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**DRUG EXPOSED INFANTS:
A Generation at Risk**

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SUMMARY
ON DRUG-EXPOSED INFANTS: A GENERATION AT RISK

In 1988, some 5 million women in the United States reported using illicit drugs. Drug use during pregnancy can cause major health problems for both the mother and infant. Drug-addicted pregnant women are in need of prenatal care and drug-treatment services, and many drug-exposed infants need intensive health care services. In addition, the costs of the continued care of these children to the health care and social services systems will be high.

To study the problem of drug-exposed infants, GAO visited 10 hospitals in five cities that primarily served a high proportion of persons receiving Medicaid and other forms of public assistance. Data from the records at these hospitals and from the National Hospital Discharge Survey were analyzed. Leading neonatologists, social welfare authorities, and drug-addicted pregnant women were also interviewed.

GAO found that:

- Tens and perhaps hundreds of thousands of drug-exposed infants are born each year. The exact number is unknown, in large part because hospitals are not identifying many of them.
- Drug-exposed infants need medical and social services that will cost billions of dollars in the years to come. One estimate of the cost of services for a drug-exposed infant who is significantly impaired is \$750,000 for the first 18 years of life.
- Despite the demonstrated ability of prenatal care and drug treatment to reduce the number of infants affected by drug abuse, less than 11 percent of women in need of drug treatment are estimated to receive services because of a shortage of programs.
- Less than 1 percent of funds under the federal anti-drug strategy is targeted specifically at drug treatment for women. For drug-addicted pregnant women, the percentage of federal expenditures is even less.

The problem of drug-exposed infants calls for an urgent national response. Expanding drug treatment services might reduce the number of drug-exposed infants and alleviate some of the social problems associated with their care.

With additional federal funding the large gap between the number of women who could benefit from drug treatment and the number of residential and outpatient slots available could be reduced. GAO believes that this commitment of funds could save money in the long term as well as improve the lives of future generations of children.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss our report on the growing and costly problem of substance-abusing mothers and their infants.¹ At your request we have reviewed the extent of the problem, its impact on the health and social welfare systems, and the availability of drug treatment and prenatal care to drug-addicted pregnant women. In brief we found that:

- Tens and perhaps hundreds of thousands of drug-exposed infants are born each year, but the exact number is unknown because hospitals are not identifying many of them.

- These infants constitute a growing national problem necessitating medical and social services that will cost billions of dollars in the years to come. One estimate puts the cost of services for drug-exposed children who are significantly impaired to be as high as \$750,000 for the first 18 years of life.

- Despite the demonstrated ability of prenatal care and drug treatment to reduce the number of infants affected by drug abuse, there is a serious shortage of drug treatment capacity

¹Drug-Exposed Infants: A Generation at Risk (GAO/HRD-90-138, June 28, 1990).

for pregnant women. Of the estimated 280,000 pregnant women nationwide in need of treatment, less than 11 percent receive care.

-- Less than 1 percent of federal funds allocated under the federal anti-drug strategy is specifically targeted at drug treatment for women. For drug-addicted pregnant women, the percentage of federal expenditures is even less.

In my testimony today I will be addressing these issues.

BACKGROUND

One of the most troubling aspects of our current drug epidemic is the number of women who are using drugs. In 1988, some 5 million women reported using illicit drugs, including cocaine, heroin, PCP, and marijuana. The use of drugs during pregnancy is of particular concern because they affect both the mother and the developing infant. Cocaine, for example, may cause constriction of blood vessels in the placenta and umbilical cord, which can result in a lack of oxygen and nutrients to the fetus, leading to poor fetal growth and development. Some infants prenatally exposed to cocaine have also suffered from a stroke or hemorrhage in the areas of the brain responsible for intellectual capacities.

Federal support for treating drug addicts is addressed in the 1990 National Drug Control Strategy.² Under this plan over 70 percent of an estimated \$10.6 billion in fiscal year 1991 would be spent on drug-supply-reduction activities; the remainder would be targeted at reducing the demand for drugs. Approximately \$1.5 billion would be spent on drug treatment, with over half of the federal funds provided through block grants to the states administered by the Alcohol, Drug Abuse and Mental Health Administration.³ The states are required to set aside at least 10 percent of these funds to provide drug-abuse prevention and treatment for women.

Moreover, two federal-state health programs are potentially available to pregnant women who abuse drugs. First, the Maternal and Child Health Services block grant program (MCH) provides grants to the states for health services to low-income persons with the intention of reducing infant mortality and morbidity, frequent consequences of drug abuse by pregnant women. Second, the Medicaid program, which provides federal financial assistance to the states for a broad range of health services for low-income persons, requires coverage of low-income pregnant women. Those pregnant drug abusers who have low incomes could qualify for services under either program.

²The Office of National Drug Control Policy, responsible for developing an annual national anti-drug strategy, was established in 1988.

³A component of the Department of Health and Human Services.

In response to the issues raised in your request, we interviewed leading neonatologists, drug treatment officials, researchers, hospital officials, social welfare authorities, and drug-addicted pregnant women. We analyzed data from the National Hospital Discharge Survey and reviewed medical records at 10 hospitals; two in each of five cities--Boston, Chicago, Los Angeles, New York, and San Antonio. The 10 hospitals, which accounted for about 45,000 births in 1989, primarily served a high proportion of persons receiving Medicaid and other forms of public assistance. In addition, we interviewed officials at 10 hospitals that served a high proportion of privately insured patients.

THE NUMBER OF DRUG-EXPOSED

INFANTS IS HIGH

Identifying infants who have been prenatally exposed to drugs is key to providing them with effective medical and social interventions at birth and as they grow up. At present, however, the actual number of drug-exposed infants born each year is unknown. The two most widely cited estimates are 100,000 and 375,000. Neither of these estimates is based on a national representative sample of all births.

A major reason that the total number is unknown is that hospitals do not systematically screen and test for maternal drug use.

Hospital officials acknowledged to us that under their current procedures, many drug-exposed infants are not being identified.

In reviewing maternal and infant medical records at only 10 hospitals, we found approximately 4,000 infants born in 1989 who had been prenatally exposed to drugs. However, the range in the number of drug-exposed births across hospitals was wide--from 13 per thousand births at one hospital to 181 per thousand at another. This variation may be associated with the procedures hospitals use to detect drug use during pregnancy. The hospital with the lowest recorded incidence of drug-exposed infants did not have a protocol for assessing drug use during pregnancy. At the other nine, protocols to identify drug-exposed infants were based primarily on whether the mother told hospital staff she used drugs and whether the baby exhibited drug withdrawal symptoms.

However, these screening protocols miss many drug-exposed infants. Women are reluctant to admit they use drugs for fear of being incarcerated or having their children taken away. In addition, many cocaine-exposed infants display few overt drug withdrawal signs. Some will show no signs of drug withdrawal, while for others withdrawal signs will be mild or will not appear until several days after hospital discharge. The visual signs of drug exposure vary from severe symptoms to milder symptoms--such as irritability and restlessness, poor feeding, and crying--which

would not lead to a suspicion of maternal drug use unless urine testing is conducted.

In cases where more rigorous detection methods have been used, many more drug-exposed infants are identified. A 1989 study at a large Detroit hospital found that 600 drug-exposed infants (or 8 percent of total births) were identified when self-reported drug use by the mother was the basis for screening. However, a more sensitive test for detecting drug use found the incidence of drug-exposed infants at this hospital to be 42 percent, or nearly 3,000 births, in 1989.

DRUG-EXPOSED INFANTS HAVE MORE
HEALTH PROBLEMS AND HIGHER COSTS

In our review of medical records at these 10 hospitals, we also found that mothers of drug-exposed infants are more likely to receive little or no prenatal care. Their infants have significantly lower birth weights, are more likely to be born premature, and have longer and more complicated hospital stays.

During my recent visit to a neonatal intensive care unit in Boston, I personally observed the tragedy of infants suffering from the consequences of their mothers' drug addiction. These infants required the assistance of complex high-technology medicine to overcome the effects of drugs. Such treatment, and

the extended length of hospitalizations for many, translate into costly care, which is predominately paid for by public funds. In fact, our study revealed that charges for these infants were up to 4 times greater than those for nonexposed infants. Although the long-term physical effects of prenatal drug exposure are not well known, indications are that some of these infants will continue to need expensive medical care as they grow up.

IMPACT ON SOCIAL WELFARE

SYSTEM IS PROFOUND

In addition to the costly medical treatment, some infants remain in the hospital because their parents either are unwilling to care for them or they have been determined by child welfare authorities to be unfit to provide for their care. These "boarder babies" often are placed in foster care.

Through our medical records review, we found that a substantial proportion of drug-exposed infants did not go home from the hospital with their parents. Of the 4,000 infants we identified as drug exposed, 30 percent, or 1,200, were placed in foster care. The estimated yearly cost of foster care for these infants alone is \$7.2 million.

The infants who are discharged from the hospital with their drug-abusing parents are at risk of abuse and neglect. The child

protection agencies in the five cities in our survey all reported that they are investigating a growing number of child abuse and neglect cases due to substance abuse by the parents. These investigations often lead to foster care placement. Hospital officials are also seeing many children from drug-abusing families admitted and readmitted to their hospitals suffering from physical neglect or injury.

City and state officials we contacted told us that prenatal drug exposure and drug-abusing families are placing increasing demands on their social welfare systems. Although they perceived the problem to be growing, most could not provide statistics on the numbers of drug-related foster care placements. Officials in New York, however, estimate that 57 percent of foster care children come from families that allegedly are abusing drugs.

Because the estimated demand for foster care nationwide increased 29 percent from 1986 to 1989, there is concern as to whether the system can adequately respond to the needs of drug-abusing families. Specifically, problems have been identified with the availability of foster parents who are willing to accept children who have been exposed to drugs, the quality of foster care homes, and the lack of supportive health and social services to families who provide foster care to these children.

In addition to concerns about the safety and care of drug-exposed infants, many may also have long-term learning and developmental disabilities. Without intervention we would expect major problems in school and high dropout rates. The cost of helping these children overcome the effects of drug exposure will vary with the severity of disabilities.

We recently visited a pilot preschool program for mildly impaired drug-exposed children in Los Angeles. To minimize the effects of prenatal drug exposure, the program provides an enriched environment, smaller classrooms, and more direct attention to the children at an annual cost of \$17,000 per child. On the other end of the spectrum, the Florida Department of Health and Rehabilitative Services estimates that for drug-exposed children who show significant physiologic or neurologic impairment, total service costs to age 18 could be as high as \$750,000.

LACK OF DRUG TREATMENT AND PRENATAL
CARE IS CONTRIBUTING TO THE NUMBER
OF DRUG-EXPOSED INFANTS

To address the problems associated with the growing numbers of drug-exposed infants, pregnant women who use drugs need to be offered comprehensive treatment services. Recent studies have found that significant positive effects in the health of the infant can be achieved if the mother is able to stop drug use

during pregnancy. The risk of low birth weight and prematurity that often require expensive neonatal intensive care are minimized by treatment services and prenatal care.

However, in the five cities we visited, drug treatment services were either insufficient or inadequate to meet the demand for services for drug-addicted pregnant women. Many programs that provide services to women, including pregnant women, have long waiting lists. In fact, nationwide, drug treatment services are insufficient. A 1990 survey conducted by the National Association of State Alcohol and Drug Abuse Directors estimated that 280,000 pregnant women nationwide were in need of drug treatment, yet less than 11 percent of them received care.

In addition to insufficient treatment capacity, some programs deny services to women because they are pregnant. A survey of 78 drug treatment programs in New York City found that 54 percent of them denied treatment to pregnant women because of fear of legal liability. Drug treatment providers fear that certain treatments using medications and the lack of prenatal care or obstetrical services at the clinics may have adverse consequences on the fetus.

Other barriers to treatment exist. Pregnant addicted women told us that the lack of child care services often made it difficult for them to seek treatment. These women may also have additional

needs--such as parenting, education, and nutritional guidance-- that are not provided in most treatment programs. Another barrier to both drug treatment and prenatal care is the potential for criminal prosecution. The increasing fear of incarceration and of losing their children to foster care is discouraging pregnant women from seeking care.

Many health professionals believe comprehensive residential drug treatment that includes prenatal care services is the best approach to helping many women give up drug use during pregnancy. This also assures the developing infant the best chance of being born healthy. However, such programs are scarce. Massachusetts officials told us that the lack of residential treatment slots was a major problem. Only 15 residential slots are available to pregnant addicts statewide. California hospital officials reported a similar problem. When they are unable to place drug-addicted pregnant women in residential treatment, they resort to such options as battered women shelters or nursing homes.

MATTERS FOR CONSIDERATION

In conclusion, the increasing number of drug-exposed infants has become a serious health and social problem that calls for an urgent national response. Expanding drug treatment services might reduce the number of drug-exposed births and alleviate some of the

family dysfunction that is contributing to the growing number of child abuse and neglect cases and foster placement.

With additional federal funding, the large gap between the number of women who could benefit from drug treatment and the number of residential and outpatient slots available could be reduced.

If the Congress should decide to expand the current federal resource commitment to treatment for drug-addicted pregnant women, several options could be used. These include:

- Increasing the alcohol, drug abuse and mental health services (ADMS) block grant to the states in order to provide more federal support for drug treatment.
- Increasing the ADMS Women's Subsidy from 10 percent to assure that expanded treatment services under the block grant are targeted specifically to substance-abusing pregnant women.
- Creating a new categorical grant to provide comprehensive prenatal care and drug treatment services to substance-abusing pregnant women.

- Increasing funding of the Maternal and Child Health Services block grant specifically for substance-abuse treatment for pregnant women.

- Requiring states to include substance-abuse treatment as a part of the package of services available to pregnant women under Medicaid.

These options could require more funds initially, or funding could come from a realignment of the federal allocation for drug-supply-reduction and demand-reduction activities. We believe that this commitment of funds could save money in the long term as well as improve the lives of a future generation of children.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions you may have.