

EPIDEMIC OF HYPE

How hysteria over methamphetamine has become the latest excuse to “take the child and run.”

“A cohort of babies is now being born whose future is closed to them from day one. Theirs will be a life of certain suffering, of probable deviance, of permanent inferiority. At best, a menial life of severe deprivation. And all of this is being biologically determined from birth.”¹

If that sounds like something you just read about methamphetamine, that’s understandable. It certainly sounds like the apocalyptic quotes that have appeared in 2005 and 2006 everywhere from *The New York Times* to *Newsweek* to CBS and NBC News.

In fact, the quote dates back to 1989. Columnist Charles Krauthammer was writing not about methamphetamine, but about crack cocaine.

None of it was true.

More than two decades later, it is clear that the horrifying predictions about so-called “crack babies” were the result of hype and hysteria, not science and scholarship. Indeed, as the website *stats.org* concluded: Being labeled a “crack baby” appears to have done more harm to these children than the cocaine itself did.”² Another *stats.org* article on media meth myths is available here: <http://bit.ly/7T7Fln>³

But it wasn’t just the babies who were stereotyped and stigmatized. We were repeatedly told that crack was harder on children because of its special appeal to women. We were told that crack was so addictive that it stole these mothers’ material instinct. And we were told crack addiction was virtually untreatable.

None of it was true.

The false claims were used as an all-purpose justification for soaring numbers of foster care placements, by child welfare systems whose response to every problem can be boiled down to “take the child and run.” The label “crack addict” was thrown around with the same abandon as the label “crack baby,” and the assumption was that, since there was no hope for the mothers, the only alternative was foster-care for the children. Any time anyone questioned the high rate at which children were removed from their homes, the child welfare establishment blithely labeled every case a “crack case” and insisted there was no choice.

None of it was true.

Indeed, by October 2004, *Columbia Journalism Review* had published an article ending with a plea to journalists not to make the same mistakes with “meth” as they made with crack.⁴ But, it seems, few reporters listened. One need only substitute “crack” for “meth” and the recent crop of stories sound identical to their counterparts from the 1980s.

If anything, the term used for children this time is even more insidious: To call a child a “meth orphan” writes off both the child and his or her parents.

The problem is real, the solutions have been phony

There is something else that addiction to crack and meth have in common: Both are very serious, very real problems. Addiction to either substance requires intervention to ensure that children are safe. The issue is how to intervene. Sometimes there truly is

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no choice but to remove the children and place them in foster care. In other cases, children can be placed with extended family members. But in many other cases, there is another option that should be tried first: drug treatment, including inpatient programs where parents can remain with their children.

Meth addiction is treatable

A review of the literature by Prof. Richard Rawson, Associate Director of Integrated Substance Abuse Programs at UCLA's David Geffen School of Medicine, concludes that addiction to methamphetamine is just as treatable as addiction to cocaine. Furthermore, it takes no longer to treat meth addiction than to treat any other drug addiction.⁵

And Dr. Rawson is not alone in his assessment.

His assessment that meth is just as treatable and takes no longer to treat is confirmed by a Washington State study. The title says it all: Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug.⁶ (If clicking on this link: <http://bit.ly/6paRyG> leads to a password request, click "cancel" and you'll still be able to see the document).

According to a letter signed by 93 medical doctors, scientists, researchers in psychology and treatment specialists:

*"[C]laims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and re-incarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems. Research also suggests the need to improve and expand treatment offered to methamphetamine users."*⁷

Further evidence comes from a county often identified in media accounts as hard-hit by meth, Sacramento County, California. According to the federal government's National Center on Substance Abuse and Child Welfare, the county developed a comprehensive approach to such cases, emphasizing treatment. Between 1998 and 2004, the number of children taken from their parents actually has declined by more than one-third.⁸ The emphasis on treatment has reduced the length of time in foster care for children who must be removed from their homes. And the county actually is getting better treatment results for parents addicted to meth than for those using cocaine or heroin.⁹

The notion that there is no point in trying drug treatment in meth cases because it won't work or it takes too long is one more meth myth.

Why bother with treatment?

But why bother? Why bother helping a parent who is addicted to meth? Here again, there are lessons from crack.

University of Florida researchers studied two groups of infants born with cocaine in their systems. One group was placed in foster care, the other with birth mothers able to care for them. After six months, the babies were tested using all the usual measures of infant development: rolling over, sitting up, reaching out. Consistently, the children placed with their birth mothers did better. For the foster children, being taken from their mothers was more toxic than the cocaine.¹⁰

Still another study looked at foster care "alumni." Among the conclusions:

- Alumni of foster care suffer Post Traumatic Stress Disorder at a rate more than double the rate for Gulf War Veterans.

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- At least one-third said they were abused by a foster parent or another adult in a foster home. (The study didn't even ask about one of the most common sources of abuse in foster care, foster children abusing each other, so the real figure almost certainly is higher).

- Only 20 percent of the alumni could be said to be doing well.¹¹ (For more on this study, see NCCPR's analysis, *80 Percent Failure*, available at www.nccpr.info.)

It is extremely difficult to take a swing at "bad mothers" without the blow landing on their children. If we really believe all the rhetoric about putting the needs of children first, then we need to put those needs ahead of everything – including how we may feel about their parents. That doesn't mean we can simply leave children with addicts. It does mean that drug treatment for the parent is almost always a better first choice than foster care for the child -- because it is urgent to save children from people in the grip of another addiction: an addiction to foster care so powerful that they would throw children far too easily into a system that churns out walking wounded four times out of five.

Statistics abuse

Estimates of the number of cases in which drugs in general or any drug in particular are "involved" in child welfare cases are just guesses – a caseworker checks a box on a form because she thinks maybe there are drugs involved in some way; a supervisor guesses how often that box has been checked on the form, the p.r. person for the child welfare agency guesses how often supervisors have told him they're seeing the box checked on the form. And everyone has an incentive to guess high – since it's considered an automatic justification for tearing a child from everyone loving and familiar.

It's no wonder that estimates for the proportion of cases involving any drug, range from 20 percent to 90 percent.

The term "involved" contributes to the hype.

Consider a case profiled in a thoughtful, careful way by the *Portland Oregonian*. The mother used meth, but was in outpatient treatment and doing well. The father was not accused of drug use at all. The child was in foster care because there was no inpatient drug treatment facility in the local community for the mother, and because of child welfare systems' pervasive bias against fathers.¹²

Yet, for statistical purposes, this is a "meth case." And when child welfare agencies claim that a huge percentage of their cases "involve" meth use, that includes cases like this one.

The problem is compounded when organizations lobbying for more funding get into the mix. Many news accounts still accept at face value a stacked-deck survey from the National Association of Counties. Among the claims repeated over and over again: 71 percent of the counties surveyed in California reported an increase in foster care because of meth. But only reporters who looked at the fine print would discover that only seven of California's 58 counties were surveyed.¹³

But what about the labs?

Unlike crack cocaine, methamphetamine can be manufactured in home labs – and almost every news account emphasizes the labs and children taken from those labs. But such cases represent only a tiny fraction of "meth cases."

Between 2000 and 2003, child protective services agencies removed children from their parents 1,188,000 times.¹⁴ During that same time period, 10,580 children were found to be "affected" by methamphetamine manufacture, with 4,662 living in labs

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and 2,881 of them placed in foster care.¹⁵ (Many of the others probably were placed informally with relatives).

In other words, of all the entries into foster care from 2000 to 2003, *at least* 99.1 percent of them had nothing to do with meth labs.

Even in Oregon, the substance abuse program manager for the state child welfare agency says that "...the number of times that [child protective] workers confronted actual manufacturing was rare in their practice compared to the number of families affected by methamphetamine abuse and dependence."¹⁶

Some states respond better than others

Oregon is one state that has been hard hit by meth. But, unfortunately, like other states, such as Iowa and Colorado, Oregon also is a state addicted to excuses.

- Oregon took away children, proportionately, at one of the highest rates in the country as far back as 1985.¹⁷ Why were so many children being taken then, long before any "meth epidemic"?

- Oregon, Iowa, and Colorado all take away children at a rate significantly higher than California – long another state known for having a serious meth problem.¹⁸

- Alabama has a serious meth problem – and it's had an impact on the foster care population, with increases in removals in recent years. But before meth hit, Alabama was hit by a class-action lawsuit requiring the state to thoroughly reform its system to emphasize family preservation. As a result, Alabama gained years of experience in safely keeping children out of foster care, making it better able to handle the influx of meth cases. So today, despite meth, Alabama still takes away children at one of the lowest rates in the nation. At the same time, re-abuse of children left in their own homes has been cut by 60 percent – to less than half the national average¹⁹ – and, an independent court monitor has found that, as a result of the reforms, child safety has improved.²⁰

- Illinois also has a meth problem. Yet Illinois removes children at a rate even lower than Alabama, and, again, independent court-appointed monitors say as foster care has been reduced, child safety has improved.²¹

And as noted above, by emphasizing treatment, Sacramento County, California has been able to cope with a serious meth problem while reducing entries into foster care.

A good child welfare system does such a good job of keeping other children safely in their own homes, that when a new drug becomes the scourge of the state, the system can handle it.

A political agenda

Hysteria over drugs has always been fueled by those with a vested interest in taking away children, and the current wave of meth stories is no exception.

In part, there is a political motivation behind the false claims about meth. The federal government wants to allow states to use billions of dollars now reserved for foster care for various prevention programs, including drug treatment. But the child welfare establishment wants to hoard the money for foster care.

Not only can this money be used only for foster care, the funding is fueled by child removal. For every eligible child they put into foster care, states get from 50 to 83 cents back on the dollar for foster care costs.

The child welfare establishment wants us to believe that methamphetamine is virtually untreatable because they want us to believe the only option for the children is

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foster care. They want us to believe the only option is foster care in order to justify their demand that those billions of dollars be reserved for foster care, and nothing else.

Indeed, the campaign against making foster care funding flexible has been led by the Child Welfare League of America, the trade association for public and private agencies. Most private agencies are paid for each day they hold a child in foster care. Anything that threatens to close the “open spigot” of federal foster care aid threatens the ability of states to keep doling out *per diem* payments to private agencies for endless foster care. That threatens the private agencies’ existence.

And that’s why the biggest addiction problem in child welfare is neither meth nor crack nor any other drug. The biggest addiction problem in child welfare is great big, prestigious, mainstream private child welfare agencies with blue-chip boards of directors that are *addicted* to their *per diem* payments for holding children in foster care.

And they’re putting their addiction ahead of the children.

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¹ Cited in Kendra Hurley, “The Crack Legacy: Ditch the low expectations for ‘meth babies’” *Newsday*, April 14, 2004.

² Maia Szalavitz, “The Media Go Into ‘Crack Baby’ Mode Over Meth,” *Stats.org*, August, 2005.

³ Maia Szalavitz, “The Media’s Meth Mania,” *stats.org*, August 04, 2005

⁴ Mariah Blake, “The Damage Done: Crack Babies Talk Back,” *Columbia Journalism Review*, September/October 2004.

⁵ Richard A. Rawson, Ph.D., *Challenges in Responding to the Spread of Methamphetamine Use in the US: Recommendations Concerning the Treatment of Individuals with Methamphetamine-Related Disorders* (Los Angeles: UCLA Integrated Substance Abuse Programs, David Geffen School of Medicine).

⁶ Bill Luchansky, Ph. D., *Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug*, Olympia, WA: Looking Glass Analytics, December 2003

⁷ The letter was distributed by National Advocates for Pregnant Women. Copies are available from NCCPR.

⁸ Nancy K. Young, Director, National Center on Substance Abuse and Child Welfare, *Fighting Meth in America’s Heartland: Assessing the Impact on Local Law Enforcement and Child Welfare Agencies*, statement to the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources, July 26, 2005, p.4., available online at <http://reform.house.gov/UploadedFiles/Nancy%20Young%20Testimony.pdf>

⁹ *Ibid*, pp. 15-18.

¹⁰ Kathleen Wobie, Marylou Behnke et. al., *To Have and To Hold: A Descriptive Study of Custody Status Following Prenatal Exposure to Cocaine*, paper presented at joint annual meeting of the American Pediatric Society and the Society for Pediatric Research, May 3, 1998.

¹¹ Peter Pecora, et. al., *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study* (Seattle: Casey Family Programs, 2005).

¹² Bryan Denson, Emily Tsao and Lori Tobias, “Meth or Motherhood,” *Portland Oregonian*, March 27, 2005.

¹³ National Association of Counties, *The Meth Epidemic in America: Two Surveys of Counties*, July 2005.

¹⁴ U.S. Department of Health and Human Services, Trends in Foster Care and Adoption, chart, available at http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars_stats.htm

¹⁵ Young, note 6, supra, p.12.

¹⁶ Cited in Young, note 6, supra, p.11.

¹⁷ U.S. Department of Health and Human Services, Administration for Children, Youth and Families, *Child Welfare Statistical Fact Book, 1985: Substitute Care*. (Washington, DC: Maximus, Inc.), pp. I-7 to I-11

¹⁸ NCCPR compares rates of child removal by dividing the number of children taken away over the course of a year in each state by the total number of impoverished children in each state.

¹⁹ Erik Eckholm, “Once Woeful, Alabama Is Model in Child Welfare,” *The New York Times*, August 20, 2005.

²⁰ Ivor D. Groves, *System of Care Implementation: Performance, Outcomes, and Compliance*, March, 1996, Exec. Summary, p.3.

²¹ Matthew Franck, “The Pendulum,” *St. Louis Post-Dispatch*, February 1, 2005.