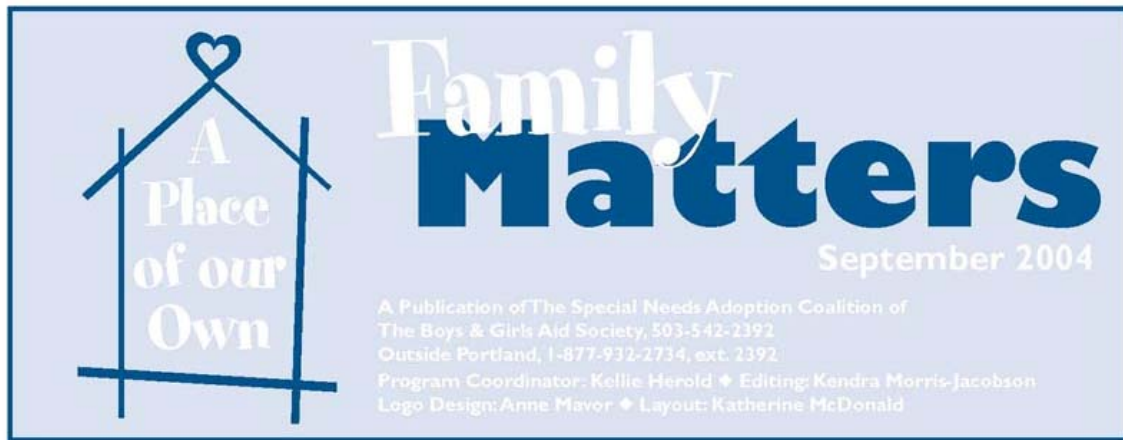
Initiate or continue your efforts at substance abuse prevention education. Coordinate efforts with the school’s health class or special assemblies on this topic. Refer to the website [www.theantidrug.com](http://www.theantidrug.com). Your child might view this site as well.

An excellent book that has guided parents of alcohol exposed children through adolescent and early adult challenges is *Fantastic Antone Grows Up*, edited by Judith Kleinfeld.

Some of the suggestions may also be helpful for meth exposed youth. Written by parents, helping professionals, and alcohol exposed youngsters themselves, the various vignettes offer suggestions on topics such as adjusting to high school, finding and keeping a job, relationships, learning to drive, emancipation, and marriage.

A final suggestion: read Diana Haskins’ book *Parent as Coach: Helping your teen build a life of confidence, courage and compassion*. It helps parents move beyond the kind of authoritarian role that we know does not work effectively with drug and alcohol exposed adolescents.

Part IV: Reprinted Articles



**Methamphetamine Abuse and Its Effects**

by Janie Huff-Slankard RN, MSN, CPNP

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Many of the children I see in private practice are drug-affected. While cocaine, tobacco, alcohol and other illicit drugs compromise many of the infants I see, I am most concerned about the infants who have been exposed to methamphetamine. This is a drug like no other.

"Meth" has been described as the most potent drug available, legally and illegally. This drug releases a massive amount of dopamine (the pleasure chemical) in the brain and produces feelings of euphoria, increased alertness and an exaggerated feeling of confidence. It has been described as an intense rush of feelings; so much so that the user can only crave more and more, wanting to sustain that level of feeling at all times. Meth addiction is fast yet subtle and before the user realizes it, the illness is full blown and out of control.

**Finding Methamphetamine**

Different areas of the country have very different rates of meth abuse. Western and Southwestern states have much higher treatment center admissions for

meth abuse than the Northeast and Central states. In the recent past, the drug was classified as an urban problem, but is now spreading to more rural areas where the risk of getting caught making and distributing the drug is less. Meth use is not limited by sex, age, ethnicity or income. More and more the "average" meth user is a young adult with an above poverty-level income.

Meth is easily made with household, grocery shelf materials and cheap to produce. "Meth labs" are easily hidden in basements and garages and are usually in neighborhoods that are quiet and inconspicuous. The renewed interest in neighborhood patrols in many communities has been responsible for drug raids on such meth labs. Local law enforcement agencies will come to community meetings and set the neighborhood up with resources and plans of action when a "high risk" home is identified.

**Using Methamphetamine**

It is estimated that 8.8 million Americans, 4% of the total population, have used meth at some point in their lifetime. In the most recent studies, the rate of meth use has stabilized, not increasing in addiction rates, among illicit drug users. While this fact is heartening, the teenagers and young adults who have addiction problems or the addictive personality may see using non-injectable drugs as less addictive and therefore not as dangerous.

Tolerance to meth occurs within minutes, which means that before the drug levels in the blood even begin to fall, the pleasurable effects to the user are dropping. This makes the drug easy to abuse in a "binge and crash" pattern. More and more of the drug is needed to maintain the euphoria or rush. A binge is known as a "run" in which the addict can ingest as much as a gram of the drug over a two to three hour period over several days until the user runs out of the drug or is too confused and delirious to continue.

Meth is available in many forms and can be smoked, taken by mouth, snorted in the nose, or injected intravenously. The effect of the drug and how it alters mood is totally dependent on how it is taken. "Snorting" or ingesting through the nose can be felt in a few minutes while ingestion by mouth can be felt in 15 to 20 minutes, prolonging the "rush" or intensity of the high to for as long as half of a day. The intravenous user experiences an intense "rush" and is limited to a few moments of pleasure. The person who injects meth intravenously has been shown to exhibit more violent behavior soon after injection than any other sequelae of ingestion in other venues.

**Addiction**

Addiction is one of the most worrisome effects of long-term meth use. Addiction is a chronic, relapsing state, which left untreated results in functional and mo-

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### Methamphetamine Abuse and Its Effects

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lecular changes in the brain. The addict can demonstrate behaviors of violence, anxiousness, confusion and psychosis. Paranoia, delusions, auditory hallucinations and mood disturbances are not uncommon.

Even though methamphetamine, amphetamine and cocaine are in the same class of psycho-stimulants, treatment of the meth user is different because while cocaine and amphetamines are removed quickly by the body's cleansing mechanisms, meth has a much longer duration of action and a percentage of the drug remains unchanged in the body for a longer period of time. Since meth has a longer duration of action and is in the brain longer than the other stimulants, the user has prolonged stimulant effects.

Meth abuse is especially harmful to the cardiovascular system and nervous system. Rapid heartbeat, irregular heart rate, hypertension and irreversible damage to the small blood vessels in the brain, which can lead to stroke, are the most serious side effects. The effects on the cognitive functioning of the brain can sometimes persist for months or years after abuse has ended.

Treatment for the meth user is behavioral in origin, where the goals are to help change the user's thinking, expectations and behaviors. Coping with various life stressors without drugs is a major treatment goal as with any addiction. Early intervention is the most essential part of treatment for the meth addict.

#### Prenatal Effects

The most disturbing statistic in the meth research is that over half of meth drug abusers are women of childbearing age. Of women who use illicit drugs, approximately 50% are women of childbearing age. About 80% of these women also abuse tobacco and alcohol. Some women abuse only in early pregnancy; others abuse throughout the entire nine months. Substance abuse during pregnancy has been researched well enough to correlate abuse with increased incidence of perinatal morbidity, low birth weight and decreased estimated gestational age. The abusing population has a higher rate of sexually transmitted diseases and hepatitis, both of which are

transmitted vertically to their infants. Numerous congenital anomalies have been directly linked to substance abuse. These women are more likely to have spontaneous abortions, premature rupture of the membranes and meconium stained amniotic fluid.

Prenatal substance exposure increases the infant's risk of premature birth, sepsis and respiratory compromise with decreased oxygen resulting in anoxia. The sequelae include cerebral palsy, developmental delays, cognitive dysfunction and severe lifelong problems. As you can see, a circle of interlinked problems results and the severity of the problems increases proportionately with increased substance abuse. Poor fetal development is further exacerbated since the majority of these mothers also have other risk factors such as poor health, malnutrition and poly-drug use.

#### Literature Review

To date, there are few studies that have looked at exclusively meth-exposed infants. The majority of studies completed have focused on cocaine-exposed babies. Many more European meth studies, particularly in the Norwegian countries, have begun and are still in trial without findings ready to be published.

Except for the effects of prenatal alcohol, the findings around the effects of long-term child development have been equivocal. The population of children who have been exposed to intrauterine drugs have the same variables, low socioeconomic status, poor nutrition and late prenatal care, as do the non-substance abusing population. A study done in Oslo, Norway decreased the variables by looking at infants who had been exposed in utero and then went on to live in the same socioeconomic and cultural population, and infants who had been exposed in utero but then were placed in foster families where the post-natal conditions around the child were optimized.

A previous Norwegian study also looked at gender differences in outcomes and found that males may be more vulnerable than females from the beginning of life. It is also generally agreed that infants and toddlers are

difficult to assess for cognitive function and one must wait until preschool age is attained where the challenge of a new task such as school can be measured. This has been called the "sleeper-effect." Studies have shown that biochemical and environmental variables influence cognitive functions differentially. Perceptual performance functions may be more susceptible to biological risks, and general cognitive functioning may be more strongly influenced by environmental factors.

The outcome of this study drew five main conclusions. First, the substance-exposed children scored significantly less in gestational age, birth weight and head circumference. Second, even if the substance-exposed children scored within normal range, significance was found in the developmental assessments at one and 4.5 years of age. Third, the vulnerability of the male children was demonstrated even at 4.5 years of age. Fourth, data revealed special weaknesses in the area of visual motor and perceptual abilities in the substance-exposed group. The fifth point being parental socioeconomic status and the child's early developmental status made a significant contribution to perceptual performance, as well as general cognitive index. The clinical implication of this study is that social workers, healthcare providers, psychologists and educators should be aware of the possibility that many substance-exposed children will be children with special needs in the future.

One study in the United States compared the infant outcome of children with mothers who received no substance abuse treatment during their pregnancy and pregnant women who were not substance abusers. They found that for every ten weeks of treatment the mothers received, the birth weight increased, estimated gestational age increased and head circumference increased. This increase in fetal growth parameters significantly decreased the risk for poor neonatal outcomes. As important was the fact that the treatment group demonstrated less maternal and infant perinatal complications.

*Continued on page 7.*

## Methamphetamine Abuse and Its Effects

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### Additional Research

There are numerous studies around the drug withdrawal symptoms in infants, but these studies are primarily looking at heroin abuse. Few, if any, have looked at the neonatal abstinence score of children exposed to meth. One small study looked at meth abuse and found that subtle alterations of state regulation and attention may be missed on the routine neonatal physical examination. Earlier studies did show that prenatal meth exposure is associated with subsequent aggressive behavior, delays in mathematic and language skill learning, and difficulty with physical fitness activities. Significantly poorer visual recognition memory, a measure correlated with IQ, was also found in the meth-exposed children. Meth use in all trimesters of the pregnancy was associated with decreased birth weight and head size relative to infants who were only exposed for part of the pregnancy.

Two positive electron tomography (PET scan) studies showed decreased dopamine transporters in chronic meth users, indicating long-lasting neurotoxicity. Also, meth depletes endogenous depression receptors in the abuser. This finding supports the fact that the low rate of severe withdrawal symptoms does NOT indicate protection from neurotoxicity for the developing fetus. Another study using magnetic resonance imaging (MRI) and chemical imaging analysis found that biochemical markers were decreased in meth-exposed infants, indicating potential neuronal loss. Because biochemical pathways affect executive functioning, changes in the energy metabolism because of decreased biochemical markers could have clinical implications.

Research into the effects of meth on children is clearly needed. Because of the findings about cocaine exposure, other toxic substances and their impact on development, it is a logical assumption that any toxic substance will have effects on an unborn child.

### Meth-Exposed Children

Parents must be aware of the potential effects of meth abuse during a pregnancy in order to plan for the care of the meth-exposed child. It should be mandatory information for foster and adoptive families who take on the parenting of these children. The health care provider seeing a meth-exposed child in the first year of life may need to use medications for sleep, for the child's inability to self-soothe and for gastrointestinal symptoms similar to those of a colicky baby. While we know from research that Phenobarbital helps cocaine-exposed infants during the withdrawal period, it is unsure whether this drug needs to be used in the meth-exposed child. Some infants exhibit behaviors similar to cocaine-exposed infants, but many do not.

A thorough history and physical relying on the caregiver's observations is essential in the pharmacological management of meth-exposed infants. The same is true for gastrointestinal problems such as feeding intolerance, poor weight gain and failure to thrive. Again, the observations of the caregiver are vital in order to manage the infant. Many infants do present in our office with frequent vomiting after each feeding and it is worsening with time. These infants sometimes appear to be in pain, as if vomiting hurts. These babies need to be evaluated for gastroesophageal reflux and put on appropriate formula or medication.

The bulk of the evidence to date about the problems these infants face points to learning disabilities and higher brain function impairment. While a meth-exposed infant may be relatively symptom-free, the toddler, preschooler and school-age child need to be monitored and evaluated for cognitive function. Behavior at home and at school should be assessed at every well-child visit, and proper intervention at an earlier age is standard and appropriate for these kids. Early Intervention services should be offered to all drug-exposed infants. Follow-up visits to assess progression or regression of developmental milestones is paramount to identifying these children early so that intervention and treatment is begun. An observant parent is the healthcare provider's eyes and ears; subtle differences in the child that are reported during an examination may be the only indicator of problems in the making.

While the scientific evidence at this point in time is small, the significance is anything but small. As caregivers for children born with meth exposure, we know the magnitude of the problems facing these children. Furthermore, many children are entering foster care to due to issues relating to parental meth use. Fortunately, access to healthcare, adequate nutrition, and a nurturing environment do make a difference in the outcome of these children. This is our future. Marian Wright Edelman said it best, "Somehow we are going to have a concept of *enough* for those at the top and at the bottom so that the necessities of the many are not sacrificed for the luxuries of the few."

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## Meth Gives Rise to a New Tide of Child Endangerment

by Diane Riggs

“**S**atan dust” is just one of more than 300 slang terms—including meth, crank, crystal, ice, glass, speed, chalk, zip, tweak, Tina, and rocket fuel—used to identify methamphetamine, an old drug that is newly confounding child welfare workers. As we have learned over the past decade, and more fully in the past few years, the risk to children from adults’ rising use and manufacture of meth is frightening in scope, and the time to protect them is now.

### What’s So Bad about Meth?

The link between parental substance abuse and child welfare is nothing new. Meth, however, is different from alcohol, cocaine, and heroin in several important ways. First, the drug is highly potent and almost instantaneously addictive. Users who snort meth feel the effect within five minutes, and many are hooked after just one hit.

Second, the meth high and subsequent fall are more prolonged than with cocaine or heroin. On a steady diet of meth, a user can stay awake for a solid week or more, and then crash correspondingly hard and long. Mood disturbances caused by the drug—such as extreme irritability, depression, and paranoia—can last well beyond the drug-using event. Withdrawal symptoms are also much more severe and enduring.

Another cause for concern is that meth is increasingly accessible. Sometimes described as the “poor man’s cocaine,” meth costs much less than cocaine or heroin and can be made at home from relatively inexpensive and commonly available ingredients.

### How Meth Affects Child Welfare

Initially thought to be a problem mainly in western states, meth use has stretched across the U.S., and child welfare involvement has followed right behind. Published this summer, reports from Kentucky and North Dakota suggest that birth parents’ meth use is causing the demand for foster and adoptive families to rise beyond the available supply. Officials in North Dakota estimated that about 15 percent of children who enter foster care have meth-affected family members.

A more recent survey of Minnesota counties revealed that meth production and use is a factor 31 to 81 percent of reported child-protection cases. Tennessee’s Department of Children’s Services estimates that it will remove about 750 children from meth-affected homes in 2004, a 25 percent increase over last year. And, in a statement made earlier this year, North Carolina’s attorney general asserted that children are found in about a quarter of that state’s meth lab raids.

But what about children who live with meth? What price do they pay?

During pregnancy, a woman who uses meth passes dangerous chemicals to her unborn child. In the fetus, meth raises blood pressure, may slow growth, and can cause prenatal strokes, heart damage, and even death. For more than a month after they are born, meth babies show signs of withdrawal such as excessive fussiness, failure to suck and swallow properly, and hyper-sensitivity to stimulation.

By the time prenatally meth-exposed children reach school, problems with behavior, language, and learning are often evi-

dent. Poor social skills and aggression emerge, and attention deficit hyperactivity disorder is a common diagnosis. Most researchers are still waiting, however, to definitively identify the long-term consequences of prenatal meth exposure.

Children who live with meth-using parents face more dangers. While on meth, parents often don’t eat and may not think to feed their children. While high, parents may simply neglect their children, but if provoked, may fly into an abusive rage. Meth also endows many users with a stronger sex drive—an urge that may be turned on children or inappropriately acted out in front of children. When parents fall into a lethargic depression after a high, they are incapable of doing much for themselves, much less a child.

When exposed to the home manufacture of the drug, children inhale toxic fumes and absorb dangerous chemicals into their skin, clothing, and personal possessions—contaminates that cause neurological and respiratory problems. Very young children can ingest toxic materials used in production and frequently sustain chemical burns. And, since meth cooking vapors can ignite without a heat source, the risk of being caught in a fire is substantially magnified.

### Protecting Children from Meth

As the tide of meth use broadens and affects an increasing number of children, more jurisdictions are taking strides to protect meth’s victims. Through child endangerment teams, legislative action, government task forces, and education, officials are attempting to remove children from danger and combat the drug that is rapidly destroying so many families.

Fortunately, many jurisdictions have realized that situations involving meth and child welfare are best handled by a team of professionals. Formally sanctioned by the White House Drug Policy Office last

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# PARENTING CHILDREN WHO HAVE BEEN EXPOSED TO METHAMPHETAMINE

## A BRIEF GUIDE FOR ADOPTIVE, GUARDIANSHIP AND FOSTER PARENTS

### **Meth Gives Rise...** *from page 1*

October, Drug Endangered Children or DEC programs (which have existed in western states for many years) attempt to coordinate the efforts of law enforcement, fire and emergency services, health care, and social services.

Announced this September, for example, Tennessee's new DEC Team has this protocol: Police who bust a meth lab alert fire officials and call a child welfare agency worker to assume custody of any children at the scene. The children are then evaluated and cared for at a medical facility before being placed in a foster home.

Child removal from meth-affected homes, however, poses unique challenges. If a child has been living where meth is cooked, he is contaminated, as are his clothes, and his favorite toys—children must leave everything behind. In some cases, law enforcement or social service workers must literally hose children off and supply them with clean clothes before taking them to a medical facility for a more thorough decontamination.

Recognizing the serious risks to children who live with meth producers, Alabama, Arizona, Colorado, Idaho, Iowa, Minnesota, Montana, North Dakota, Oregon, Tennessee, Utah, and Washington State have all passed laws in the past few years expanding their child abuse and endangerment statutes to include drug manufacturing in a child's presence. Just this year, Virginia, North Carolina, and Georgia also passed legislation making meth production in the presence of a child a felony offense.

## Adoptalk

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Effective December 1st, a new law in North Carolina will institute tougher penalties for those who manufacture meth around a child or where a child lives. Illinois' attorney general is also promoting legislation that would double the maximum sentence and fine for any crime involving meth production near or in a manner that endangers children.

Quite few states (including California, Illinois, Indiana, Iowa, Missouri, Montana, New Mexico, North Carolina, Oregon, Pennsylvania, and Tennessee) have set up meth task forces as well. In Oregon—where the governor recently identified meth use and production as the "single biggest factor that leads to the removal of children from their homes"—the Methamphetamine Task Force won approval from the Oregon Board of Pharmacy on October 13th to enact an emergency six-month restriction on the sales of pseudoephedrine, a common decongestant used in homemade meth.

Meth task forces, as well as community groups, are also hosting regular meth trainings and conferences. Aimed both at service professionals (police, social workers, teachers, physicians, etc.) who encounter meth users and meth-affected children at work, as well as the general public, trainings typically focus on community and worker safety as well as ways to help meth-affected children.

### **Hope for Recovery**

For child welfare professionals facing meth's growing threat to child safety and well-being, the priority must be helping young meth victims to heal. Hospitals must learn to diagnose meth exposure in infants and children, and foster parents must understand how the drug affects children. Those who care for meth babies, for example, must have an abundance of patience to endure inconsolable, high-pitched screaming during the long weeks of withdrawal.

Older children present other challenges. As one foster mom explains from her experience with children removed from meth addicts, "They don't think they're going to get fed. If electricity goes out because of a storm, they're sure we didn't pay the bill. They are surprised when we go shopping when the shelves aren't bare." Living in a stable family can be very unsettling for children raised in chaos, and they may create chaos to feel better.

Teachers and child care workers can help too. Child psychologist Dennis Embry

encourages teachers to kneel to greet students face to face and model good touching. The touching, he suggests, can help to soften the anti-social nature of meth-exposed children who are programmed to withdraw from or fight against a dangerous and unpredictable world. Embry also recommends programs that teach meth-exposed children how to play appropriately, and those in which volunteers provide extra help with learning.

Other ways to heal meth-affected children include ongoing therapy and support. One northern Minnesota county has even formed an informal support group for foster children, many of whom were removed from meth-addicted parents.

The recovery potential for parents ensnared in meth addiction is less certain. What researchers have learned so far is that 30-day drug treatment programs rarely offer parents enough help to resist the lure of meth for long. Even after two years of staying clean, many users will again succumb to the craving for meth. Even those who don't relapse must still deal with the neurological and organ damage caused by meth, and judicial decisions that may separate them from their children forever.

Fortunately, in Washington State an intensive recovery program is helping to keep some families together. Safe Babies, Safe Moms is available to mothers whose babies test positive for meth or other drugs at birth. To enroll and stay in the program, the women must make a three-year commitment.

In return, program participants receive individual support from a case manager who connects them to drug treatment, transitional housing, education, birth control, and other services. After three years, many of the women have been able to completely break their drug habit, and start a healthy new life together with their children.

### **Conclusion**

As law enforcement officials, medical professionals, and the child welfare community have come to realize, methamphetamine is a uniquely formidable foe, and no single profession or organization can keep it from hurting children. Our best hope lies in raising awareness about the drug's dangers, and supporting partnerships between communities and professionals to both stem meth's use and help children to emerge from the shadow of their parents' addiction. There is no time to lose. ☘

**PARENTING CHILDREN WHO HAVE BEEN EXPOSED TO METHAMPHETAMINE  
A BRIEF GUIDE FOR ADOPTIVE, GUARDIANSHIP AND FOSTER PARENTS**

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**Appendix A: Recommended Resources**

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**Books, Booklets and Videos:**

Most of these resources are available through the ORPARC library.

**Attachment:**

- *Attachment*, ORPARC Information Packet
- *Attaching in Adoption*, Deborah Gray

**Parenting:**

- *Parent as Coach*, Diana Haskins
- *Self-Esteem: A Family Affair*, Jean Illsley Clarke

**Adoptive Parenting:**

- *The Child With Special Needs*, Stanley Greenspan
- *Raising Adopted Children*, Lois Melina
- *Twenty Things Adopted Kids Wish their Adoptive Parents Knew*, Sherrie Eldridge
- *Telling the Truth to Your Adopted or Foster Child*, Keefer and Schooler

**Parenting Drug/Alcohol Exposed Children:**

- *Trying Differently Rather Than Harder*, Diane Malbin
- *Fantastic Antone Grows Up*, edited by Judith Kleinfeld
- *Bruised Before Birth*, Joan McNamara

Videos:

- *Worth the Trip*
- *Students Like Me*

**Websites for more information:**

National Institute on Drug Abuse

[www.drugabuse.gov](http://www.drugabuse.gov), select “Methamphetamine”

National Center of Substance Abuse and Child Welfare

[www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov), search for “Methamphetamine”

Office of National Drug Control Policy

[www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov), search under “Drug Facts” for “Methamphetamine”

Parents: The Anti Drug

[www.theantidrug.com](http://www.theantidrug.com)

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**Appendix B: Sources used for this packet**

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**Note to the Reader:** Many times links to specific articles on websites change. A Web Administrator may remove or relocate a particular article on the site. If you would like to receive further information on a topic it is probably best to access the basic URL (web) address (i.e., [www.drugabuse.gov](http://www.drugabuse.gov)) and select or search a particular topic.

*America's Most Dangerous Drug. Newsweek.* Aug 8, 2004. p. 41-48.

*Methamphetamine – Drug Facts 2005*

Office of National Drug Control Policy

[www.whitehousedrugpolicy.gov](http://www.whitehousedrugpolicy.gov), select “Drug Facts,” select “Methamphetamine” under “Fact Sheets”

*Medical Evaluation of Children Removed From Clandestine Labs FAQ # 2*

*How to Care for Children Removed from a Drug Endangered Environment FAQ # 3*

The Colorado Alliance for Drug Endangered Children.

[www.colodec.org](http://www.colodec.org), select “Questions and Answers,” see “Frequently Asked Questions #2 - Medical Evaluation of Children Removed from Clandestine Labs” and “Frequently Asked Questions #3 - How to Care of Children Removed from a Drug Endangered Environment,” Fact Sheets published in both Microsoft Word and Adobe Acrobat formats

*NIDA Community Drug Alert Bulletin: Methamphetamine*

National Institute on Drug Abuse

[www.drugabuse.gov](http://www.drugabuse.gov), select “Methamphetamine”

National Center of Substance Abuse and Child Welfare

[www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov), search for “Methamphetamine”

*Children at Clandestine Meth Labs*

US Department of Justice: [www.ojp.usdoj.gov](http://www.ojp.usdoj.gov), enter “Children at Clandestine Meth Labs” in sites search (two versions: December 28, 2004 and January 11, 2006)

*Care for Kids Exposed to Drugs*, Coehlo, Deborah Padgett. Handout from October 2005 DHS training.

*Methamphetamine Abuse and its Effects.* Huff-Slankard, Janie. **Family Matters.** September 2004.

Administration for Children and Families, Children’s Bureau. Keynote speech. Amatetti, Sharon. National Conference, Washington, DC. Fall 2005.

Many thanks to Dr. Charlene Sabin for providing input on this Information Packet.