Testimony of

Nancy K. Young, Ph.D.
Director, Children and Family Futures, Inc.
National Center on Substance Abuse and Child Welfare

Before the United States Senate
Committee on Finance

The Social and Economic Effects of the Methamphetamine Epidemic on America's Child Welfare System

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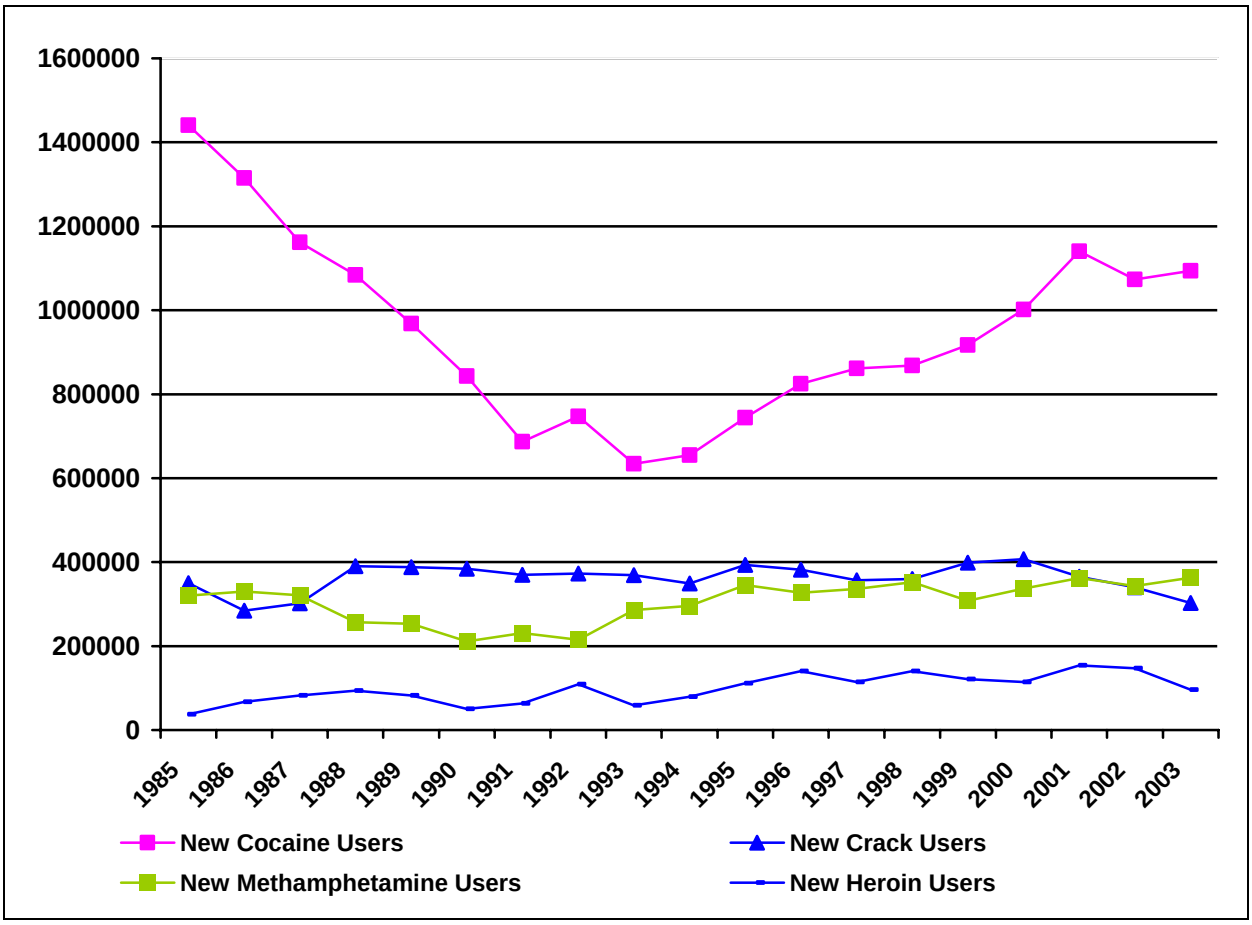
Children and Family Futures, Inc.
4940 Irvine Boulevard, Suite 202
Irvine, CA 92620
714-505-3525
www.cffutures.org

Summary Charts for Oral Testimony

Chart 1: Number of Persons over Age 12 who first used Specific Substances in the Prior Year[1]

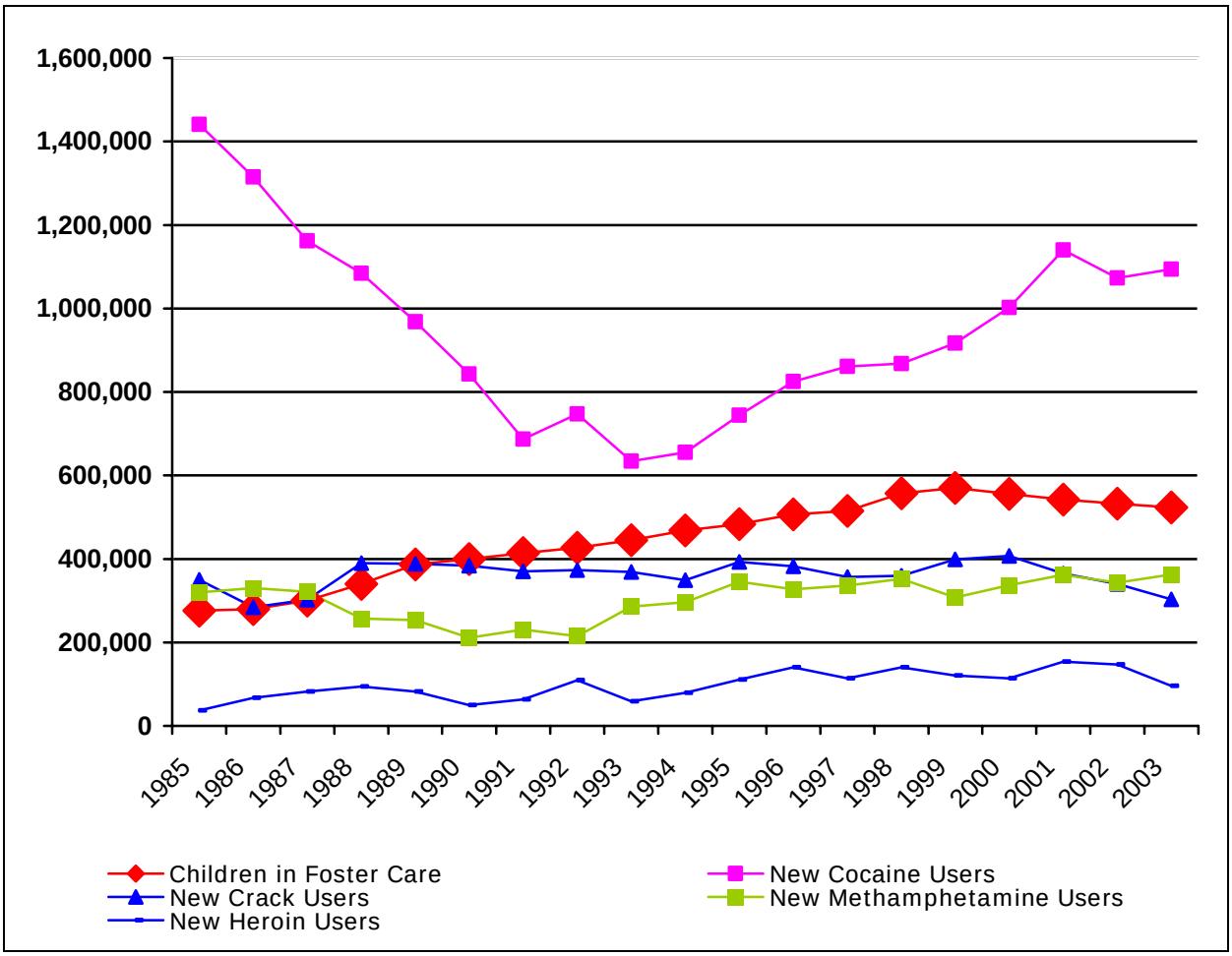


It is important to monitor trends in the new users of specific substances, those that begin using a substance in a given year, as they are a leading indicator of drug use trends and the data can suggest future trends of substance-related health, social and economic consequences for the nation.

The annual number of new users of methamphetamine has increased by 72% over the past decade. New methamphetamine users exceeded the number of new crack users for the first time in 2003 since the mid 1980s.

However, since the early 1990s new cocaine users have also increased; since 1993 there has been a similar rate of increase (73%) in new cocaine users with a total of 1.1 million in 2003. New marijuana users increased between 1990 and 2001 by 88% and in the prior last two years reported in the National Survey on Drug Use and Health.

Chart 2: Number of Persons over Age 12 who first used Specific Substances in the Prior Year and the Number of Children in Out of Home Care on the Last Day of Each Fiscal Year[2]

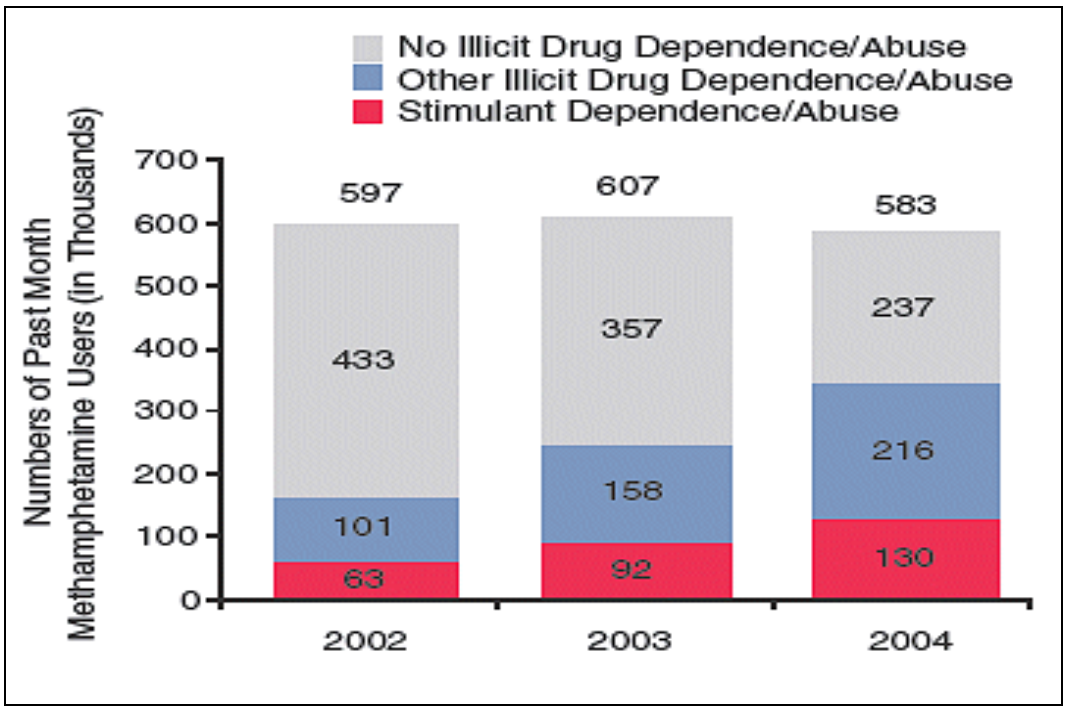


The bold red line in the same chart shows the number of children in out-of-home care on the last day of each fiscal year.

While the number of methamphetamine, cocaine and marijuana users (not shown in this graph) has been increasing, the number of children in out of home placements has been steadily declining since its high point of nearly 600,000 children in 1999.

These data begin to show that the connection between parents with substance use disorders and child abuse and neglect are extremely complex. Variations across States and local jurisdictions regarding policies and practices as well as access to appropriate resources for families suggest that it is not solely the use of a specific substance that affects the child welfare system. Rather, a complex relationship between the substance use pattern, knowledge and skills of workers and access to health and social supports for families is imperative.

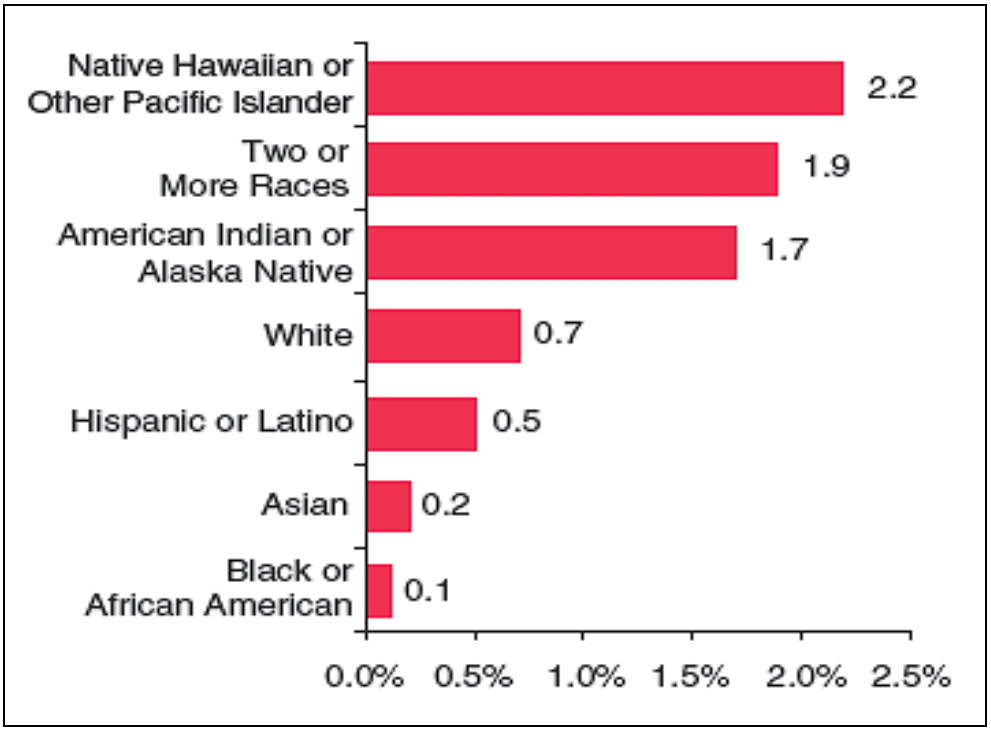
Chart 3: Methamphetamine Use in Past Month among Persons Aged 12 or Older, by Dependence and Abuse: 2002, 2003, and 2004[3]



This chart shows that persons who are "current methamphetamine users" (e.g., they used the substance in the prior month) are increasingly suffering adverse consequences and increasingly meet clinical criteria for substance abuse or dependence.

The number of persons meeting clinical criteria of methamphetamine abuse or dependence doubled between 2002 and 2004 from 164,000 persons to 346,000. The increased need for access to treatment resources for persons with methamphetamine abuse or dependence may continue for the next several years as the number of new users of methamphetamine continues to rise.

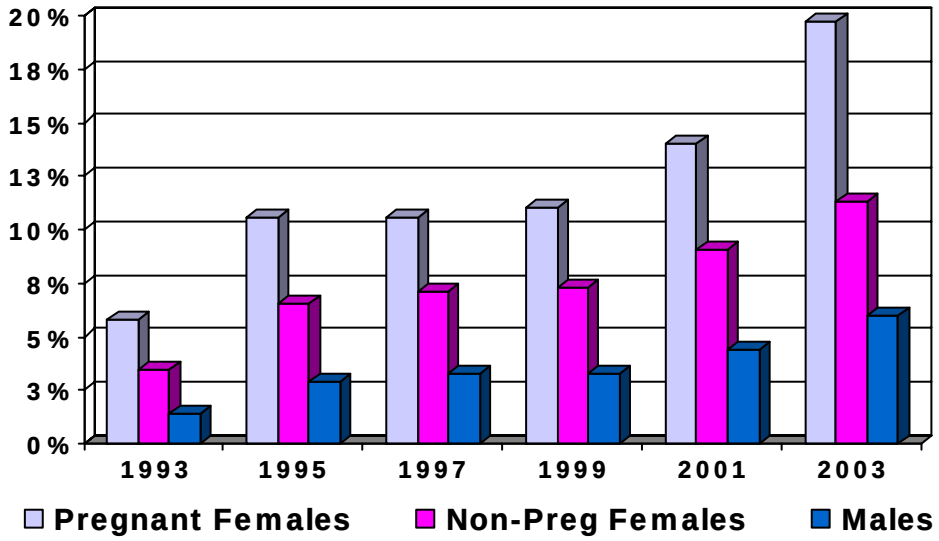
Chart 4: Methamphetamine Use in Past Year among Persons Aged 12 or Older, by Race/Ethnicity: 2002, 2003, and 2004[4]



There are important distinctions among racial and ethnic groups in regard to groups who are using methamphetamine. America's native populations, Hawaiians and Native Americas use methamphetamine at two to three times the rate of Caucasians and African Americans are using methamphetamine at the lowest rate.

These use patterns are very different than the use patterns we experienced in the crack epidemics of the late 1980s and early 1990s. These different use patterns among geographic areas of the country, among racial and ethnic groups and among women are challenging communities to respond. The challenge seems to be experienced most critically among those communities that may have not had experience with stimulant users during the cocaine and crack epidemic.

Chart 5: Methamphetamines as Primary Substance by Gender and Pregnancy Status: 1993-2003 (Percent of Total Admissions)



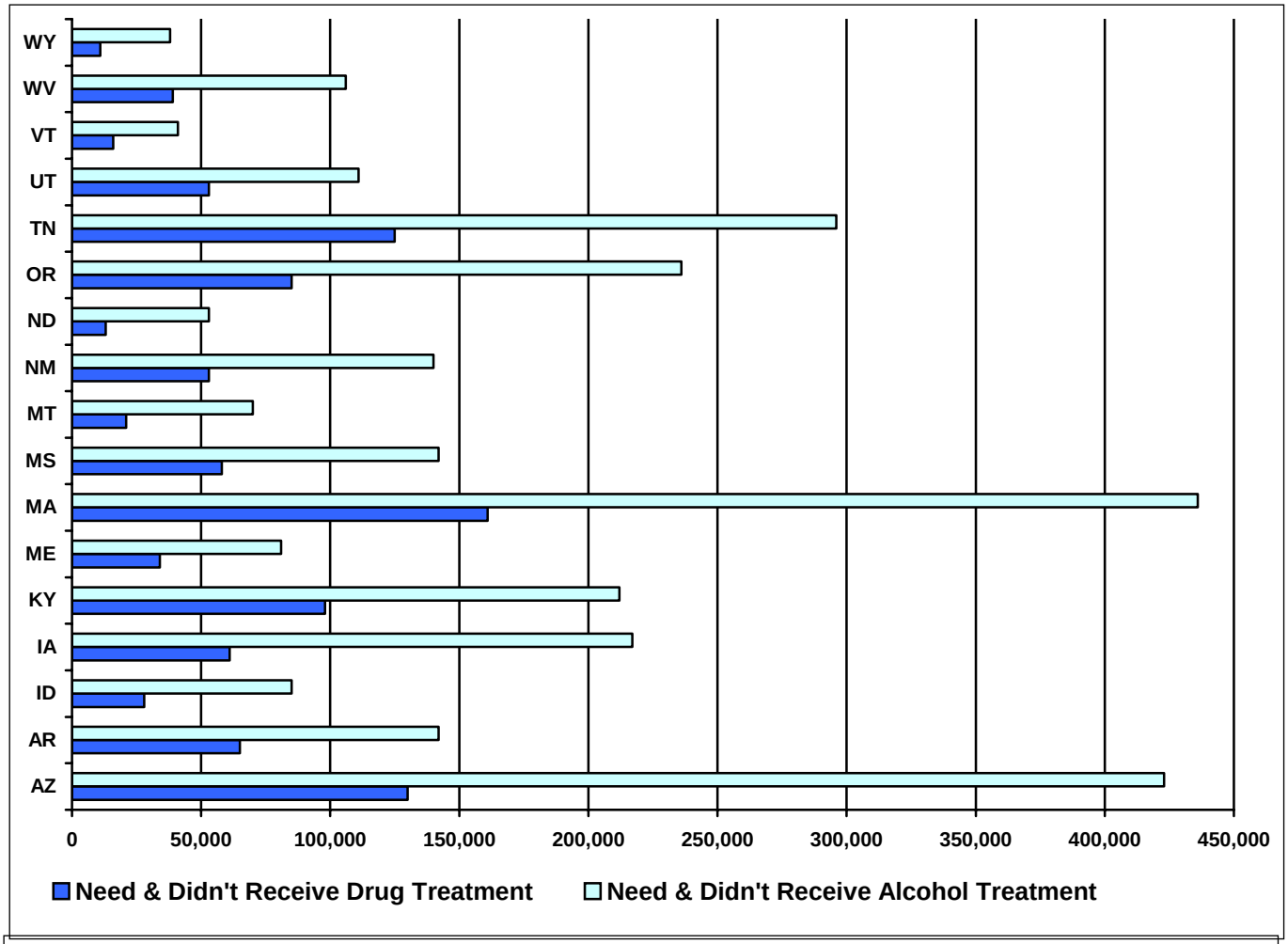
While overall treatment admissions for primary methamphetamine problems are increasing, they are increasing at the fastest rate among pregnant women.

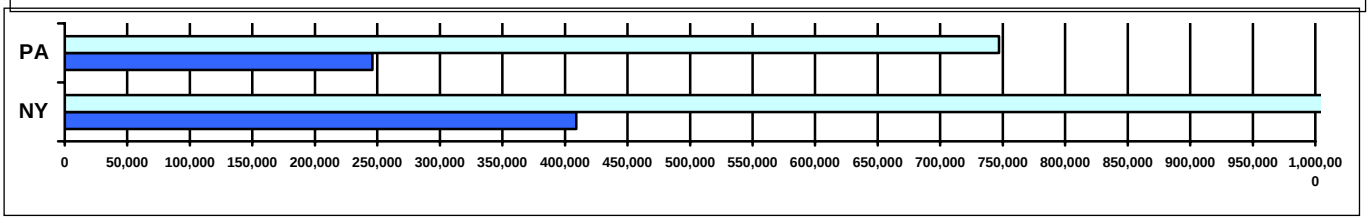
At the same time, as reported in the written testimony document, we have seen a decrease in the number of treatment programs that provide specialty services for pregnant and post-partum women.

Estimated Total for United States – 2003, 2004

- Needed and didn't receive drug treatment – 6.43 million
- Abused or were dependent on any illicit drug – 7.1 million
- Needed and didn't receive alcohol treatment – 17.37 million
- Abused or were dependent on alcohol – 22.0 million

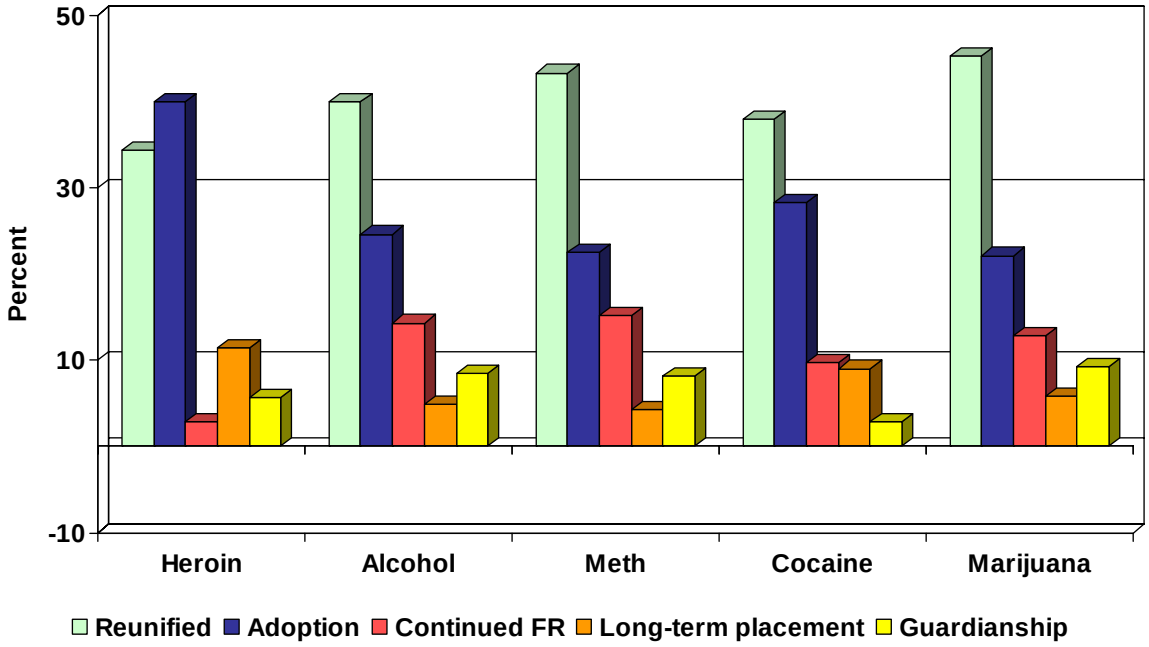
Chart 6: The number of persons in the States represented by members of the Senate Finance Committee who needed but did not receive treatment[5]





The unmet need for substance abuse treatment across the nation is profound. The Senators on the Finance Committee collectively represent about 1.7 million persons who need treatment for drug abuse and 4.9 million persons who need treatment for alcohol abuse.

Chart 7: Sacramento County, California Child Place Outcomes resulting from Comprehensive Services Reforms



Despite the challenges our communities are experiencing, there are models of successful collaboration and programming in many jurisdictions. Sacramento County has implemented several key system reforms over the past dozen years and is achieving significant outcomes for families and cost savings for the county. This graph shows that parents with primary methamphetamine problems (over half of the cases) reunified with their children at rates similar to parents with other primary substances of abuse.

Summary Points from Written Testimony

Monitoring Methamphetamine Use, Dependence and Need for Treatment

The data from the nation's monitoring systems for methamphetamine use disorders and the need for treatment are summarized as follows:

New Users

- The annual number of persons who are new users of methamphetamine (363,000) has increased over the past decade and currently slightly exceeds the number of new users of crack (303,000)
- There has been an annual increase in new users of cocaine (1.1 million) since the mid 1990s, and increases in new users of marijuana (2.4 million) since the early 1990s

Current Users

- The number of persons who used methamphetamine in the past year and in the past month has remained relatively stable over the past few years
- There are profound regional differences in the number of persons using methamphetamine
- The number of current cocaine users is approximately three and a half times greater (2.1 million) than the number of current methamphetamine users (600,000)

Methamphetamine Users who Met Criteria for Substance Use or Dependence

- The percentage of current methamphetamine users who met criteria for substance abuse or dependence doubled between 2002 (27.5%) and 2004 (59.3%)

Treatment Admissions for Primary Methamphetamine Use Disorders

- Admissions to the publicly-funded treatment system for primary methamphetamine use disorders represent 7% of all treatment admissions
- There has been a 373% increase in treatment admissions for stimulant disorders
- While overall treatment admissions increased by 14% between 1993 and 2003 (1.618 million to 1.842 million), admissions for person with stimulant disorders increased from 28,900 in 1993 to nearly 137,000 in 2003

Unmet Need for Substance Abuse Treatment in the United States

- The vast majority of persons who need treatment for substance use disorders do not receive it
- Nearly six and half million persons who needed treatment for drug problems did not receive it in 2002/2003

- Over seventeen million persons who needed treatment for alcohol problems did not receive it

Current trends in the number of children who are victims of child abuse or neglect and those who are placed in protective custody

- The total number of children in out-of-home care doubled over 15 years from approximately 276,000 children in 1985 to a high of 565,000 in 1999
- The most rapid increase was between 1986 and 1992 with a 50% increase
- Since 1999, the caseload of children in out-of-home care has continued to decline to an estimated 518,000 children at the end of fiscal year 2004
- The decrease in children in care is largely due to increased numbers of children exiting care each year
- The decrease of children in care is also seen in many of the large states such as California, which has been heavily impacted by methamphetamine, and in Illinois, which has not experienced a rapid increase in methamphetamine use
- The caseload data of children in out-of-home care varies by State and County based on local practice and policies

The impact of parental substance use disorders on child welfare agencies and the specific impact of methamphetamine

- In a study of the prevalence of substance abuse and dependence in a representative sample of "in-home" cases, a lower level of prevalence was found than had previously been reported by multiple sources
- However, in this study, case workers mis-identified caregivers with substance use disorders most of the time
- Studies of cases in which children have been removed generally report two-thirds to three-quarters of cases are affected by parental substance use

Children are affected by parents with substance use disorders in many ways

- Many more children are affected by parents who use, abuse, and are dependent on methamphetamine than are affected by manufacturing activities
- It is important for child welfare workers to understand which group of children they are working with and to include screening and assessment for substance use in the child risk and safety assessments
- Screening and assessment practices are still inadequate to detect most of the prenatal and post-natal substance use affecting children in the child welfare system.
- In communities with know high prevalence of methamphetamine use, approximately 5% of babies were identified as exposed to methamphetamine during pregnancy
- The majority of babies exposed to methamphetamine in the prenatal period are also exposed to alcohol and tobacco; alcohol is a known to cause neuro developmental effects and the deleterious effects of tobacco use during pregnancy are well documented

- Youth who had ever been placed in foster care have higher rates of substance use and need for alcohol and drug treatment than do youth who have never been in care

Methamphetamine users differ from users of other substances

- Treatment admissions for methamphetamine represent a small yet growing group among those entering treatment in most areas of the country
- The impact of methamphetamine is experienced disproportionately by America's Native populations; Native Hawaiians and Native Americans are using the substance at higher rates than other ethnic and racial groups
- Women are also disproportionately affected by methamphetamine; the gender ratio of treatment admissions for all substances is 1 woman for every 3 men, while for methamphetamine, the ratio is 1 woman for every man
- Women's admission rates in various States reflect the regional differences in methamphetamine use
- Young girls represent 70% of all treatment admissions for methamphetamine among 12- to 14-year-olds
- While cocaine use has increased in the general population, pregnant women entering treatment are increasingly reporting methamphetamine as their primary substance of abuse
- The percentage of treatment programs with specialty services for pregnant and post-partum women has decreased in the past few years

The unique characteristics of women methamphetamine users pose new challenges to substance abuse treatment and child welfare organizations

- There are critical differences between women and men with regard to methamphetamine use patterns and co-occurring disorders
- These gender differences should be addressed in specialty programs that address the whole family's needs
- Women with methamphetamine use disorders are highly likely to have been victims of childhood physical or sexual abuse
- Addressing the mental health and trauma specific services in substance abuse programming is critical

Methamphetamine treatment outcomes for women

- Treatment for women with methamphetamine problems has been as effective as treatment for other substances of abuse
- In a sample of women followed for 4 years, 30% of women remained continuously abstinent from methamphetamine use for the entire 48 months

Models of effective child welfare and substance abuse services

- Comprehensive models of substance abuse, child welfare and the courts working together have been developed in many communities across the country
- In Sacramento County where efforts have been underway for nearly a dozen years, comprehensive reforms have led to significant differences for families
- In comparison to families who received services before the system reform efforts:
    - More parents are completing substance abuse treatment
    - More children are being reunified
    - Children are spending less time in out-of-home care
    - Children are reaching permanent homes faster
- These outcomes did not vary by primary drug problem

What Can Be Done

1. Identify the problem: improve our information systems

- We need to collect better information on methamphetamine use from both the substance abuse treatment system and the child welfare system, and put their information together so that we know about parents and caretakers who are in both systems.
- Substance abuse information needs to be a component of the Child and Family Services Review system—the primary tool for Federal review of State outcomes in child welfare.
- Substance abuse treatment agencies need to collect data about the children of parents seeking services.
- We need to collect data from hospitals and the maternal and child health systems about the prenatal and at-birth screening they conduct.

2. Improve our interventions for children

- We need earlier diagnosis and intervention with children affected by the prenatal and post-natal effects of their parents' methamphetamine use.
- We need evidence-based prevention programs for children who are in the child welfare system and are children of substance abusers; these children are several times more likely than other children to become substance abusers.

3. Improve and increase the availability of staff training in the child welfare and substance abuse treatment systems

- We need to continue to invest in better training for child welfare workers and court staff so that they can recognize the problems of methamphetamine use and other substance use among families and ensure timely access to services.

- We need to invest in better training for substance abuse prevention and treatment workers so that they can respond with effective treatment strategies for all persons in need of treatment for substance use disorders and be better equipped to work with families.

4. Provide timely access to comprehensive substance abuse treatment

- Most critically, the need for access to substance abuse treatment cannot be over emphasized. When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the–art, comprehensive, meets the needs of the entire family, and most importantly, to meet the intent of the Adoption and Safe Families Act, we must make sure that the treatment is **available and timely**.

Written Statement of
Nancy K. Young, Ph.D.

Chairman Grassley, Ranking Member Baucus and Members of the Committee, thank you for the opportunity to appear before you today to discuss the problem of methamphetamine in America and specifically its effect on child welfare services.

I am the Director of Children and Family Futures, Inc. (CFF), a non-profit policy research firm based in Irvine, California. For the past ten years we have worked on public policy issues regarding children affected by substance use disorders in their families. Our work is primarily focused on children in the welfare and child welfare systems. In addition, in 1994 my husband and I became foster and then adoptive parents to two children who embody many of the issues confronting children of parents with substance use disorders who have been abused or neglected. So I am also speaking as an adoptive mother of children affected by these issues.

In 2002, Children and Family Futures was awarded a competitive contract from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to develop and implement the National Center on Substance Abuse and Child Welfare (NCSACW). NCSACW is funded by both the Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect and SAMHSA and we work with both agencies. However, my testimony today represents my own views and not those of the Federal agencies.

There are nine topics I will address in this statement, including a list of suggested actions:

1. The data on the prevalence of methamphetamine use and the number of persons who need treatment for methamphetamine;

2. The data on the number of children who are victims of child abuse or neglect and those who are placed in protective custody;

3. The impact of parental substance use disorders on child welfare agencies and the specific impact of methamphetamine;

4. The ways that children are affected by parents with methamphetamine and other substance use disorders;

5. The unique characteristics of methamphetamine use that pose new challenges to child welfare organizations;

6. The data regarding the effectiveness of treatment for women with methamphetamine use disorders;

7. Models of effective child welfare and substance abuse services; and

8. Recommendations for action – what we can do to address these issues.

1. Monitoring methamphetamine use, dependence and need for treatment

There are several ways in which the impact of methamphetamine is monitored across the country. We monitor:

1. New users of methamphetamine – a leading indicator of use and epidemics
2. Current users of methamphetamine – those who report use in the past year or prior 30 days
3. Persons who meet criteria of methamphetamine abuse or dependence – and the related measure of those needing treatment
4. Treatment admissions for methamphetamine – indicating those who are experiencing negative consequences of use and have sought treatment in the nation's publicly funded substance abuse treatment programs
5. The need for treatment for substance use disorders

I will discuss each of these data sources and comparisons to other drugs of abuse that are frequently seen among parents in the child welfare system. In the next section, I will compare this data with the data about the number of children who have come to the attention of the nation's child welfare agencies as victims of child abuse or neglect.

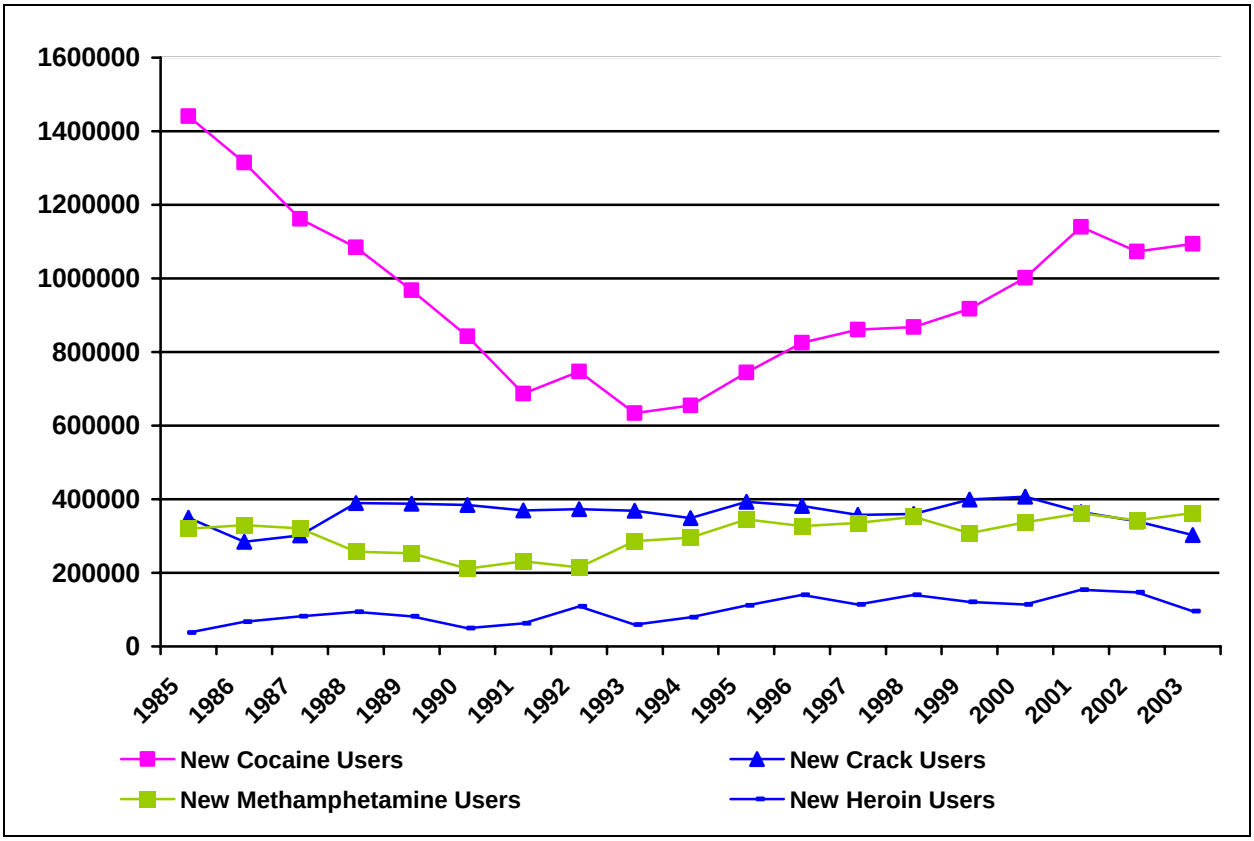
New Users of Methamphetamine[*]

Monitoring new initiates to substance use is a way to assess drug use trends and emerging substances of abuse. As shown in Figure 1 on the following page, the estimated number of annual new methamphetamine users has increased over the past decade from a low of 211,000 persons in 1990 to 363,000 persons in 2003—a 72% increase. New users of methamphetamine exceeded new crack users in 2002 for the first time since the late 1980s. In 2003, there were an estimated 303,000 persons who began using crack. These numbers are alarming; yet they are overshadowed by the number of persons who first used cocaine in the same year (approximately 1.1 million—a 73% increase over its lowest point in 1993).

Marijuana use has also increased over the past decade; the number of persons who initiated marijuana use increased by 88% between 1990 and 2001. There were 2.4 million new marijuana users in that year—an all time high number. Between 2001 and 2003, there has been a 12% decrease in the number of new marijuana users.

[*] Methamphetamine use as recorded by SAMHSA's National Survey on Drug Use and Health includes both prescription preparations (i.e., Desoxyn® and Methedrine) and non-prescription/illicit methamphetamine.

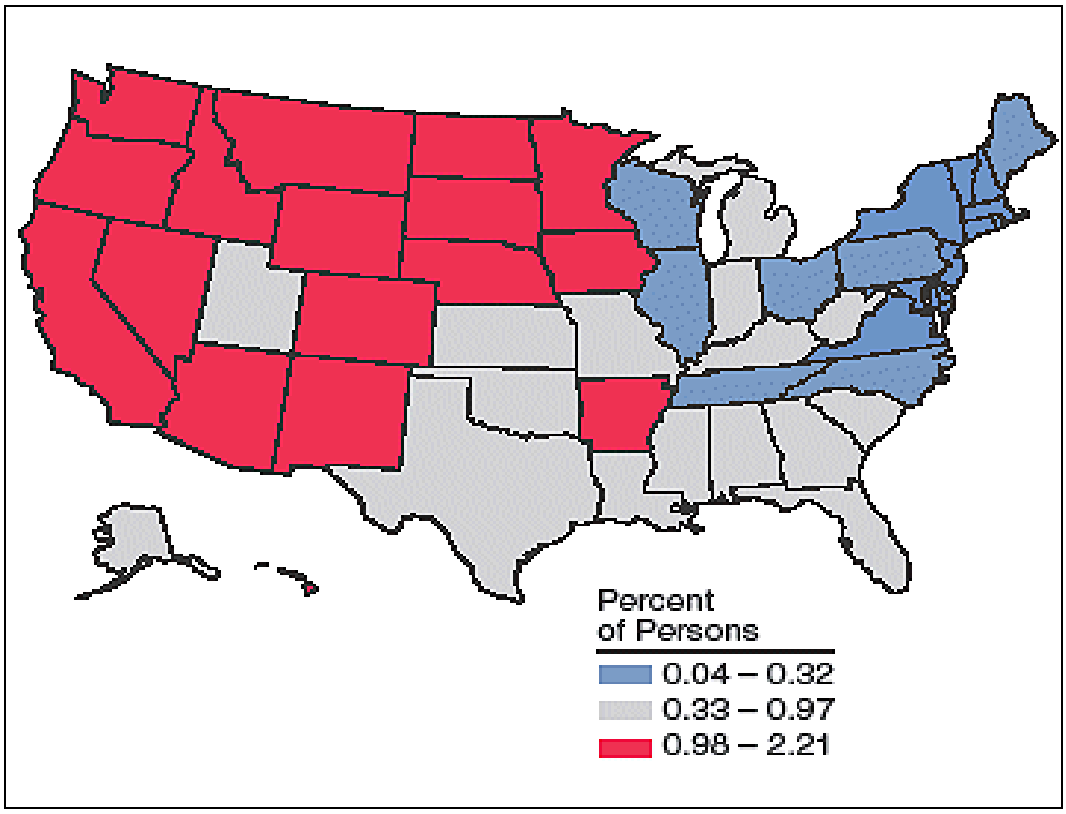
Figure 1: Number of Persons over Age 12 who First Used Specific Substances in the Prior Year[6]



Current Users of Methamphetamine

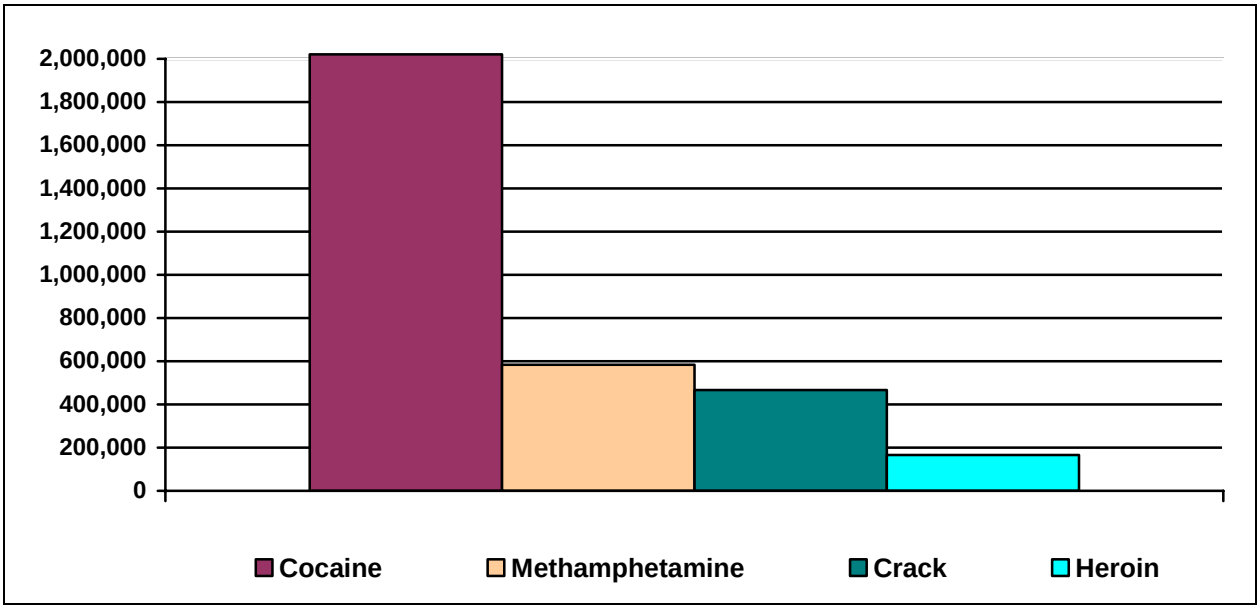
Current users of substances are important to monitor because they are often the population that create health, social and economic costs to our society. The number of current users is estimated by asking people about their use in the prior 12 months and the prior 30 days. Overall, the number of current users of methamphetamine remained stable between 2002 and 2004; however, this does not reflect changes in drug use patterns in some regions in the country. Figure 2 shows the States by the percentage of the population reporting the use of methamphetamine in the prior year.

Figure 2: Methamphetamine Use in Past Year among Persons Aged 12 or Older, by State: 2002, 2003, and 2004[7]



In addition, in 2004, there were 583,000 persons reporting methamphetamine use in the prior 30 days; the number of current methamphetamine users now exceeds the number of current crack users (467,000) and current heroin users (166,000). However, there is a much larger number of current cocaine users at 2.021 million, and there are 14.6 million marijuana users.[8] These data are shown in Figure 3.

Figure 3: Number of Person who Reported Past Month Use of Specific Substances in 2003[9]



Persons Meeting Criteria of Methamphetamine Abuse or Dependence

Perhaps more important to consider in regard to the implications for child welfare services are those persons who meet criteria of substance abuse or dependence, including the most widely abused substance of abuse, alcohol. A person is defined as needing treatment for a substance use disorder if they met criteria for substance abuse or dependence according to criteria established in the Diagnostic and Statistical Manual, 4th Edition (DSM-IV). The map in Figure 4 shows the States by percentage of their population who met clinical criteria of substance abuse or dependence.

Figure 4: Dependence on or Abuse of Any Illicit Drug or Alcohol in Past Year among Persons Aged 12 or Older, by State: Percentages, Annual Averages Based on 2003 and 2004 National Survey on Drug Use and Health[10]

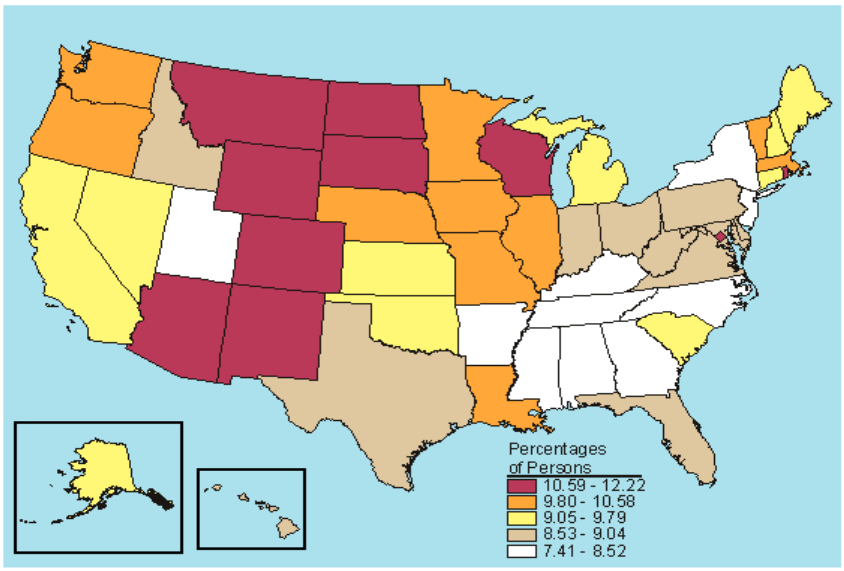
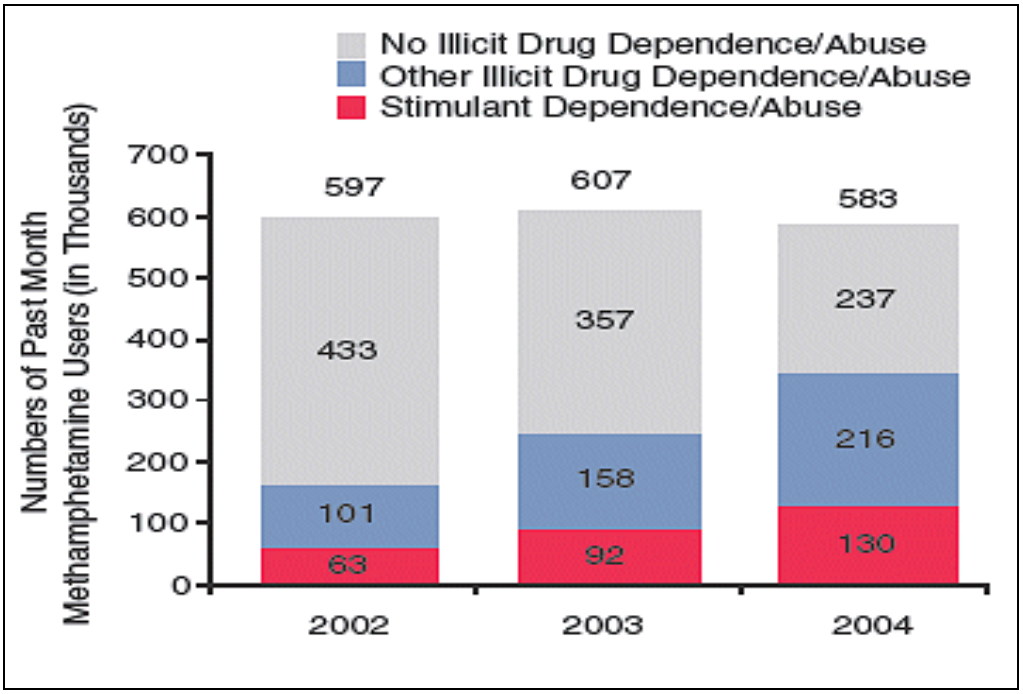


Figure 5 shows a substantial increase in persons experiencing negative consequences of methamphetamine use. While the prevalence of methamphetamine use has remained constant over the past few years, the percentage of current methamphetamine users who met criteria for drug dependence or abuse in the prior 12 months increased from 164,000 (27.5 percent of past month methamphetamine users) in 2002 to 346,000 (59.3 percent) in 2004.

Figure 5: Methamphetamine Use in Past Month among Persons Aged 12 or Older, by Dependence and Abuse: 2002, 2003, and 2004[11]



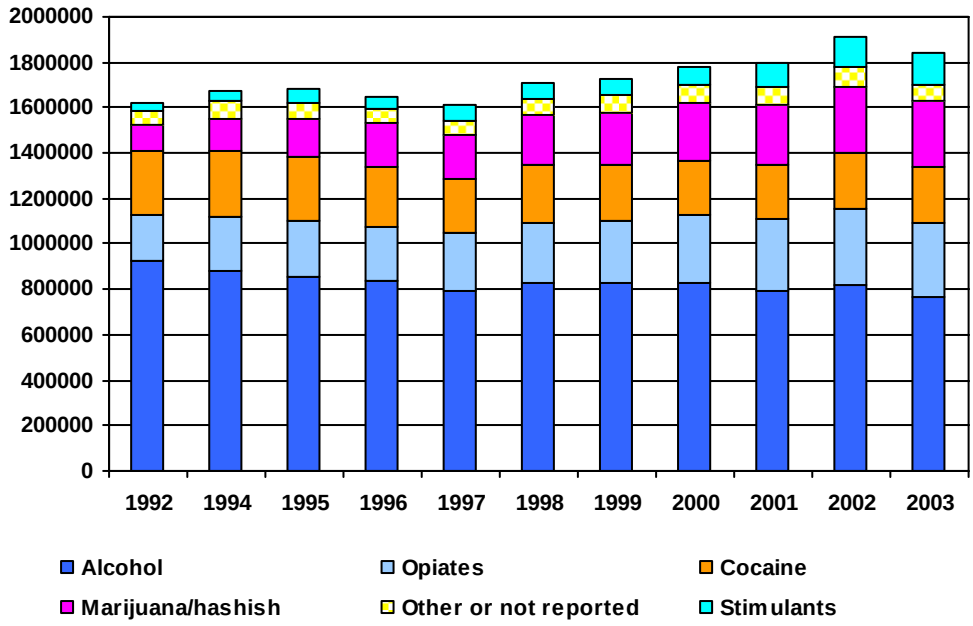
Methamphetamine and Treatment Admissions

Related to the increasing number of persons meeting criteria of methamphetamine abuse or dependence are those persons who need access to substance abuse treatment. Much of the information on methamphetamine in the popular press has been based on the increasing percentage of treatment admissions with a primary methamphetamine problem.

Treatment admission data are a "lagging" indicator of drug use patterns. Persons entering publicly-funded substance abuse treatment are those who are experiencing consequences and problems in areas of life functioning (e.g., health, social relationships, employment, criminal behavior or psychological problems) related to their substance use and were able to access treatment services.

Figure 6 shows the number of persons reported by the States entering treatment by primary substance. The data for stimulants (the top of the bar) includes both methamphetamines and other stimulants (other stimulants account for approximately 1% of the admissions). While overall treatment admissions have increased by 14% between 1993 and 2003 (from 1.618 million to 1.842 million), admissions for persons with stimulant disorders increased from 28,900 in 1993 to nearly 137,000 in 2003, an increase of 373%. However, it must be noted that admissions to treatment for stimulant abuse and dependence represent only 7% of all admissions.

Figure 6: Treatment Admissions by Primary Substance[12]



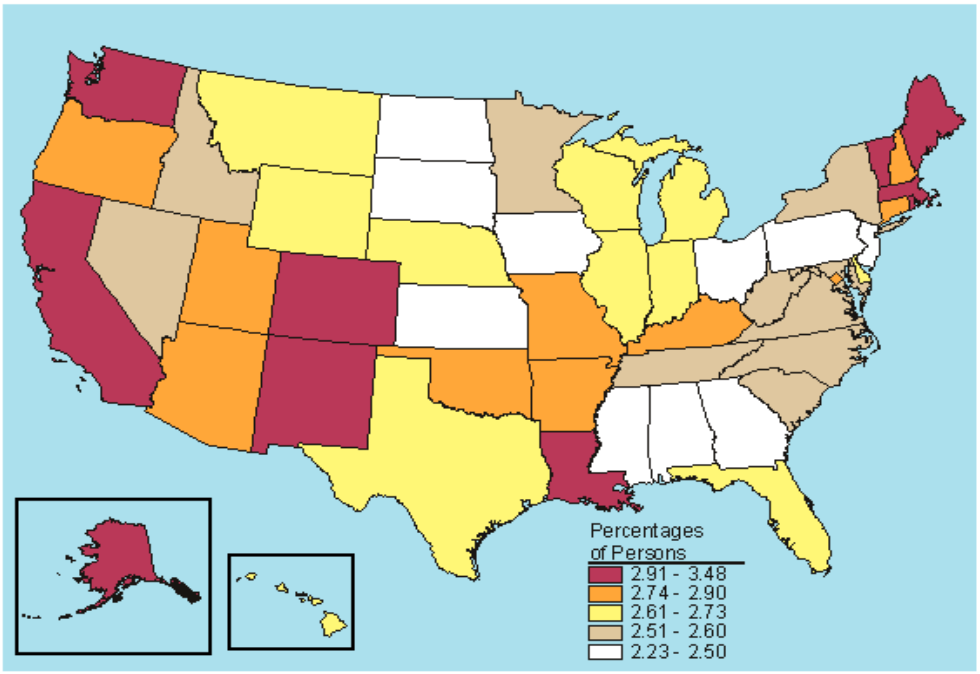
While these 1.8 million persons accessed treatment services, the unmet need for substance abuse treatment continues to be a critical gap in our nation's response to drug epidemics. Based on the survey data from 2003 and 2004, there were an

estimated 6.4 million persons who did not receive needed drug treatment and over 17 million persons who did not receive needed alcohol treatment.

The definition of a person needing but not receiving treatment for a substance use disorder is that the person met the criteria for abuse or dependence on illicit drugs or alcohol according to the DSM-IV, but has not received specialty treatment for an illicit drug problem in the past year. Specialty treatment is treatment received at a drug and alcohol rehabilitation facility (inpatient or outpatient), hospital (inpatient only), or mental health center.

In 2003-2004, Alaska had the highest percentage of persons aged 12 or older needing but not receiving treatment for an illicit drug use problem (3.5 percent), while South Dakota had the lowest rate (2.2 percent). The States in the top fifth for needing but not receiving treatment for an illicit drug use problem among persons 12 or older were mainly in the West (five States) or in the Northeast (four States). New Mexico was the only State in the top fifth for persons with unmet treatment needs across all age groups: those aged 12 to 17, 18 to 25, and 26 or older.

Figure 7: Needing But Not Receiving Treatment for Illicit Drug Use in Past Year among Persons Aged 12 or Older, by State: Percentages, Annual Averages Based on 2003 and 2004 National Survey on Drug Use and Health[13]



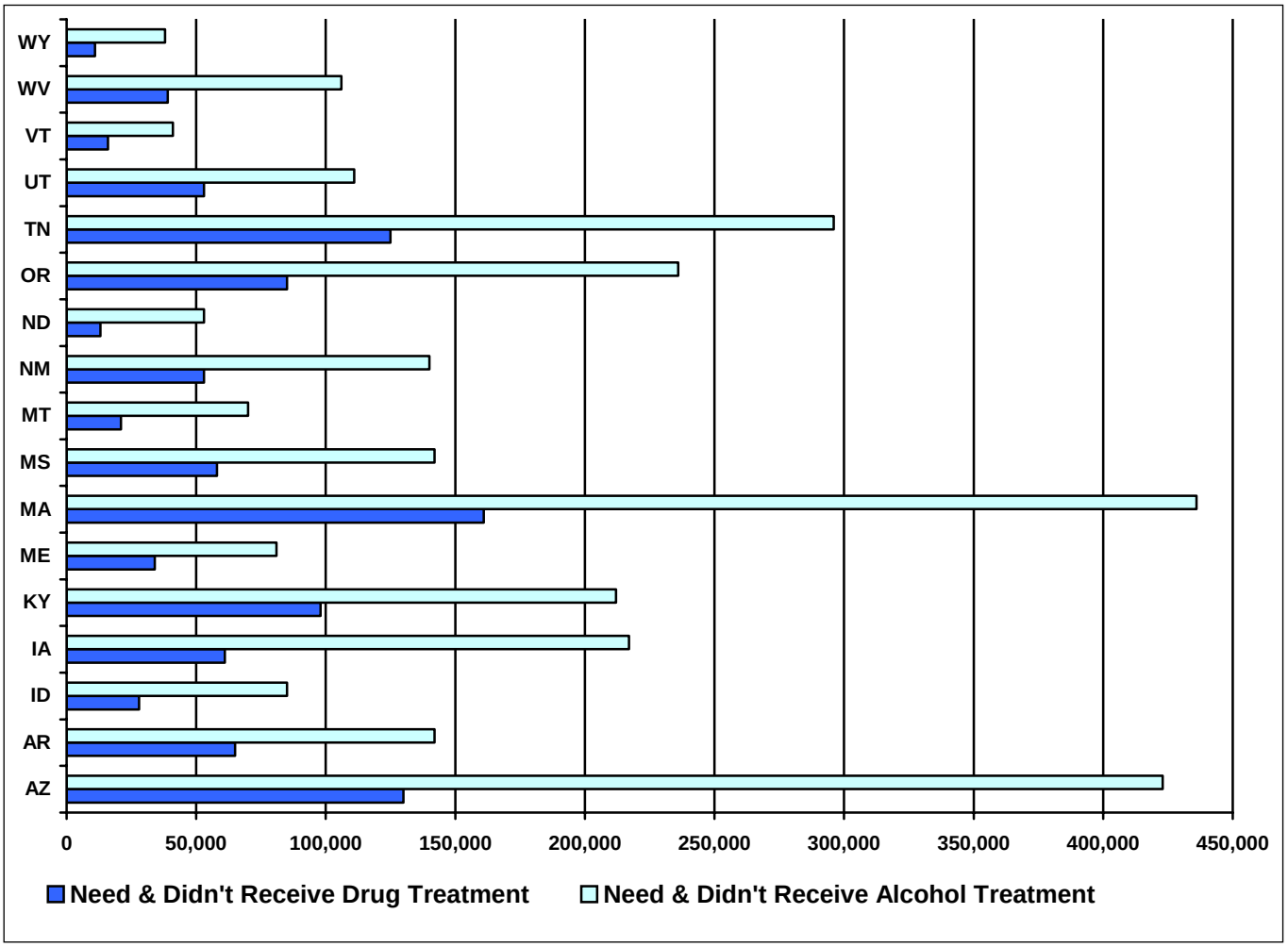
These percentages by State translate to very large number of persons who are not accessing treatment for their substance abuse. Nationally, the numbers are:

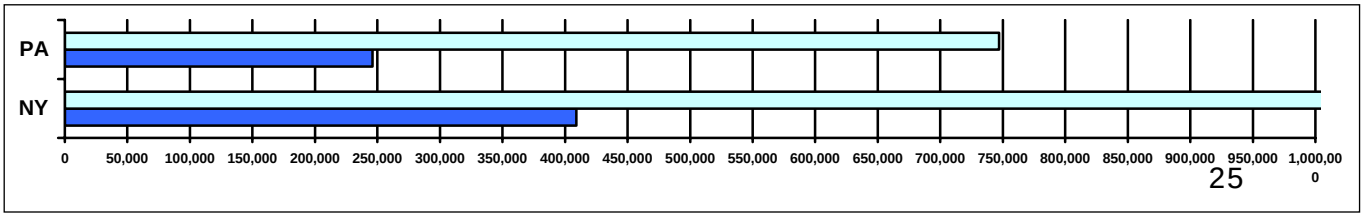
Estimated Total for United States – 2003, 2004

- Needed and didn't receive drug treatment – 6.43 million
- Abused or were dependent on any illicit drug – 7.1 million
- Needed and didn't receive alcohol treatment – 17.37 million
- Abused or were dependent on alcohol – 22.0 million

The number of persons in each of the States represented by members of the Senate Finance Committee who needed but did not receive treatment are shown in Figure 8. Collectively the Senators on this Committee represent 1.706 million persons who needed treatment for drug problems and 4.856 million people who needed treatment for alcohol problems.

Figure 8: Estimated Number of Persons in Selected States who: Needed But Did Not Receive Drug or Alcohol Treatment[14]





Summary

The data from the five monitoring systems of methamphetamine use and the need for treatment are summarized as follows:

New Users

- The annual number of persons who are new users of methamphetamine (363,000) has increased over the past decade and currently slightly exceeds the number of new users of crack (303,000)
- There has been an annual increase in new users of cocaine (1.1 million) since the mid 1990s, and increases in new users of marijuana (2.4 million) since the early 1990s

Current Users

- The number of persons who used methamphetamine in the past year and in the past month has remained relatively stable over the past few years
- There are profound regional differences in the number of persons using methamphetamine
- The number of current cocaine users is approximately three and a half times greater (2.1 million) than the number of current methamphetamine users (600,000)

Methamphetamine Users who Met Criteria for Substance Use or Dependence

- The percentage of current methamphetamine users who met criteria for substance abuse or dependence doubled between 2002 (27.5%) and 2004 (59.3%)

Treatment Admissions for Primary Methamphetamine Use Disorders

- Admissions to the publicly-funded treatment system for primary methamphetamine use disorders represent 7% of all treatment admissions
- There has been a 373% increase in treatment admissions for stimulant disorders
- While overall treatment admissions increased by 14% between 1993 and 2003 (1.618 million to 1.842 million), admissions for person with stimulant disorders increased from 28,900 in 1993 to nearly 137,000 in 2003

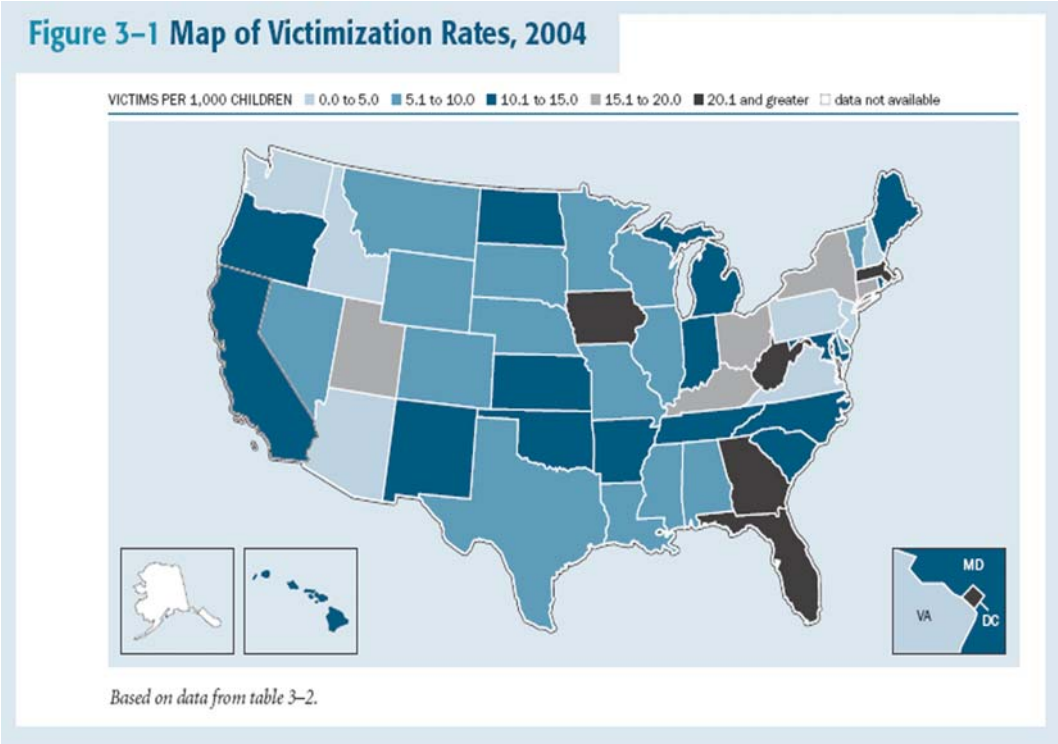
Unmet Need for Substance Abuse Treatment in the United States

- The vast majority of persons who need treatment for substance use disorders do not receive it
- Nearly six and half million persons who needed treatment for drug problems did not receive it in 2002/2003
- Over seventeen million persons who needed treatment for alcohol problems did not receive it

2. Current trends in the number of children who are victims of child abuse or neglect and those who are placed in protective custody

Child protective services (CPS) agencies respond to the needs of children who are alleged to have been maltreated and ensure that they remain safe. Based on a rate of 47.8 per 1,000 children, an estimated 3,503,000 children received an investigation by CPS agencies in 2004. Based on a victim rate of 11.9 per 1,000 children, an estimated 872,000 children were found to be victims. A child was counted each time he or she was the subject of a report. The count of victims is, therefore, a report-based count and is a "duplicated count." The victimization rates in individual State are illustrated in Figure 9.

Figure 9: Map of Rate of Child Victims, 2004[15]

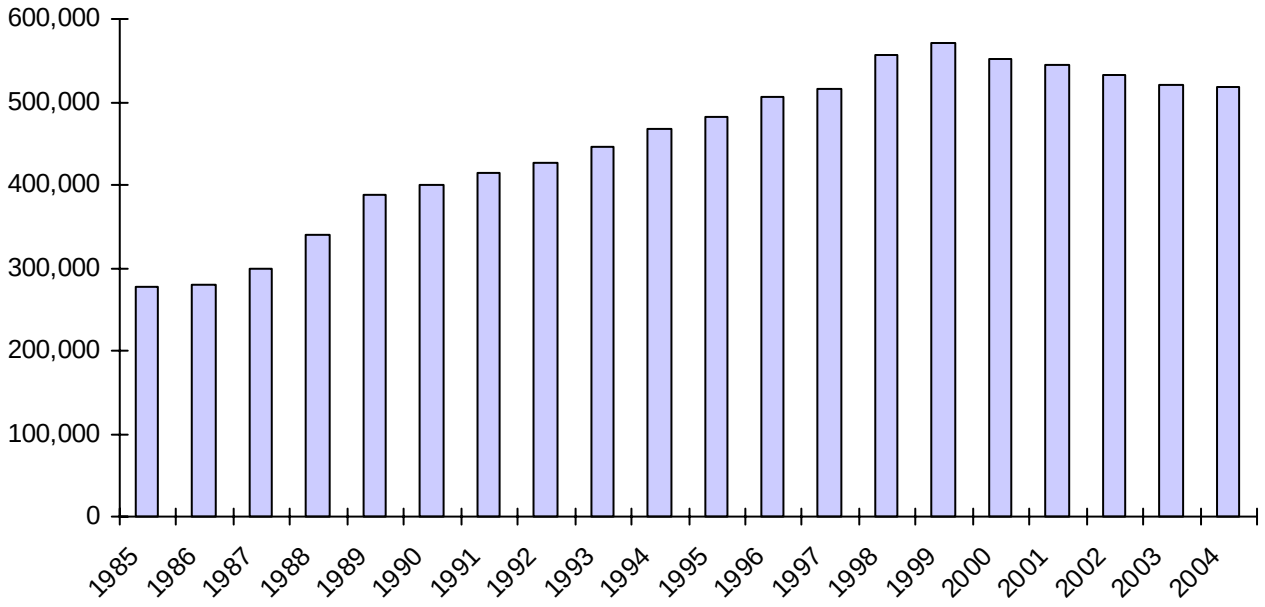


Despite the relatively rapid increase in rates of methamphetamine abuse and dependence, particularly in specific regions across the nation, there has not been an increase in the rate of victims of child abuse or neglect. The rate of all children who received an investigation or assessment increased from 36.1 per 1,000 children in 1990 to 47.8 per 1,000 children in 2004, which is a 32.4 percent increase. This indicates that more of the reports that are called into CPS agencies are being investigated. However, the rate of victimization (children for whom the allegations of abuse or neglect are found to be true) decreased from 13.4 per 1,000 children in 1990 to 11.9 per 1,000 children in 2004. These data are shown in Figure 10.

Figure 10: Investigation or Assessment and Victimization Rates, 1990-2004[16]

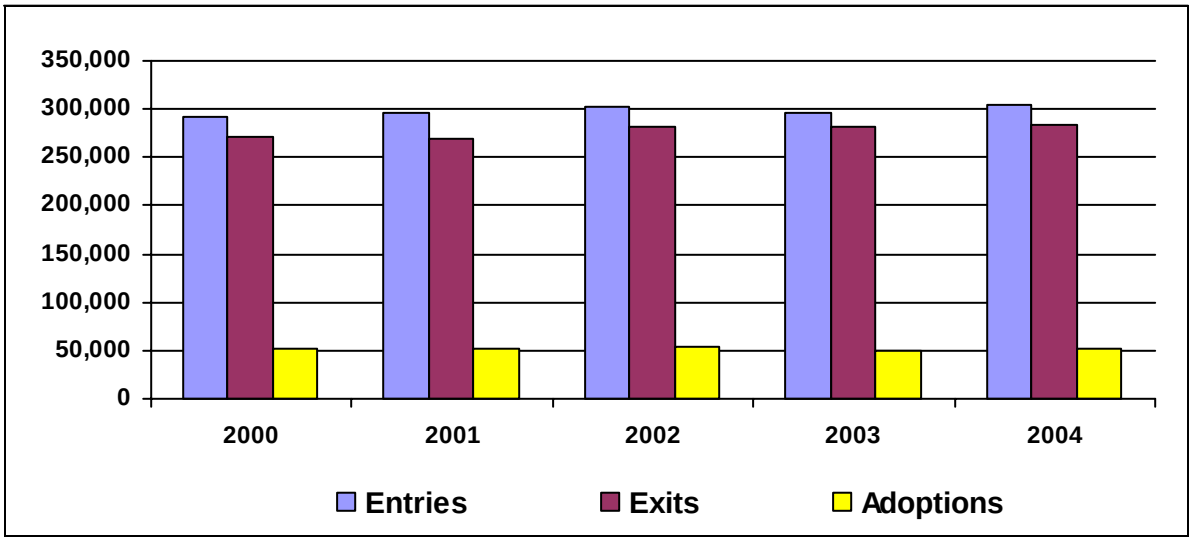
In addition to the recent decreases in the rate of child victims, the population of children in out-of-home care has been on a steady decline since 1999, with approximately 518,000 children in care at the end of the 2004 fiscal year. That decrease comes after a decade in which the number of children in care doubled from approximately 276,000 in 1985 to a high of 565,000 in 1999.[17] These data are shown in Figure 11.

Figure 11: Foster Care Population at the End of Each Fiscal Year



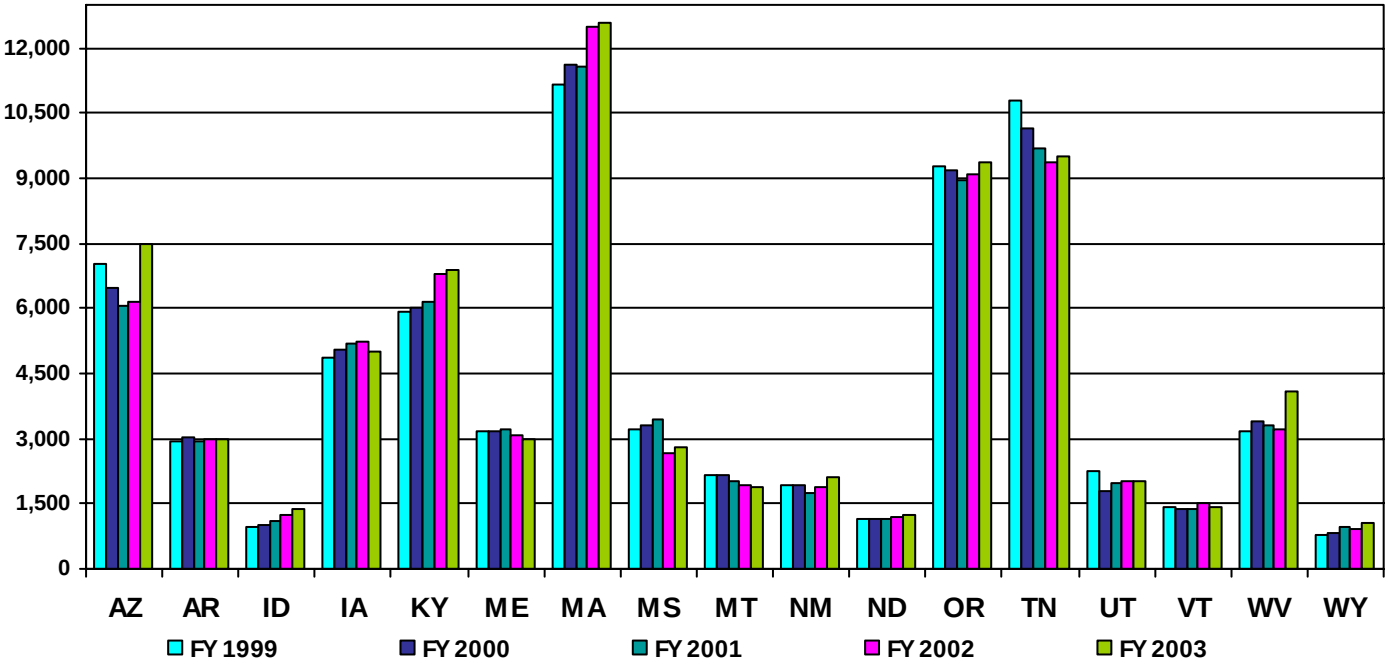
The Adoption and Safe Families Act (ASFA) was signed into law in the fall of 1997 and fully implemented over the following few years. The decrease in the point-in-time estimate of children in out-of-home care results from several underlying factors. The estimated data from fiscal year 2000 and 2004 indicate that the annual number of children entering foster care has remained relatively stable—between 293,000 and 304,000. The number of children exiting foster care each year increased from 272,000 to 283,000. The estimated number of children adopted annually remained relatively constant at approximately 50,000. These data are shown in Figure 12.

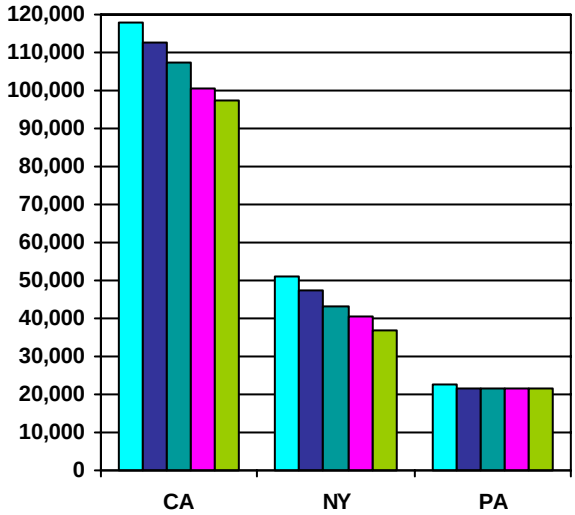
Figure 12: Trends in Foster Care and Adoption, FY 2000 to 2004[18]



These data show a decrease in the foster care population that is also evident when we look at specific states. Figure 13 shows the last four years of the foster care population in the 19 states that are represented by members of the Finance Committee and California (the States with larger caseloads, California, New York and Pennsylvania, are shown in a separate graph due the difference in scale with the smaller States). Of these States, California, Illinois and New York have experienced fairly dramatic reductions in the number of children in out-of-home care. While some of the States may be just beginning to experience the impact of methamphetamine, clearly California has felt the impact of methamphetamine for a decade, and yet they have continued to see an overall reduction in children in care.

Figure 13: Foster Care Population on September 30 of Each Fiscal Year in Selected States[19]

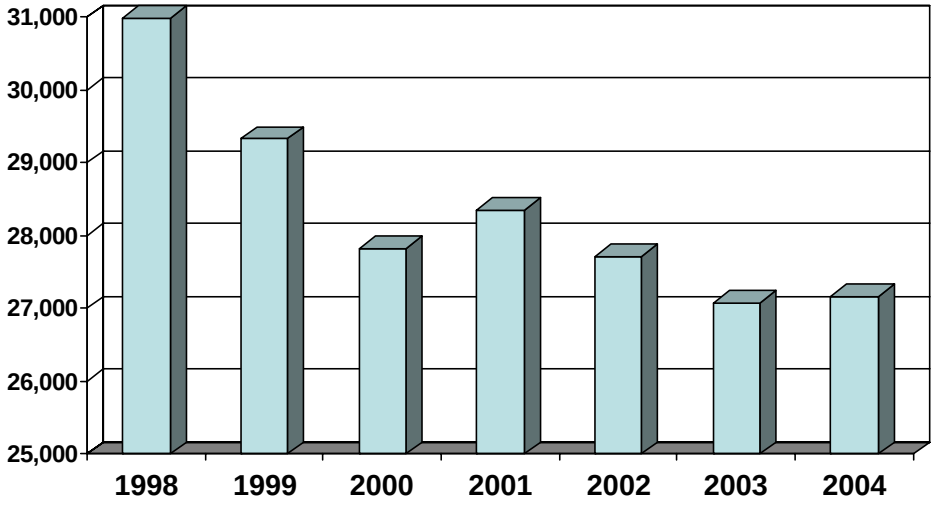




Another State example is shown in Massachusetts. The Federal data show that in Massachusetts the caseload increased through 2003.[20] More recent State-level data show that the trend reversed in 2004 and there were approximately 9,500 children in out-of-home care at the end of 2005. During this time frame, as shown in Figure 2, methamphetamine use has not been a dramatic factor in the State. Rather, heroin use is the primary substance of abuse in terms of persons entering treatment.[21]

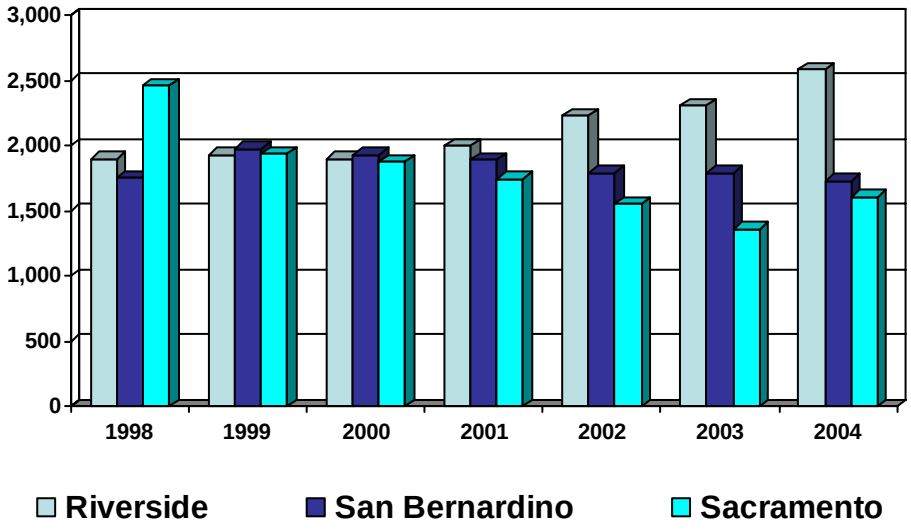
In California, this reduction reflects both fewer children coming into care and more children exiting care over the past six years. Figure 14 shows the decreasing number of children entering care in California (among children who stayed in care for five or more days) with a leveling of that number between 2003 and 2004. So while California has been faced with the increasing number of persons using and dependent on methamphetamine for a decade, through 2004, they have not experienced an overall increase in children being removed from their parents' custody.

Figure 14: Entries to Out-of-Home Care in California[22]



Yet we know that the impact of specific substances and child welfare practice regarding parental substance use can vary greatly from State to State and county to county. For example, Figure 15 shows three California counties that have been discussed in the media as having been particularly affected by methamphetamine production; as the chart shows, they have very different patterns of the number of children entering care.

Figure 15: New Entries to Foster Care: Riverside, San Bernardino and Sacramento Counties[23]



The data showing differences at the local level suggest that local child welfare practice, skills and practice protocols to work with these families and access to high quality substance abuse treatment play an important role in the number of children entering out-of-home care associated with parental methamphetamine use. Indeed, Jay Wurscher from the Oregon State child welfare agency says, "we had a handle in Oregon on parents with methamphetamine problems. Then, the treatment funds were cut and we're back to seeing increases in kids coming into care."[24]

Summary

- The total number of children in out-of-home care doubled over 15 years from approximately 276,000 children in 1985 to a high of 565,000 in 1999
- The most rapid increase was between 1986 and 1992 with a 50% increase
- Since 1999, the caseload of children in out-of-home care has continued to decline to an estimated 518,000 children at the end of fiscal year 2004
- The decrease in children in care is largely due to increased numbers of children exiting care each year
- The decrease of children in care is also seen in many of the large states such as California, which has been heavily impacted by methamphetamine, and in Illinois, which has not experienced a rapid increase in methamphetamine use
- The caseload data of children in out-of-home care varies by State and County and suggests that local practice, policies and access to treatment resources play a significant role in child placement.

3. The impact of parental substance use disorders on child welfare agencies and the specific impact of methamphetamine

Despite the attention paid to the prevalence of parental substance use disorders among the families in child welfare services that was generated 15 years ago during the cocaine and crack epidemics, there is very little national data on the number of children in foster care due to parental substance use disorders. While we haven't seen overall increases in children in out-of-home care, we lack the data to know if there are increases in the number of children coming into care affected by substance use, we do not have data on the number of children in foster care specifically affected by methamphetamine and we do not have the data specific to how families with substance use disorders do on the national outcome measures of child safety, permanency and well-being.

Since the national data systems do not require these data be routinely collected, there are various estimates of the extent of the problem that have been published. The Department of Health and Human Services (DHHS) in its Report to Congress in 1999[25] stated that between one-third and two-thirds of children in the child welfare system are affected by substance use disorders. They associated the lower percentage with those cases in which children were not removed from the parents' care and the larger percentage with those cases in which children were placed in protective custody.

The wide variation in the estimates is attributed to many factors, including the population studied (e.g., in-home versus out-of-home cases); the definition of the substance use disorder (any use versus meeting criteria of substance abuse or dependency); the method used to determine substance involvement (e.g., risk assessment measures, prospective assessment tools or retrospective case reviews); and whether the substance use is a primary or secondary contributing factor in the child welfare case.

There is only one published study estimating the prevalence of substance use disorders among child welfare-involved families in which the children have not been removed from the parent(s)' custody (often referred to as "in home" cases). The data come from the National Study of Child and Adolescent Well-Being (NSCAW) which has collected data from a nationally representative sample of children in child welfare services. [26]

The research protocol included assessing caregivers' substance abuse and dependence using the Composite International Diagnostic Interview Short Form (CIDI-SF) and questions from the child welfare worker interview. The CIDI-SF evaluates criteria of substance abuse or dependence in the year prior to the data collection. Among caregivers retaining custody of their children, 9.6% of caregivers had a problem with alcohol or drugs according to the child welfare worker assessment, and only 3.9% of caregivers were alcohol or drug dependent according to the CIDI-SF. Overall, 11.1% of caregivers whose children live at home with them had a substance abuse problem.[27] This is a rate lower than what has been generally estimated[28] and is similar to the percentage of children in the general population (11%) who are living with a parent who is alcoholic or needs treatment for illicit drug abuse.[29]

However, it was noted in the NSCAW study that child welfare workers did not identify a substance abuse problem among 61% of caregivers who met DSM-IV criteria for alcohol or drug dependence.[30]

Among cases in which children have been removed, a higher percentage of parental substance use disorders is often reported. In the early 1990s, several studies reported substance use with various methods and operational definitions of substance abuse; a selection of these studies is briefly summarized in chronological order below.

For parental substance abuse to be included in their study, Murphy and colleagues required that substance abuse be noted in reports from a psychiatrist or psychologist or in a court-ordered screening. In their sample of 206 cases from Boston, they found that in 43% of the cases, at least one of the parents had a documented problem with either alcohol or drugs. The percentage rose to 50% when the case included allegations of substance use in the court report. Alcohol, cocaine, and heroin were the three most frequently mentioned abused substances. Parents with documented substance abuse were significantly more likely than non-substance abusing parents to have been referred previously to child protective agencies, to be rated by court investigators as presenting high risk to their children, to reject court-ordered services, and to have their children permanently removed.[31]

A study by the U.S. General Accounting Office in 1994 found that in random samples of case files in California, New York, and Pennsylvania, 78% of foster children's cases that were reviewed had at least one parent who was abusing drugs or alcohol.[32] Another study by the GAO, at the request of the Senate Finance Committee, reviewed case records in Los Angeles and Chicago in 1998. They estimated that about two-thirds of all foster children in both California and Illinois had at least one parent who abused drugs or alcohol, and most had been doing so for at least 5 years. Most of these parents abused one or more drugs such as cocaine, methamphetamines, and heroin.[33]

Besinger and his colleagues (1999) operationally defined substance abuse to include any known history of substance abuse and, therefore, found relatively higher rates of substance abusing parents in their study. They studied an urban sample located in the Southwest and reported that 79% of children in foster care had a parent with "parental substance abuse."[34]

McNichol and Tash reported in 2001 that the percent of children in specialized foster care with a primary reason of parental substance abuse was 14%. Another 76% of children were "affected in some way by parental substance abuse."[35]

In a recent study using a random sample of 443 children with substantiated child abuse or neglect in an urban setting, Jones found that 68% of the children had mothers who abused alcohol or drugs and 37% of them had mothers who abused both.[36]

Finally, the Children's Bureau's outcome monitoring system, the Child and Family Service Reviews, included in-depth reviews of 50 cases in each of the States over the past few years. The CFSR reports found a wide range of cases affected by substance abuse issues. Only 32 States reported parental substance abuse as a factor in the cases reviews. It was identified as a factor that brought the child to the attention of the child welfare agency in 16 to 61 percent of cases; substance abuse was a primary factor 34 states and was identified in 2 to 44 percent of those cases. Substance abuse by the child was reported in seven states. It was identified as a factor bringing the child to the child welfare agency's attention in 2 to 48 percent of cases.[37]

It is important to note however that studies of the prevalence of the substance use disorders do not tell us the nature and extent of an individual's substance use disorder or more importantly how the parents' substance use might affect the risk or safety factors associated with child abuse or neglect. The presence of a substance use disorder does not by itself give enough information to make decisions about the custody status of children or how the parents' substance use should be included in the case plan to remedy the problem so that reunification might occur. This remains a significant challenge to many child welfare agencies across the country.

Summary

- In a study of the prevalence of substance abuse and dependence in a nationally representative sample of “in-home” cases, a lower level of prevalence was found than had previously been reported in various site-specific estimates
- However, case workers were unable to identify caregivers with substance use disorders most of the time in this study
- Studies of cases in which children have been removed generally report half to three-quarters of cases are affected by parental substance use
- In the Child and Family Service Reviews, 32 States identified substance abuse as a factor in the cases they reviewed; the prevalence of substance abuse in those cases ranged from 16 to 61 percent

4. Children are affected by parents with methamphetamine and other substance use disorders in different ways

Children of parents with substance use disorders may experience multiple risks to their safety and well-being. These risks are well documented and include:

- Chronic neglect
- Chaotic home lives
- Violence associated with drug sales
- Inconsistent parenting
- Entry to foster care and multiple placements
- Incarcerated parents
- Risk of HIV exposure if parent is a needle user

In addition to these risks, it is particularly important for child welfare to understand the different types of parental methamphetamine use that affect children. There are six situations in which children are affected by their parent's involvement in methamphetamine:

- The parent uses or abuses methamphetamine (episodic use)
- The parent is chemically dependent on methamphetamine
- The mother uses methamphetamine while pregnant with the child
- The parent "cooks" methamphetamine in the home
- The parent sells, transports, or distributes methamphetamine (traffickers)
- The parent manufactures large quantities of methamphetamine (superlabs)

While much of the media attention and child welfare training has been focused on parents who "cook" methamphetamine, each situation presents specific risks and dangers for the child and specific concerns for the child welfare worker. As Jay Wurscher, the substance abuse program manager for the Oregon Department of Children and Families, stated, "The Oregon workers started out being trained, largely by the criminal justice system, to address issues related to methamphetamine manufacturing. What they found over time was that workers had to be much more prepared to work with families with methamphetamine abuse and dependence and that the number of times that workers confronted actual manufacturing was rare in their practice compared to the number of families affected by methamphetamine abuse and dependence."[38] Each separate situation confronting child welfare in their need to differentiate the risk to children is discussed below.

Parents Who Use or Abuse Methamphetamine

Episodic parental use or abuse of methamphetamine is the most common means by which children are affected by parental methamphetamine use. This method of exposure accounts for the highest number of children exposed to methamphetamine, compared to the numbers found in the other categories.

Similar to parents who abuse other substances, particularly stimulants such as cocaine, parents under the influence of methamphetamine pose a danger to their

children. When “high,” the parent may exhibit poor judgment, confusion, irritability, paranoia, and increased violence; they may fail to provide adequate supervision. Even during periods in which the parent may not be actively under the influence, the family and social environment may be inadequate, and the children may be at risk of abuse and neglect due to the family dynamics associated with substance use.

In households where a family member smokes the substance, children may be exposed to secondhand methamphetamine smoke. They may accidentally ingest the substance if it is kept in the home.

Because methamphetamine users typically use other substances at the same time, including alcohol, tobacco, and other drugs, the risks to their children accumulate, and it becomes difficult to attribute a particular effect to a particular substance.

Dependent Parents

When the parent is substance dependent, meaning they meet criteria for a diagnosis of substance dependence rather than substance abuse or use, chronic neglect of the children becomes more likely, and the family and social environment is more likely to be inadequate. The children are exposed to the drug-affected parent more frequently and for longer periods of time. They may be living in inadequate conditions, lacking food, water, gas, and electricity. They may lack medical care, dental care, and immunizations. These children may also be at greater risk of abuse. Some researchers have found persons with methamphetamine dependence to have an increased association between drug use and high risk sexual behaviors[39] which may place their children at higher risk of sexual abuse than children of parents with other substance use disorders.

Prenatal Exposure

Many studies of the effects of prenatal substance exposure compare methamphetamine-exposed infants to non-exposed infants without also comparing them to cocaine-exposed or other stimulant-exposed infants, so it is not known whether the effects are associated with methamphetamine in particular or with all stimulants.

The direct effects (when chemicals enter the fetus’ blood system) and indirect effects (the decrease in blood flow to the fetus as a result of decreased blood from the mother)[40] of substances, including the legal drugs, tobacco and alcohol, can cause birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders. Methamphetamine and other stimulants jeopardize the development of the fetal brain and other organs.[41] As was previously found with crack cocaine exposure, a high dose of methamphetamine taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus, which can lead to stroke or brain hemorrhage.[42] Prenatal stimulant exposure has been associated with difficulty sucking and swallowing, and hypersensitivity to touch after birth.[43]

Stimulant-exposed children are often affected by other substances used by the mother, and by environmental risk factors such as the mother's nutritional and health status. The cumulative effects of the use of multiple substances and other environmental risk factors have significant adverse effects on the newborn. These effects may be greater than the effects of stimulant use alone.[44] Substances such as alcohol can have severe long-term effects on prenatally-exposed children. Children with Fetal Alcohol Spectrum Disorders (FASD) exhibit a range of central nervous system effects, including mental retardation;[45] hyperactivity and attention deficits;[46] poor impulse control; perceptual and motor problems;[47] expressive language delays;[48] delayed motor development;[49] poor listening skills;[50] poor abstract thinking skills; poor problem-solving skills; poor social adaptation; and deficits in attention and memory.[51]

Thus the most significant forms of substance use during pregnancy may be the use of alcohol and tobacco, given the total number of children affected, the severe central nervous system impairments that can result from alcohol exposure, and the low birth weight associated with smoking. Many of the central nervous system-related disorders are caused in the first trimester of pregnancy. Recent surveys indicate that far too many women are using substances during the early months of pregnancy. Figure 16 shows the percentage of pregnant women reporting substance use. The number of infants is derived from that percentage and the 4.1 million annual births in the country.[†] Clearly the message regarding alcohol use and pregnancy has reached women, resulting in substantial declines in binge alcohol use by the third trimester. Yet there is a continuing urgency to reduce substance use during pregnancy, particularly in the first trimester.

Figure 16: Substance Use during Pregnancy[52]

Substance Used (Past Month)	**1st Trimester**	**2nd Trimester**	**3rd Trimester**
Any Illicit Drug	7.7% women 315,161 infants	3.2% women 130,976 infants	2.3% women 94,139 infants
Alcohol Use	19.6% women 802,228 infants	6.1% women 249,673 infants	4.7% women 192,371 infants
Binge Alcohol Use	10.9% women 446,137 infants	1.4% women 57,302 infants	0.7% women 28,651 infants

These data are collected through self report and then analyzed for those who also said they were pregnant. Trained interviewers as well as toxicology screens at birth have found much higher rates of substance abuse. However, these studies have not been conducted on a nation-wide basis and the last representative State-level study monitoring prenatal substance exposure was in California in 1992.

[†] Note: for purposes of this paper, it is assumed that the pattern of drug use among all pregnant women is the same as among those who actually gave births to live children, although live births were 63.4% of all pregnancies in 2000, due to miscarriages and terminations.

With the changing drug use patterns across the country it seems important to conduct in-depth studies in locations throughout the nation, including prevalence studies in hospitals that can be accomplished with random screening. This would increase our knowledge about the drugs used by parents who prenatally expose their infants to harmful substances.

Data from the Infant Development, Environment, and Lifestyles (IDEAL) study has recently been published. The prevalence of drug use have been determined by both mothers' self report of substance use during pregnancy and testing of infants' meconium at birth. The results of the IDEAL study, which were collected in sites that are known to have higher rates of methamphetamine use are not representative of the country as a whole. The data were collected in 2004 have been compared to the National Pregnancy and Health Survey which was collected in 1992-1993. Nearly half (44%) of the methamphetamine users had used other illicit drugs. The results are shown in Figure 17.[53]

Figure 17: Infant Development, Environment, and Lifestyles (IDEAL) and the National Pregnancy and Health Survey (NPHS)

Substance	IDEAL (2004)	NPHS (1992-1993)
Alcohol	22.8	18.8
Tobacco	25.4	20.4
Marijuana	6.0	2.9
Methamphetamine	5.2	0.1
Any Illicit Drug	10.7	5.5

When the figures in each of the tables are evaluated together, the data on prenatal substance exposure can be summarized as follows:

- An estimated 8-11% of the 4.1 million live births (in 2004) involved prenatal exposure to illegal drugs;
- Binge alcohol drinking ranges from nearly 11% of women in the first trimester to 1% in the third trimester;
- Prenatal exposure to alcohol includes an estimated 22% of pregnant women during the first trimester and nearly 5% of women in the third trimester; and,
- Tobacco use by pregnant women exposes approximately one-quarter of babies to the harmful effects of smoking during pregnancy.

Home Labs

Some parents produce quantities of methamphetamine in their homes for their own use or small-scale distribution, as compared with the superlabs where large-scale production occurs. Children in these homes are subject to the same risks noted in the sections on parents who use/abuse and are dependent on the drug, but they have additional risks associated with the substances used in the production of methamphetamine and the method of production. The children may be exposed to

toxic chemicals, contaminated food, fumes released during the "cooking" process, and the danger of fire or explosion from the manufacturing process.

The risks to children and to "first responders" including child welfare workers in homes where methamphetamine is produced are well documented. These risks include toxic chemical exposure. Children are more likely than adults to suffer health effects from exposure to chemicals. They have higher metabolic rates; their skeletal systems and nervous systems are developing; their skin is not as thick as an adult's skin, which means they absorb chemicals faster; and children tend to put things in their mouths and use touch to explore the world. Some fumes or gases are heavier than air, and will sink down to the child's level, increasing their exposure. Children also tend to imitate adult behavior and are vulnerable in chaotic and unsafe environments.[54] A review by Kolecki[55] revealed that pediatric patients with methamphetamine poisoning exhibited rapid heartbeat, agitation, inconsolable crying, irritability, and vomiting.

Trafficking

Parents who traffic in methamphetamine by selling, transporting, or distributing it, expose their children to an increased risk of violence and abuse. There may be weapons in the home. The parent's associates or customers may carry weapons, putting the children at risk for violence. These children may also be at increased risk of physical and sexual abuse by those who visit the home. Clearly, the implications of prison sentences for parents have specific implications regarding the child's long-term placement and permanency decisions that child welfare agencies must recommend.

Superlabs

Superlabs are methamphetamine laboratories where methamphetamine is produced on a large scale (estimated at 10 pounds per day). Children are sometimes found in these superlabs, but they are less likely to be present in superlabs than in the homes where smaller quantities are produced. However, these situations create the likelihood that children will have parents who are incarcerated for longer periods of time.

Number of Children in Methamphetamine Homes

Between 2000 and 2005, more than 15,000 children were affected by methamphetamine manufacturing. These figures are probably underreported, since many states do not keep records on children present at laboratory sites, nor do they medically evaluate the children for the presence of drugs or chemicals. While these children are critical, it is important for child welfare to consider these numbers in the context of the much larger number of children entering child welfare services affected by parental substance use disorders. As indicated earlier in this report, there are over 500,000 children in out-of-home care and more than 200,000 children enter care each year. During the period in which 15,000 children were reported as affected by methamphetamine, more than 1 million children

entered out-of-home care. Figure 18 shows the number of children reported to be involved where methamphetamine was being manufactured.

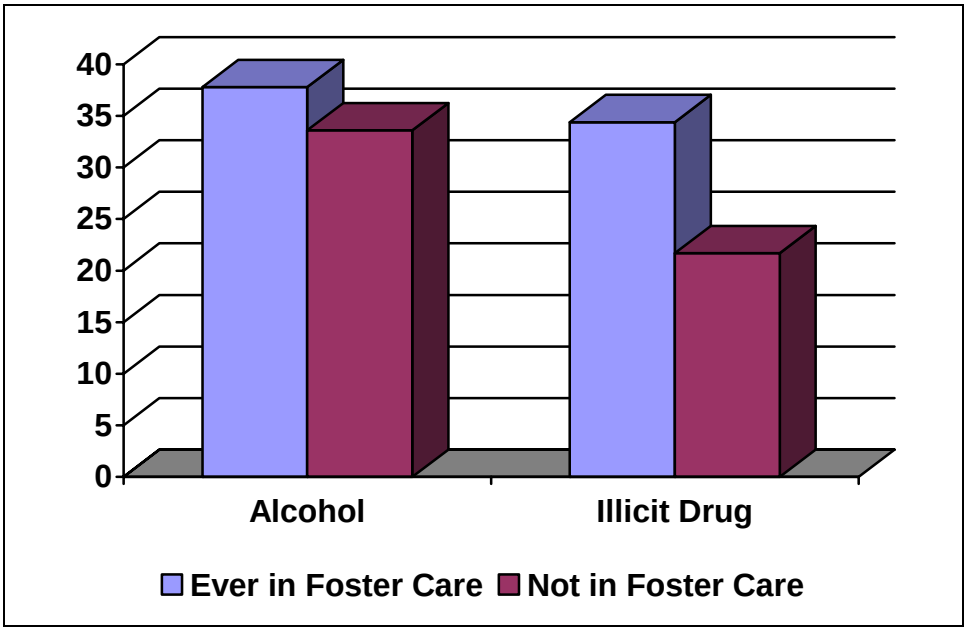
Figure 18: Children Affected in Methamphetamine Manufacturing[56]

	2000	2001	2002	2003[a]	2004[c]	2005[c]	Total
Number of Incidents	8,971	13,270	15,353	14,260			51,854
Incidents with children present	1,803	2,191	2,077	1,442			7,513
Children residing in labs	216	976	2,023	1,447			4,662
Children affected[b]	1,803	2,191	3,167	3,419	3,088	1,647	15,385
Children exposed to toxic chemicals	345	788	1,373	1,291			3,797
Children taken into protective custody	353	778	1,026	724			2,881
Children injured	12	14	26	44	13	11	120
Children killed	3	0	2	3	3	2	13

[a] The 2003 figure for the number of incidents is calendar year, while the remaining data in the column are for fiscal year; [b]Data for 2000 and 2001 may not show all children affected; [c] Data for 2004 and 2005 are incomplete.

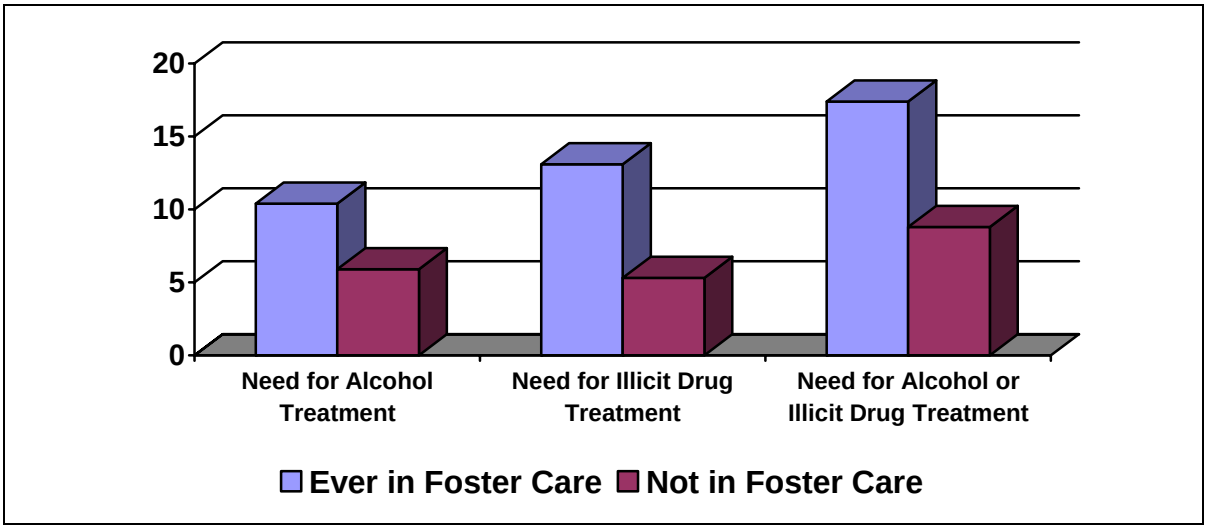
Finally, it is imperative that we address the children who are removed from their parents' custody and placed in protective custody in terms of their needs for prevention and intervention services. The Office of Applied Studies at SAMHSA has analyzed the national survey data to determine the rates of substance use among youth who have been in foster care. Youth who had ever been in foster care used substances at higher rates than youth not in foster care; these data are shown in Figure 19. These analyses also showed that compared to African-American youth, Caucasians were more likely to use alcohol (41.4% versus 29.8%) and illicit drugs (36.2% versus 26.7%).

Figure 19: Past Year Substance Use by Youth Age 12 to 17 based on Foster Care Status[57]



These data also showed that youth who had ever been in foster care had higher treatment needs than youth who had not been in care. As shown in Figure 20, these data reinforce the need for family based treatment models that allow parents and children to remain together. It also calls for dramatic action for comprehensive substance abuse prevention programming for this vulnerable group of children.

Figure 20: Percent of Youth Ages 12 to 17 Needing Substance Abuse Treatment by Foster Care Status[58]



Summary

- Many more children are affected by parents who use, abuse, and are dependent on methamphetamine than are affected by manufacturing activities
- It is important for child welfare workers to understand which group of children they are working with and to include screening and assessment for substance use in the child risk and safety assessments
- Screening and assessment practices are still inadequate to detect most of the prenatal and post-natal substance use affecting children in the child welfare system.
- In communities with know high prevalence of methamphetamine use, approximately 5% of babies were identified as exposed to methamphetamine during pregnancy
- The majority of babies exposed to methamphetamine in the prenatal period are also exposed to alcohol and tobacco; alcohol is a known to cause neuro developmental effects and the deleterious effects of tobacco use during pregnancy are well documented
- Youth who had ever been placed in foster care have higher rates of substance use and need for alcohol and drug treatment than do youth who have never been in care

5. Methamphetamine Users Differ from Those Who Use Other Substances

Child welfare unquestionably faces unique characteristics of persons who need treatment for methamphetamine use disorders. The characteristics include the effects of methamphetamine that are more pronounced than other substance of abuse, the differences in the population of persons who are using methamphetamine and the gender differences is use and need for treatment.

Effects of Methamphetamine

Methamphetamine is an addictive drug that stimulates the central nervous system. It creates a more intense effect than other substances and the effect lasts longer than other drugs of abuse. Drugs can injure the brain by damaging neurons that use the neurotransmitters. Methamphetamine affects the levels and actions of the neurotransmitters called dopamine and serotonin. New research from the UCLA School of Medicine shows that chronic methamphetamine use and altered neurotransmitters is associated with brain abnormalities.[59] While there is evidence that brains can recover, these brain abnormalities challenge both substance abuse treatment providers and child welfare workers to adapt their programs, strategies and approaches with this population.

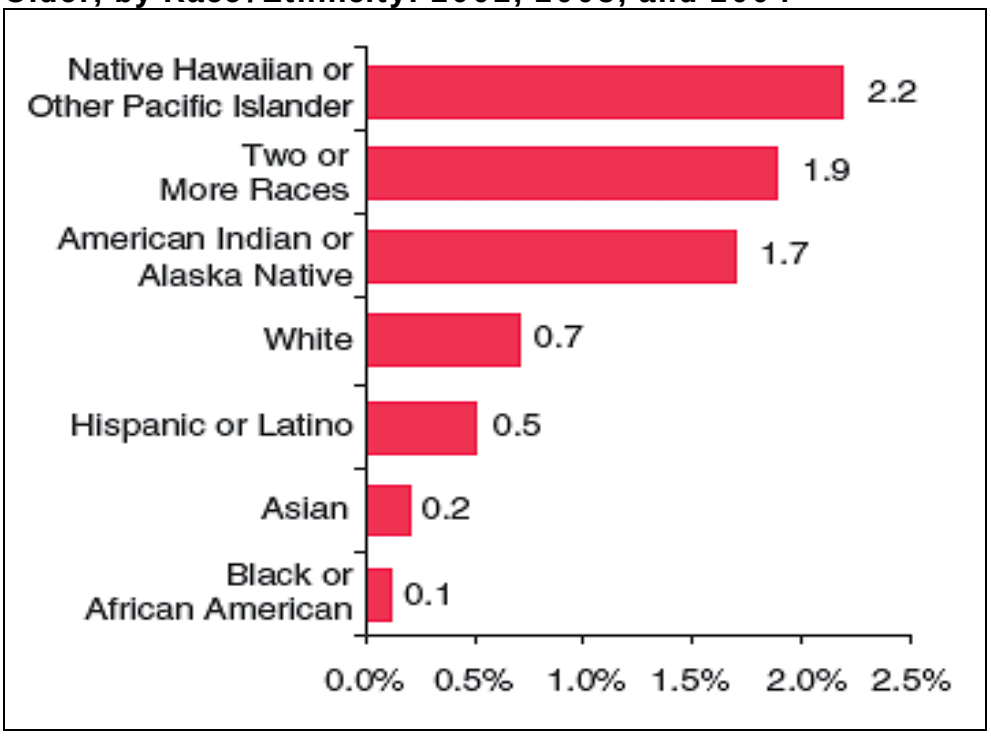
The changes in the brain may help explain the depression, paranoia and memory problems experienced by chronic users of methamphetamine. For example, effects have been documented in the area of the brain that is important for emotional and cognitive behavior; as well as the area of the hippocampus which has a role in memory.[60]

Just as child welfare has needed to adjust their practices to work with families affected by methamphetamine, substance abuse treatment agencies have needed to adjust to treating methamphetamine users in larger numbers. In particular, learning strategies to address the short-term cognitive impairments, memory deficits, and word recall and understanding is requiring resources for training and skill building among the nation's treatment professionals.

Population Differences

In addition to the differential use rates by region of the country is important information on the race/ethnicity of persons who are users of methamphetamine. America's native populations of Hawaiians and Native Americans are using methamphetamine at alarmingly high rates. Figure 21 shows the percentage of persons reporting methamphetamine use in the prior year by racial or ethnic group. These data are critical when we consider the differential impact of substances and the disproportional number of children of color in our child welfare system.

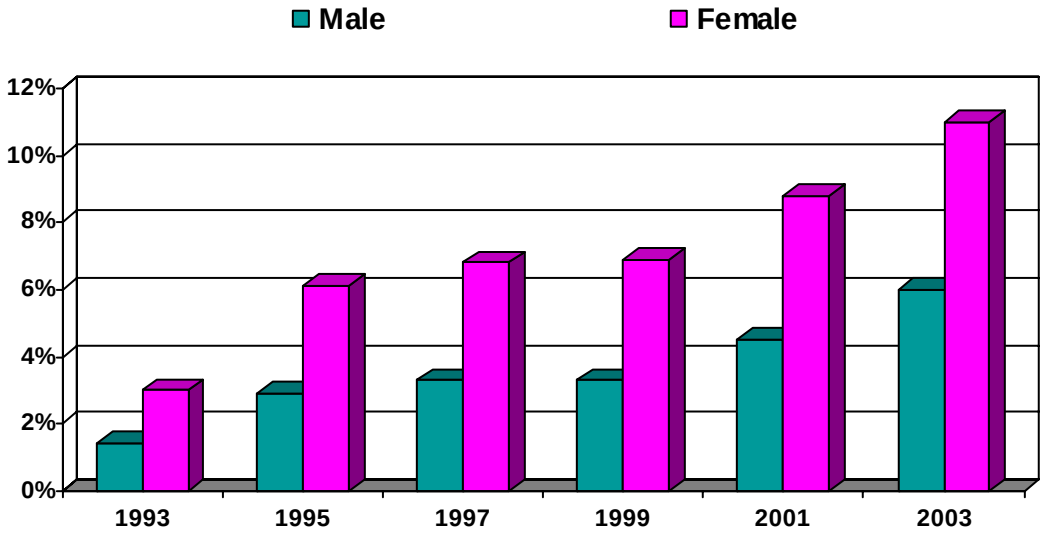
Figure 21: Methamphetamine Use in Past Year among Persons Aged 12 or Older, by Race/Ethnicity: 2002, 2003, and 2004[61]



Gender Differences in Use Patterns

Although methamphetamine admissions account for a small percentage of all treatment admissions, there are important differences by gender and pregnancy status to consider in the effect on the child welfare system. In the nation, women represented about 31% of all treatment admissions in 2003. However, methamphetamine admissions for women are much higher percentage of their overall admissions than for men – 11% compared to 6%. Figure 22 shows the treatment admission data by gender.

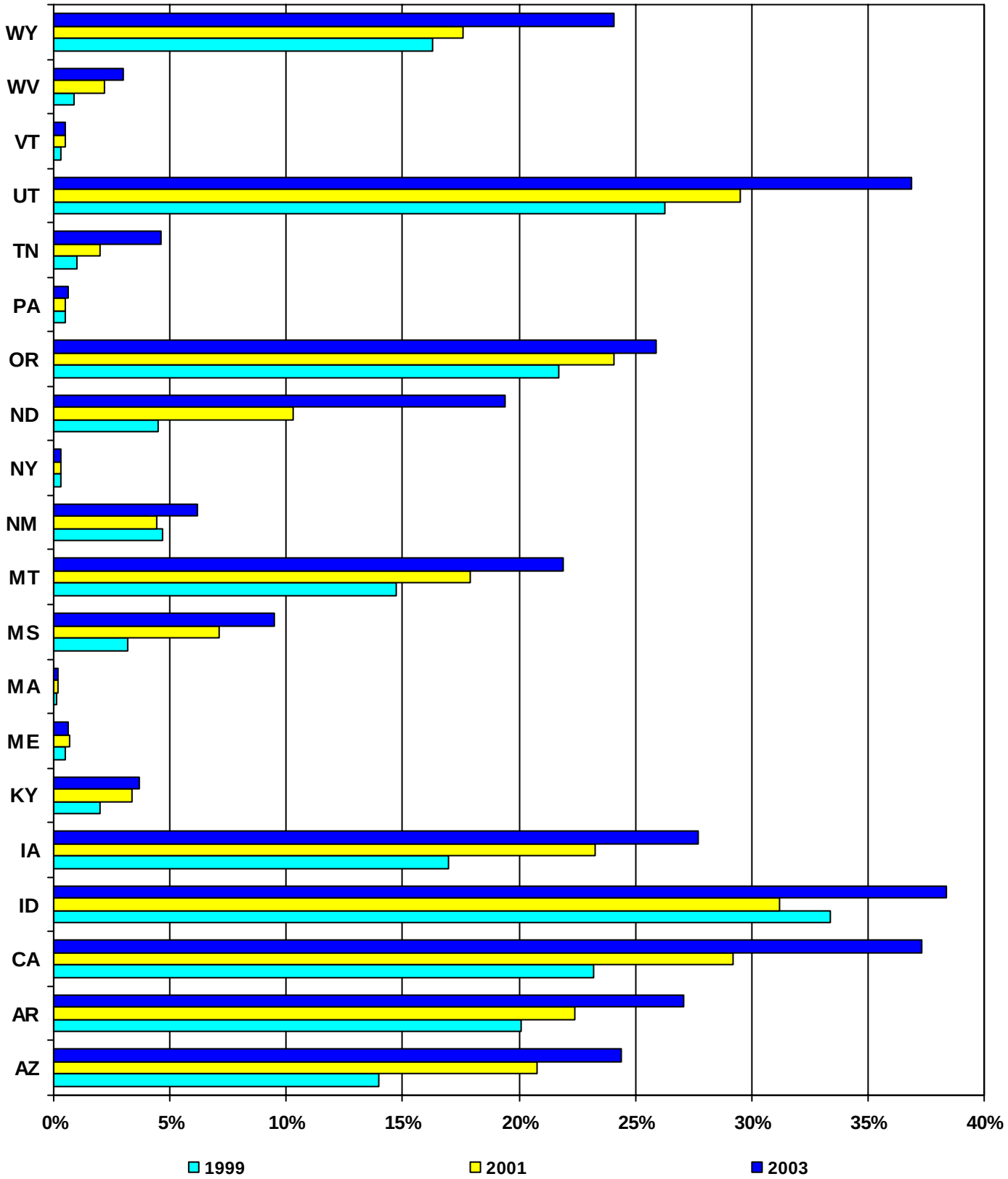
Figure 22: Percent Methamphetamine/Other Stimulants as Primary Substance at Admission 1993-2003, By Gender[62]



This trend in the national data is also seen in most of the States. Figure 23 on the next page shows the percentage of women's treatment admissions with methamphetamine/stimulants as the primary substance problem in the States represented by members of the Senate Finance Committee plus California (California is included for comparison because it has been heavily impacted by methamphetamine for more than a decade). Again, you see the regional differences in the admission data with the North-East admitting a very low percentage of women with primary methamphetamine problems. However, States such as Utah and Idaho have women methamphetamine admission percentages comparable to California's (nearing 40%).

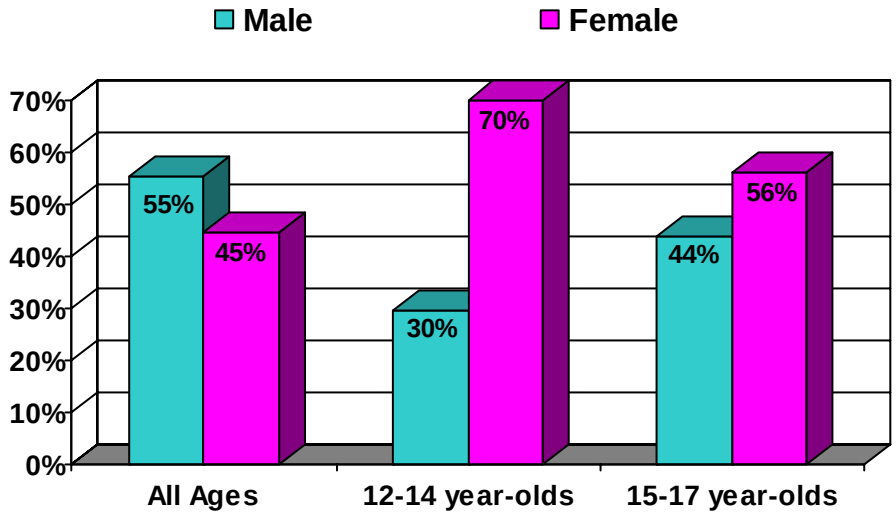
Yet, we should not be misled by these data in terms of the impact of substance use disorders on the child welfare populations in the States with low primary methamphetamine treatment admissions. In the past year and a half, the National Center on Substance Abuse and Child Welfare has begun in-depth technical assistance programs at the request of the administrations in Maine, Vermont, Massachusetts, and New York. These States recognize that substance abuse is playing a significant role in their child welfare systems, albeit not specifically related to methamphetamine use.

Figure 23: Percent of Female Methamphetamine Treatment Admissions as Primary Substance: 1999 – 2003 in Selected States[63] (percentage of all admissions)



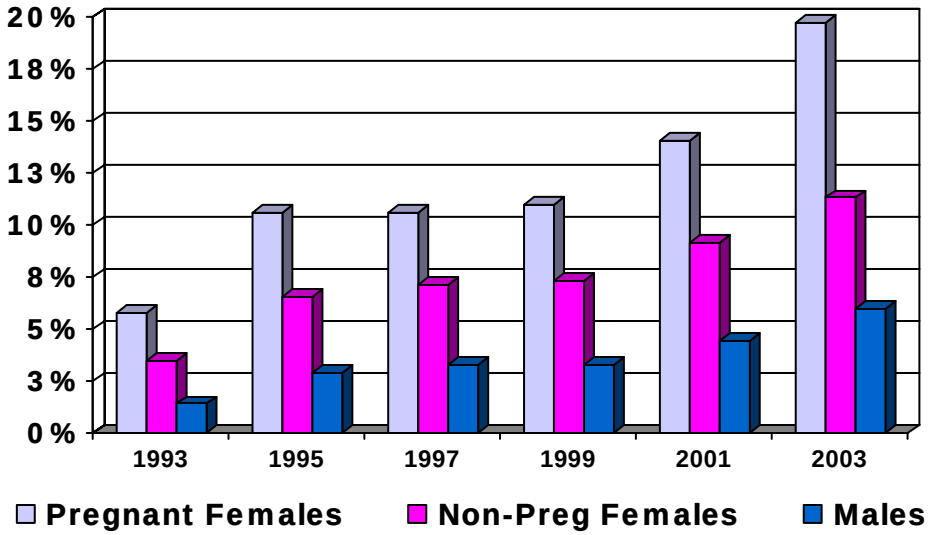
Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents. While young girls represent a smaller number of overall admissions, young girls between 12 and 14 years old represent 70% of youth admitted to treatment for methamphetamine. Figure 24 shows these data.

Figure 24: 2003 Methamphetamine/Amphetamine Admissions by Gender and Age Group[64]



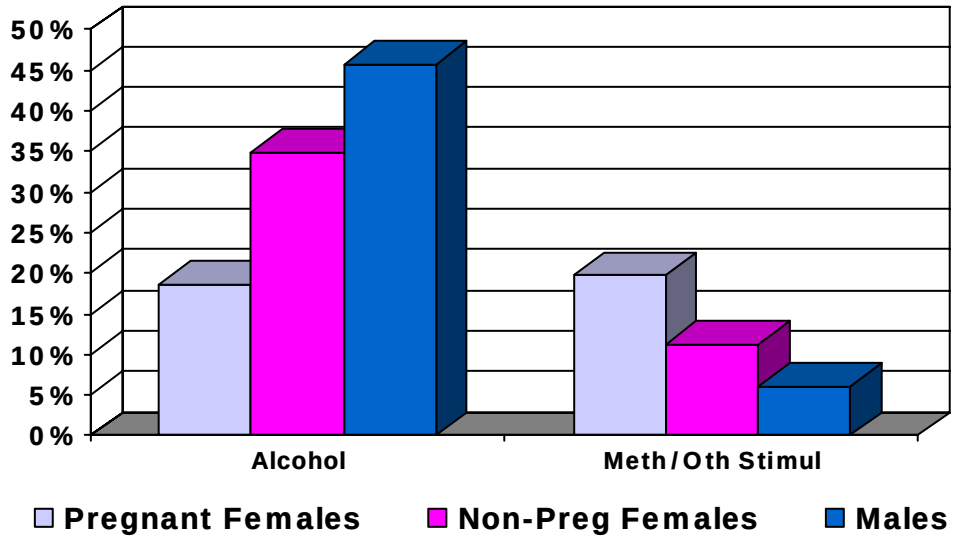
Finally, as Figure 25 shows, methamphetamine admissions as a percentage of all admissions increased from 6% in 1993 to 20% in 2003 for pregnant females, in contrast to an increase from 4% to 11% for non-pregnant females and 1% to 6% for males.

Figure 25: Methamphetamines as Primary Substance by Gender and Pregnancy Status: 1993-2003 (Percent of Total Admissions)



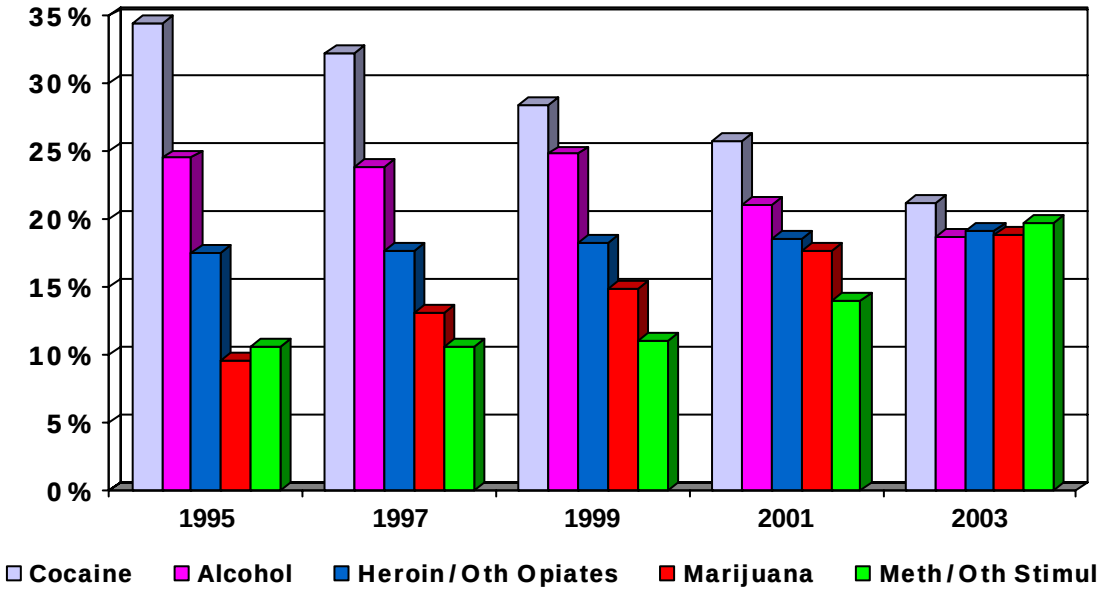
Again, it is important to recognize the larger impact that other substances have on women, the treatment system and child welfare agencies. As shown in Figure 26, admissions for primary alcohol problems represented 46%, 35% and 19%, respectively.

Figure 26: Alcohol and Methamphetamine as Primary Substances by Gender and Pregnancy Status: 2003 (Percent of Total Admissions)



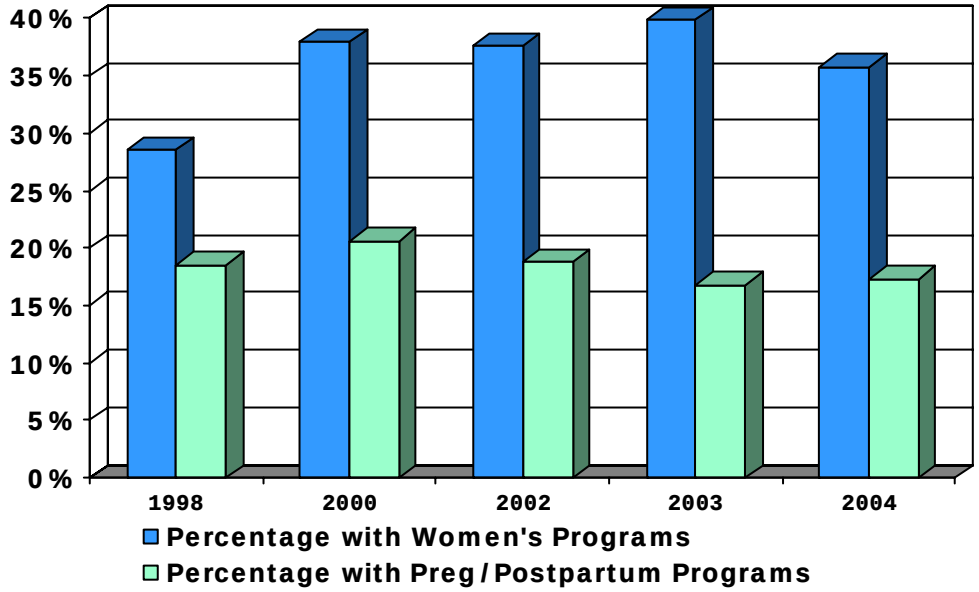
To further explore other substances of abuse and pregnant women, Figure 27 shows that among pregnant women entering treatment from 1995 to 2003, there has been a decrease in those reporting cocaine and alcohol-related problems, relative stability in admissions for heroin, and an increase of 98% for marijuana and 86% for pregnant women reporting methamphetamine disorders.

Figure 27: Percent Admissions by Primary Substance for Pregnant Females, 1995 – 2003[65]



During this time frame, the percentage of treatment facilities providing services for women increased from 29% in 1998 to 40% in 2003, although it then decreased slightly to 36% in 2004. Unfortunately, as we understand more about the need for special services for pregnant and parenting women and their families, the percentage of treatment facilities providing programs specifically for pregnant and postpartum women has decreased from 19% in 1998 to 17% in 2004. These data are shown in Graph 25.

Figure 28: Percentage of Treatment Facilities Providing Services for Women and Specific Programs for Pregnant/Postpartum Women



Summary

- Treatment admissions for methamphetamine represent a small yet growing group among those entering treatment in most areas of the country
- The impact of methamphetamine is being experienced disproportionately by America's Native populations; Native Hawaiians and Native Americans are using the substance at higher rates than other ethnic and racial groups
- Women are also disproportionately experiencing methamphetamine problems; the gender ratio of treatment admissions overall is 1:3, women's admissions for methamphetamine are 1:1 with men
- Women's admission rates in various States reflect the regional differences in methamphetamine use
- Young girls represent 70% of treatment admissions for methamphetamine among 12 to 14 year olds
- While cocaine use has increased in the general population, pregnant women entering treatment are increasingly reporting methamphetamine as their primary substance of abuse
- The percentage of treatment programs with specialty services for pregnant and post-partum women has decreased in the past few years

6. The unique characteristics of methamphetamine users that pose new challenges to child welfare organizations

To provide a perspective on challenges facing child welfare regarding methamphetamine use, it is helpful to compare methamphetamine users with the users of cocaine, another stimulant that has been a child welfare issue for the past two decades. Compared with cocaine users, methamphetamine users:

- Begin using substances at a younger age[66]
- Enter treatment at a younger age[67]
- Are more likely to use multiple drugs (especially marijuana)[68]
- Have a higher frequency of use[69]
- Are less likely to use alcohol[70]
- Report feeling less "addicted" than cocaine users[71]
- Are more likely to use methamphetamine continuously throughout the day at evenly spaced intervals and consistently over time, rather than concentrating use in the evening as cocaine users tend to do[72]
- Use fewer times per day than cocaine users (though the same amount of drug is used)[73]
- Spend less money to purchase the drug[74]
- Are more likely to be female and Caucasian[75]

In addition, several sources have documented the rural nature of methamphetamine use.[76] While over 20 million Americans who needed treatment for substance use disorders in 2003 did not receive it, access to treatment resources in rural communities is a critical issue for child welfare practice.

Women Methamphetamine Users

Of the total number of individuals admitted to treatment for methamphetamine, 47% are women. This percentage of female admissions is higher than the percentage of female admissions associated with any other drug except tranquilizers.[77] The implication is that more children are likely to be affected by a parent's use of methamphetamine than if users were predominantly male, since caretakers are often predominately female.

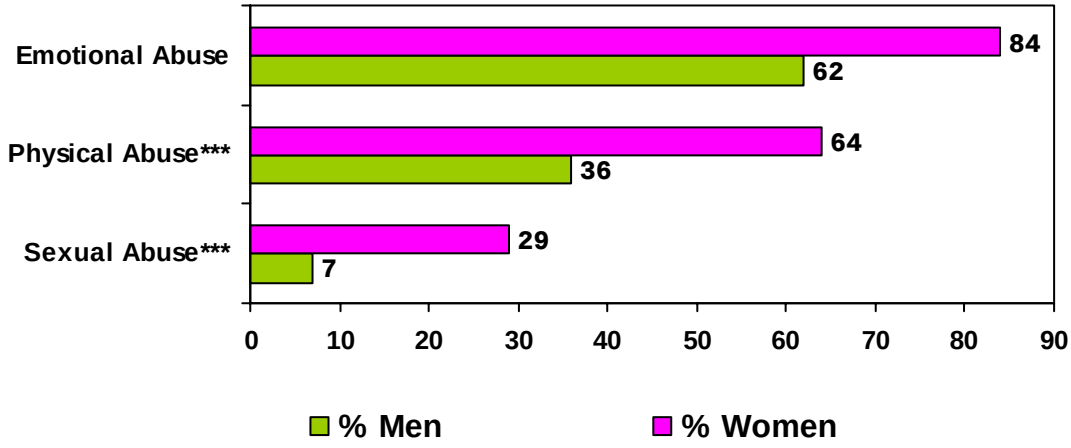
Compared with male methamphetamine users, female methamphetamine users:

- Use methamphetamine more days in a 30-day period[78]
- Smoke rather than snort or inject the drug[79]
- Are more likely to be single parents who live alone with their children[80]
- Have worse medical, psychiatric, and employment profiles[81]

These statistics indicate a greater risk for the children of mothers who use methamphetamine. The parent is likely to use the drug more often and have greater difficulty providing adequate parenting and economic support for the child. Methamphetamine users, like other drug users, are more likely than non-users to have experienced physical or sexual abuse as children. A recent study of clients of a publicly-funded treatment system found that two-thirds of women

methamphetamine users had been physically abused and nearly one-third had been sexually abused. The women were victims of this abuse at a very young age with 43% reporting that sexual abuse occurred before the age of 10.[82] The data on types of childhood abuse are shown in Figure 29.

Figure 29: Childhood Abuse among Adult Methamphetamine Clients in Treatment



***** Significant difference between women and men p < .001**

This information has crucial impact on child welfare. First, the majority of women that are mothers of children in care may have significant co-occurring mental disorders associated with their childhood abuse, including a high degree of post-traumatic stress associated with this childhood trauma. Second, these data point to the critical need for substance abuse prevention programming targeted to the children who are victims of child abuse and are in the child welfare system today.

The issues specific to women methamphetamine users also suggest a further need for training of child welfare workers in effective treatment engagement strategies, for improved screening and assessment, for child welfare information systems and drug treatment admission information systems to both be upgraded to capture this information, and a need for expanded outreach to rural areas, using formal and informal means of providing services to rural areas.

Summary

- There are critical differences between women and men in the methamphetamine use patterns and co-occurring disorders
- These gender differences should be addressed in specialty programs that address the whole family's needs
- Women with methamphetamine use disorders are highly likely to have been victims of childhood physical or sexual abuse; this strongly suggests that targeted prevention programs are needed for children, and particularly girls, in the child welfare system
- Addressing the mental health and trauma specific services in substance abuse programming is critical

7. Information about the effectiveness of treatment for women with methamphetamine use disorders

Despite these complex clinical issues and co-occurring disorders among women with methamphetamine dependence, studies have shown that treatment for methamphetamine is effective. As the committee is aware, the University of California at Los Angeles, Integrated Substance Abuse Program has conducted extensive research on treatment for methamphetamine. They have found that outcomes have not differed from other drugs of abuse treatment studies. Yet, staff need skills to work with stimulant users and to implement evidence based practices.

Positive treatment outcomes were achieved using:

- Intensive outpatient setting
- Three to five visits per week of comprehensive counseling for at least the first three months
- Cognitive behavioral approaches
- Contingency management
- Reducing consequences associated with drug use such as the need for health care, employment services and mental disorders
- Motivational interviewing & brief intervention models
- Intervening earlier and reducing cumulative harm
- Attending to co-occurring mental disorders.

Brecht[83] has analyzed the treatment effectiveness data from UCLA specifically to document treatment outcomes for women. She found positive outcomes regarding substance use among women in treatment and outcomes that are comparable to other substances of abuse. For every 10 women entering treatment, 6 were continuously abstinent for 1 month; 4 were continuously abstinent for 12 months; 3 were continuously abstinent for 24 months and 3 continued to be abstinent at 48 months. This standard is a fairly high standard to meet—continuous abstinence for 48 months.

Summary

- Treatment outcomes for women with methamphetamine problems has been as effective as treatment for other substances of abuse
- In a sample of women followed for 4 years, 30% of women remained continuously abstinent from methamphetamine use for the entire 48 months

8. Models of effective child welfare and substance abuse services

Counties and States around the country have begun the hard work of providing comprehensive programs and system reforms to better address the issue of substance use among families in child welfare. For example, positive outcomes regarding methamphetamine dependence among parents in child welfare have been documented in Sacramento County. Over the past decade, Sacramento has instituted six critical system changes in child welfare and treatment practices for parents with substance use disorders. The system changes require a comprehensive view of the county's response to substance use disorders among families in child welfare. Sacramento's system changes include:

1. **Comprehensive training—**to ensure that all workers in the Department of Health and Human Services fully understand substance abuse and dependence and are trained with skills to intervene with parents

2. **Early Intervention Specialists—**Social workers trained in motivational enhancement therapy are stationed at the family court to intervene and conduct preliminary assessments with *ALL* parents with substance abuse allegations at the very first court hearing in the case

3. **Improvements in Cross-System Information Systems**—to ensure that communication across systems and methods to monitor outcomes are in place as well as management of the county's treatment capacity

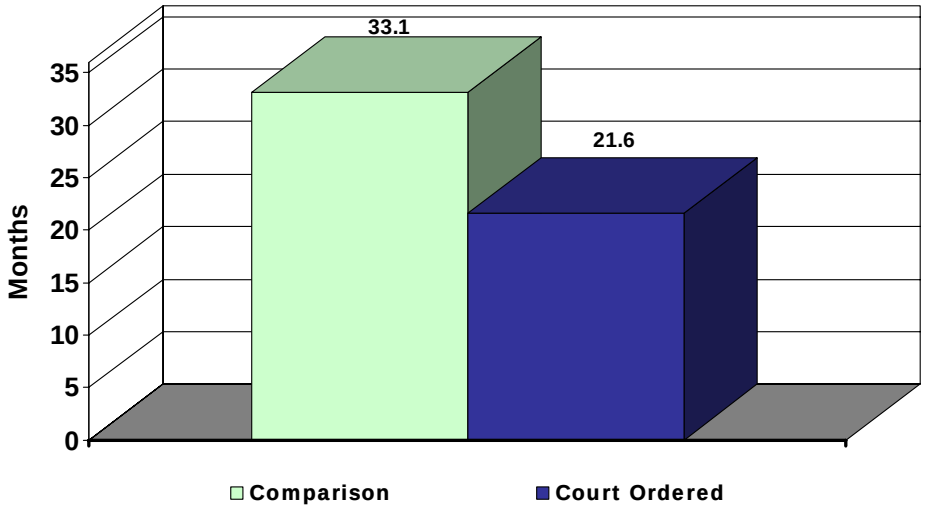
4. **Prioritization of Families in Child Protective Services**—County-wide policy to ensure that families in the child welfare system have priority access to substance abuse treatment services

5. **Specialized Treatment and Recovery Services (STARS)**—provides immediate access to substance abuse assessment and engagement strategies conducted by staff trained in motivational enhancement therapy. STARS provides intensive management of the recovery aspect of the child welfare case plan and routine monitoring and feedback to CPS and the court

6. **Dependency Drug Court**—provides a system of more frequent court appearances for *ALL* parents with allegations of substance use with immediate rewards and sanctions based on compliance with court orders regarding the recovery plan.

These strategies have produced dramatic reductions in the time that children spend in out-of-home care and cost savings to the county. There are over 900 parents and 1500 children included in the treatment group of evaluation data. At 24 months after the child welfare case opened, 42% of parents had reunified with their children compared to 27% of the comparison group. The comparison group averaged 33.1 months in out-of-home care and the treatment group averaged 21.6 months-cutting almost a year in costs of out-of-home care (see Figure 30).

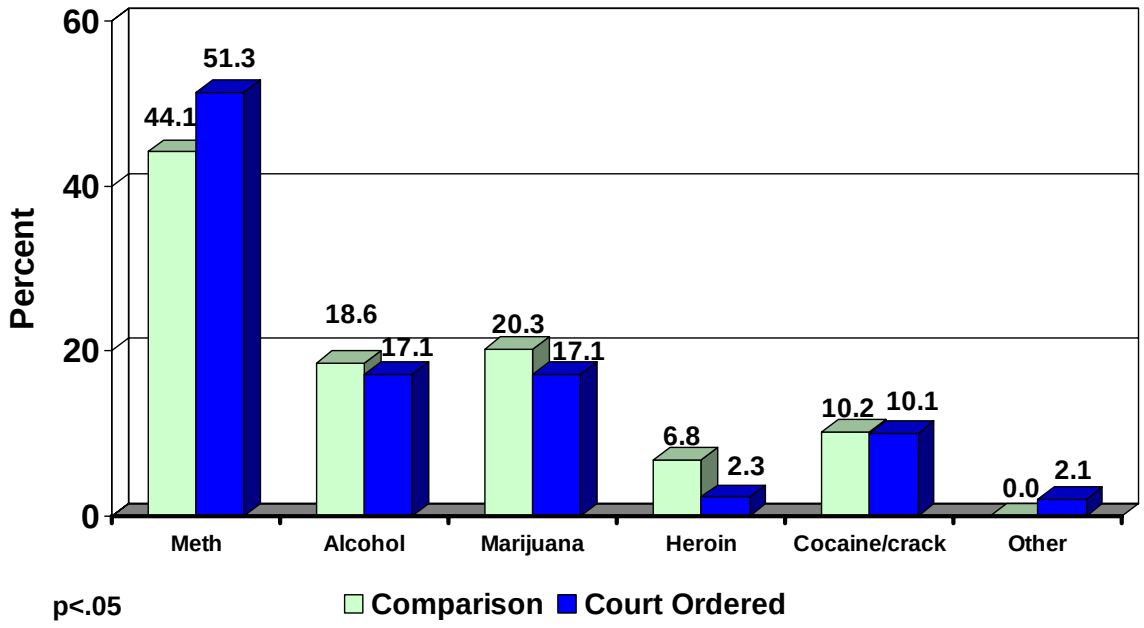
Figure 30: Sacramento County DDC Participants and Comparison Group by Time in Out of Home Care



p<.01

Figure 31 shows the primary substance for two groups of people in treatment, those who were court ordered to participate in services and a comparison group who entered child welfare services in the six months prior to the implementation of these reforms.

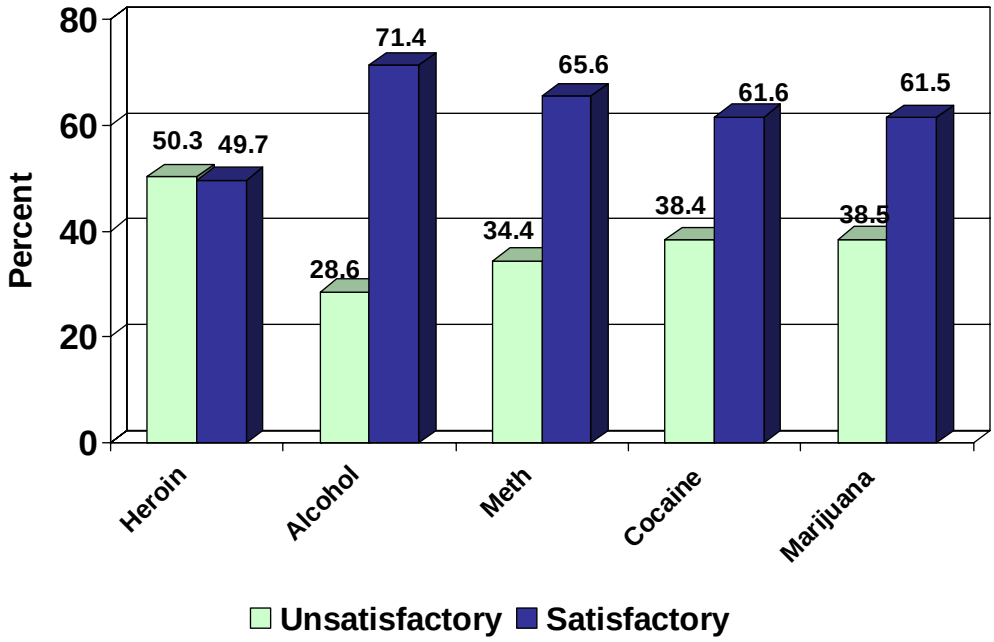
Figure 31: Sacramento County DDC Participants and Comparison Group by Primary Drug Problem



p<.05

Positive treatment outcomes have been achieved across groups of drug users as shown in Figure 32.

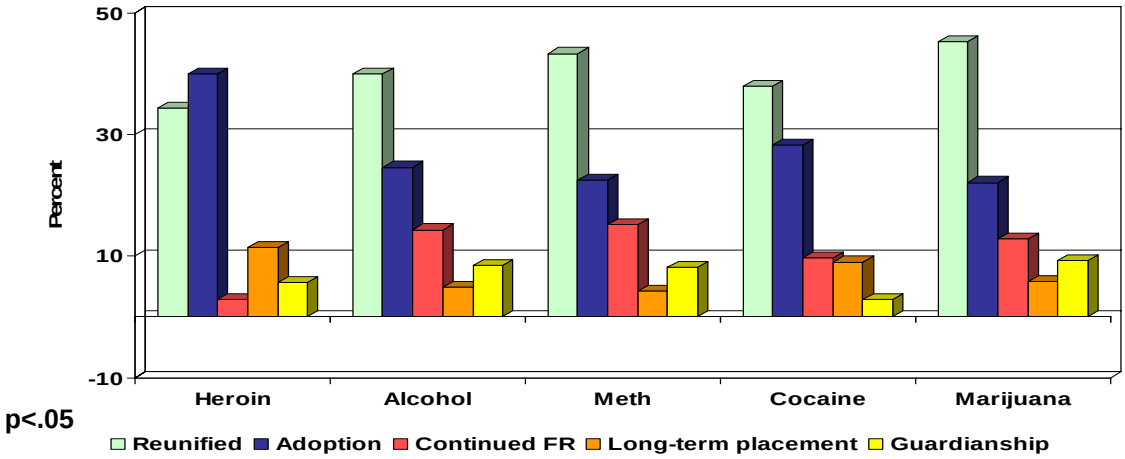
Figure 32: Treatment Discharge Status by Primary Drug Problem



p<.001

Finally, outcomes related to child permanency varied by the type of substance used by the parent as shown in Figure 33. At 24 months after the child was placed in protective custody, parents with a primary heroin problem had more children who were adopted than methamphetamine and marijuana users. In contrast, parents with a primary drug problem of methamphetamine, marijuana, or alcohol had more children in guardianship at 24 months. These outcome data include 1,063 participants.

Figure 33: 24-Month Child Placement Outcomes by Parent Primary Drug Problem



Summary

- Comprehensive models of substance abuse, child welfare and the courts working together have been developed in many communities across the country
- In Sacramento County, where efforts have been underway for nearly a dozen years, comprehensive reforms have led to significant differences for families
- In comparison to families who received services before the systems reform:
  - More parents are completing substance abuse treatment
  - More children are being reunified with their parents
  - Children are spending less time in out-of-home care
  - Children are reaching permanent homes faster
- These outcomes did not vary by primary drug problem; in particular, parents with a primary methamphetamine use disorder did as well in the program as other parents

9. What can be done to address these issues?

Many efforts are being made to address the complex issue of methamphetamine and child welfare.

The National Center on Substance Abuse and Child Welfare provides guidance to States and communities regarding methamphetamine and child welfare practices, including risk and safety factors. We have developed a white paper on women's and children's issues regarding methamphetamine that is the basis for our guidance to States, and we have compiled a list of internet-accessible resources on methamphetamine and child welfare (available at www.cffutures.org). We have made many presentations on methamphetamine and child welfare at conferences across the country. As of April 2006, we have responded to 54 requests for technical assistance on this issue from national, regional, State, and local jurisdictions, including 24 State offices.

The Center for Substance Abuse Treatment is conducting national training conferences to ensure that the States' substance abuse agencies have the information to improve their treatment programs. The Children's Bureau is conducting a national conference on methamphetamine to ensure that State child welfare agencies have accurate information about serving families where methamphetamine is an issue.

Our efforts continue, but there is a tremendous amount of work that must be done.

We offer these four recommendations:

1. Identify the problem: improve our information systems

The lack of child welfare-specific data on substance use disorders underscores the long-standing issue that child welfare workers need better protocols for screening, better cross-system linkages to assessments, and better information systems to monitor emerging issues. Our data on this problem are surprisingly sparse, given its importance.

- We need to collect better information on methamphetamine use from both the substance abuse treatment system and the child welfare system, and the two systems need to put their information together so that we know about parents and caretakers who are in both systems. In the federally mandated child welfare information system, it is an option to report data on substance abuse or dependence; in many states, child welfare workers are not required to enter this information in the record. Thus, we do not have a national monitoring system on substance abuse and child welfare issues.

- Substance abuse information needs to be a component of the Child and Family Services Review system—the primary tool for Federal review of State outcomes in child welfare. The States are not currently required to focus on substance abuse issues in this process, and the substance abuse director is not a required participant.

- Substance abuse treatment agencies need to collect data about the children of parents seeking services. In the past few years, several States have begun gathering this data, but most States do not require treatment agencies to record data about the children of clients who are parents. The National Outcome Measures being implemented by the Center for Substance Abuse Treatment do not include a focus on child welfare issues.

- We need to collect accurate data from hospitals and the maternal and child health systems about the prenatal and at-birth screening they conduct. Studies of substance-exposed births show that the great majority of these infants are not detected as drug-exposed at birth.

2. Improve our interventions for children

- We need earlier diagnosis and intervention with children affected by the prenatal and post-natal effects of their parents' methamphetamine use.

- We need evidence-based prevention programs for children who are in the child welfare system and are children of substance abusers; these children are several times more likely than others to become substance abusers.

3. Improve and increase the availability of staff training in the child welfare and substance abuse treatment systems

- We need to continue to invest in better training for child welfare workers so that they can recognize the problems of methamphetamine use and other substance use among families and ensure timely access to services.

- We need to invest in better training for substance abuse prevention and treatment workers so that they can respond with effective treatment strategies for all persons in need of treatment for substance use disorders.

4. Provide timely access to comprehensive substance abuse treatment

- Most critically, the need for access to substance abuse treatment cannot be over emphasized. When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the–art, comprehensive, meets the needs of the entire family, and most importantly, to meet the intent of the Adoption and Safe Families Act, we must make sure that the treatment is **available and timely**.

These efforts do not come together in a State or community without committing significant resources of time and personnel. We have worked with 11 States and a Tribe in our program of in-depth technical assistance over the past three years, and we understand that States need resources that cross the funding, jurisdiction and discipline-specific barriers in our health and social service systems. We have

excellent models of effective programs and systems reforms, yet there is much to be done to ensure that they can be implemented in each of the States.

Twice Senator Snowe and other Senators have introduced the Substance Abuse and Child Welfare Partnership Act. This bill has not moved through the necessary Committees; yet States and communities all across the country have continued to struggle to put together the pieces of funding, legislation, practice and protocols to better respond to these families. And more importantly, families continue to struggle to get access to treatment resources. I urge you to re-assess the Federal government's responsibility to ensure that timely access to effective services is available to these families.

Unfortunately, there is all too much that we can learn from the child welfare experience during the crack and cocaine epidemic of the late 1980s and early 1990s. We over-generalized about the problem, and we stigmatized the children involved beyond what they actually experienced as a result of prenatal exposure. The phrase "crack babies" was the subject of too many workshops that frightened teachers into believing that these children simply "could not learn." We should not repeat the same mistake with a generation of mislabeled children who are pre- or post-natally exposed to methamphetamine.

As we have seen, the impact of methamphetamine as it affects children and parents in the child welfare system must be compared with the impact of drug use and the need for treatment for all legal and illegal drugs that affect children. The rise in methamphetamine use is unmistakable, but so is the fact that the number of children affected by other drugs is far greater than the number of children affected by methamphetamine.

We must realize the scale of the methamphetamine problem—and the scale of the larger problem that includes all children and families affected by all forms of substance abuse and dependence, both legal and illegal. Your colleagues in the House Congressional Caucus on Fetal Alcohol Spectrum Disorders have made a large contribution to our understanding of the full range of substance use disorders, and we need to keep that broad perspective in view.[84]

The methamphetamine crisis unquestionably brings new challenges to the child welfare system, and child welfare workers need and deserve help in responding to it. But at the same time, this effort should not come at the expense of other efforts to help families and communities deal with the effects of legal and illegal drugs on their children. Helping families and protecting children is not a zero-sum game, in which we must take away from one effort to fund another.

When we worry about our national security, we add resources, and we change our daily routines at airports and in subways. That is the right thing to do. We don't stop funding the military; we add funding for homeland security as well. The security of thousands of children requires a similar perspective to ensure that timely access to services can be provided, to ensure the parent's recovery and the child's safety and well-being. We can do more, and so we must.

[1] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. New crack, methamphetamine and cocaine users from Detailed Tables from 2004 National Survey on Drug Use and Health. Tables 4.3A, 4.14A. Retrieved April 14, 2006 from http://www.oas.samhsa.gov/nsduh/2k4nsduh/2k4tabs/Sect4peTabs1to50.htm#tab4.3a

[2] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Ibid.

[3] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use and Health Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004. Retrieved April 22, 2006, from http://www.oas.samhsa.gov/2k5/meth/meth.htm

[4] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Ibid.

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[7] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use and Health Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004. Retrieved April 22, 2006: http://www.oas.samhsa.gov/2k5/meth/meth.htm

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[9] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use and Health: Detailed Tables. "Illicit drug use, Lifetime, Past Year, and Past Month among Persons Aged 12 and Older." Retrieved April 18, 2006: http://www.oas.samhsa.gov/nsduh/2k4nsduh/2k4tabs/Sect1peTabs1to66.htm#tab1.1a

[10] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use and Health: 2004 State Estimates of Substance Use. Retrieved April 22, 2006: http://www.oas.samhsa.gov/2k4State/Ch5.htm#Fig5.17

[11] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 2004 National Survey on Drug Use and Health Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004. Retrieved April 22, 2006: http://www.oas.samhsa.gov/2k5/meth/meth.htm

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[16] Administration for Children and Families (2005). Child Maltreatment 2004. Retrieved April 22, 2006 at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/figure3_2.htm

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