Figure. National Trends in Foster Care Entries Attributable to Parental Drug Use, 2000 to 2017

After more than a decade of declines in the foster care caseload in the United States, cases have risen steadily since 2012.1 Between 2012 and 2017, the number of children living in foster care and entering care increased by 12% and 8%, respectively.1 One proposed explanation for this recent growth is the opioid epidemic, but supporting evidence is scarce.2,3 In this exploratory study, we examine trends in the number of children entering foster care because of parental drug use and describe changes in their characteristics over time.

Methods | We analyzed data from the Adoption and Foster Care Analysis and Reporting System, a federally mandated data collection system that receives case-level information on all children in foster care in the United States. The database includes information on child demographic characteristics, health status, geographic area, and home removal reason (ie, physical/sexual abuse, neglect, child disability/behavior problems, child alcohol/drug use, parental alcohol/drug use, death, incarceration, inability to cope, abandonment, relinquishment, or inadequate housing). Data were deidentified, and this study did not meet Weill Cornell Medicine institutional review board’s definition of human subjects research.

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We identified entries of children in foster care during fiscal years 2000 to 2017 and stratified the sample based on home removals attributable to parental drug use, defined as the principal caretaker’s recurrent and lasting use of drugs. The number of entries is not synonymous with the number of children because children may enter foster care more than once. We calculated national trends of the number and proportion of foster care entries because of parental drug use and reported children characteristics at different time intervals for this population. Characteristics of children entering care for other reasons were reported for comparison. Analyses were conducted using Stata version 15 (StataCorp).

Results | There were 4,972,911 foster care entries between fiscal years 2000 and 2017 (October 1, 1999, to September 30, 2017), 1,162,668 (23.38%) of which were home removals attributable to parental drug use. The number and proportion of entries attributable to parental drug use rose dramatically and steadily during this period, from 39,130 of 269,382 removals (14.53%) in 2000 to 96,672 of 266,583 removals (36.26%) in 2017 (Figure).
Compared with children entering care for other reasons, children entering because of parental drug use were more likely to be 5 years or younger (1,441,741 of 3,653,562 removals [39.65%] vs 699,340 of 1,162,448 removals [60.16%]), white (1,597,066 of 3,524,011 removals [45.32%] vs 616,153 of 1,131,294 removals [54.46%]), and from the southern region of the United States (1,119,679 of 3,636,177 removals [30.79%] vs 519,988 of 1,162,668 removals [44.72%]) (Table). The characteristics of children entering care because of parental drug use changed over time. Notably, between fiscal years 2000 to 2005 and 2012 to 2017, the proportion of children who were white (2000-2005, 148,780 of 291,017 removals [51.12%] vs 2012-2017, 276,296 of 480,012 removals [57.56%]), from the Midwest (2000-2005, 56,734 of 300,633 removals [18.87%] vs 2012-2017, 124,535 of 492,209 removals [25.30%]), and in nonmetropolitan areas (2000-2005, 30,971 of 169,132 removals [18.31%] vs 2012-2017, 120,984 of 492,195 removals [24.58%]) increased. These patterns were not observed among children entering care for other reasons.

Discussion | The number of foster care entries attributable to parental drug use increased substantially from 2000 to 2017 (from 39,130 to 96,672 removals, an increase of 57,542 removals [147.05%]), even when entries for other removal reasons mostly declined. These findings suggest that greater parental drug use has contributed to increases in foster care caseloads and coincide with increasing trends in opioid use and overdose deaths nationwide during this period.

Foster care placement generally implies that a child has faced abuse or neglect. Adverse childhood experiences, such as abuse, neglect, or having a parent who uses drugs, increase the risk of chronic health conditions and other poor outcomes across the lifespan.4 Additionally, when children enter foster care because of parental drug use, episode duration is longer and less likely to result in reunification with the parent.5 This is of special concern because of the large proportion of children experiencing entry before age 5 years, a critical period for forming stable attachments.

Limitations of this study include potential reporting inconsistencies in parental drug use. Moreover, it is possible that factors other than drug use influenced entries for parental drug use.

Policy makers must ensure that the needs of this new wave of children entering foster care because of parental drug use are being met through high-quality foster care interventions. These have been shown to mitigate some of the adverse effects of early childhood deprivation and disruptions in attachment.6

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Correction: This article was corrected on August 19, 2019, to fix 2 labels switched in the Figure. The label “Entries owing to parental drug use” was positioned over the line that indicated the proportion of foster care entries owing to parental drug use, and the label “Proportion of entries owing to parental drug use” was positioned over the line indicating the total number of foster care entries owing to parental drug use. The labels have been moved to the correct positions.

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Acquisition, analysis, or interpretation of data: All authors.

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Association of Sleep Problems and Melatonin Use in School-aged Children

Sleep problems are reported in 25% of children and adolescents.1 Melatonin is available in many countries without a prescription and is often considered a pharmacologic strategy to treat sleep problems. However, no clinical guidelines are available, and effectiveness and long-term effects of melatonin use in children are largely unknown.1 Melatonin use has been estimated to be 1% in healthy children. Little is known about the association of objectively measured sleep with melatonin use in this population. We investigated melatonin use in school-aged children and its association with subjective sleep and objectively estimated sleep parameters.