

Reaching Out

CURRENT ISSUES FOR CHILD WELFARE PRACTICE IN RURAL COMMUNITIES

Summer 2010
SPECIAL EDITION



WHAT'S INSIDE:

Meth Grant Coming to a Close	Cover
Meth Use and Abuse in Child Welfare	2
Partnership Activities and Accomplishments	4
Developmental Screening Tools	6
Using the SAFERR Model	8
Amber's Story	10
Lake County Profile	11
Promising Practices	12
Sacramento/Mendocino Meth Grants	14
Wrap-Up on Partnership Grant	15
Additional Resources	15
Announcements	Back cover

Three-Year Methamphetamine Grant Coming to a Close: Northern Counties Share Lessons Learned

By Susan Brooks, Director, Northern California Training Academy, Center for Human Services, UC Davis Extension

In October 2007, 53 national applicants were awarded a federal grant from the Administration for Children, Youth and Families whose purpose was "to improve the permanency outcomes for children affected by methamphetamine or other substance abuse through a coordinated set of services." This grant program plus the accompanying legislation was developed in response to findings supporting what we in the child welfare field all know: that parental substance abuse is a pivotal factor in child neglect and abuse. California boasted nine of the 53 organizations to receive this funding, three of which are based in Northern California.

Northern California grantees included:
1) the Northern California Regional Partnership for Safe and Stable Families, a partnership comprised of four Northern California counties: Butte, Lake, Tehama and Trinity plus the Northern California Training Academy,
2) Sacramento County and 3) Mendocino County. While this special edition of Reaching Out focuses on the lessons learned by the Northern California Regional Partnership, we also highlight the very successful Sacramento and Mendocino projects.

This federal grant had three notable aspects. First, it included money for technical assistance to create performance measures and reporting systems. Second, this grant mandated collaboration, as only collaboration across several systems will successfully address the relationship between child abuse and neglect and parental substance abuse. Lastly, the grant funding accompanied legislation reauthorizing the Promoting Safe and Stable Families program through the Child and Family Services Improvement Act of 2006. Rarely does legislation include the offer of grants to implement targeted activities, indicating the importance the federal government is placing on this issue.

The Northern California Regional Partnership was funded to promote collaboration and service coordination among the three core systems—child welfare, alcohol and other drug treatment services (AOD) and the courts—that work with families who are struggling with issues of child abuse or neglect and drug addiction, specifically meth. In the three years since the grant money has been awarded many goals have been accomplished, and services throughout Northern California have improved. This special edition of Reaching Out will highlight these success stories.



Meth Use and Abuse: Its Impact on Families and Child Welfare

Parental substance abuse is often a key factor underlying the abuse or neglect experienced by many children in the child welfare system.¹ Studies indicate that between one-third and two-thirds of all substantiated child maltreatment reports involve substance abuse.² Anecdotally, most Northern California counties report anywhere from 80-99 percent of clients in the child welfare system are drug affected. Supporting this, the majority of county law-enforcement agencies now report meth as their primary drug problem.³

The rise of methamphetamine use, in particular among women of child-bearing age, has increased the visibility of these issues and focused attention on the need to provide comprehensive, integrated, family-centered treatment services to affected families. However, overall, from 1992 to 2005, meth-related treatment admissions increased more than tenfold.² This increase is due to both significant geographic and demographic expansion of meth users. Meth use remains a more significant problem in western states, though states in the Midwest and South contribute a large share of treatment admissions for meth.⁴

In 2006, women accounted for 46 percent of all methamphetamine/amphetamine treatment admissions. Among treatment admissions for pregnant women, from 1996 to 2006, the proportion increased from 9 percent to 24 percent while the proportion for non-pregnant females also increased from 5 percent to 13 percent.⁴

With the exception of tranquilizers and sedatives, more women are admitted to treatment for meth addiction than any other drugs in the U.S. Compared with male users, female meth users:

- use meth more days in a 30-day period
- are more likely to be single parents who live alone with their children
- have worse medical, psychiatric and employment profiles

These statistics indicate a greater risk for the children of mothers who use meth. Women are likely to use the drug more often and have greater difficulty providing adequate parenting and economic support.

Effects of meth on the brain and body

Meth is a highly addictive substance that can be taken orally, injected, snorted or smoked. When smoked or injected, the user immediately experiences an intense sensation followed by a high that may last 12 hours or more.⁵

Meth use appears to cause long-term structural damage to the regions of the brain that control memory and motor coordination. Compared to cocaine and other drugs, meth remains active in the body much longer, and a greater percentage of the drug remains unchanged in the body, producing prolonged stimulant effects.

The observable effects of meth use include cognitive deficits, health problems and psychological problems. Active meth users are impaired in their ability to learn, recall, make inferences, manipulate information and ignore irrelevant information. Physical side effects may include rapid and irregular heartbeat, increased blood pressure, hyperthermia, convulsions, stroke, insomnia, restlessness and tremors.⁵

In addition, meth users may more likely be poly-drug users,⁶ have high rates of psychiatric disorders⁷ and experience serious depressive symptoms during withdrawal.⁸ Concerns about meth use arise from its highly addictive nature and its association with a number of adverse physical effects including hypertension and other cardiovascular effects, seizures and convulsions, pulmonary impacts and dental damage.

Users also suffer psychological effects such as anxiety, irritability and loss of inhibition, which can lead to risky sexual and other behavior. Use has also been associated with mental health events such as hallucinations, paranoia and violent behavior.⁹



Episodic meth use

When high, parents may exhibit poor judgment, confusion, irritability, paranoia and increased violence. They may fail to provide adequate supervision. The family and social environment may be poor, and the children may be at risk of abuse and neglect due to the family dynamics associated with substance use. Children may also accidentally ingest the drug, and because meth users typically also use other substances, including alcohol, tobacco and other drugs, the risks to their children accumulate.

Prenatal exposure

Meth exposure during pregnancy can jeopardize the development of the fetal brain and other organs. A high dose of meth taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus that can lead to stroke or brain hemorrhage. Infants prenatally exposed to meth are significantly smaller for their gestational age compared to unexposed infants. Longer-term effects of prenatal exposure may be similar to other substances: long-term cognitive deficits, learning disabilities and poor social adjustment in older children.

The manufacture of meth for home use

Some parents produce relatively small quantities of meth in their homes for their own use. Children in these homes are subject to the same risks noted in the sections on parents who use and are dependent on the drug, but children have additional risks associated with the substances used in meth 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. And, because they are still developing, children are more likely than adults to suffer health effects from exposure to chemicals.

Treatment for meth addiction

Meth is a dangerous drug for users and puts their children at risk. However, research indicates that the physiological damage created by meth use is reversible with long-term abstinence, and the treatment models that work for addiction to other substances are also effective for meth addiction. Successful treatment for the parent may lead to family reunification and resultant benefit to both the child and the parent.

It is important to note that during the beginning stages of treatment, cognitive problems and ADHD may become worse and increase the likelihood of relapse.¹⁰

1 “The Economic Cost of Methamphetamine Use in the United States, 2005.” Authors Nicosia, N., Liccardo-Pacula, R., Kilmer, B., Lundberg, R. and Chiesa, J., RAND Drug Policy Research Center, 2009. http://rand.org/pubs/monographs/2009/RAND_MG829.pdf

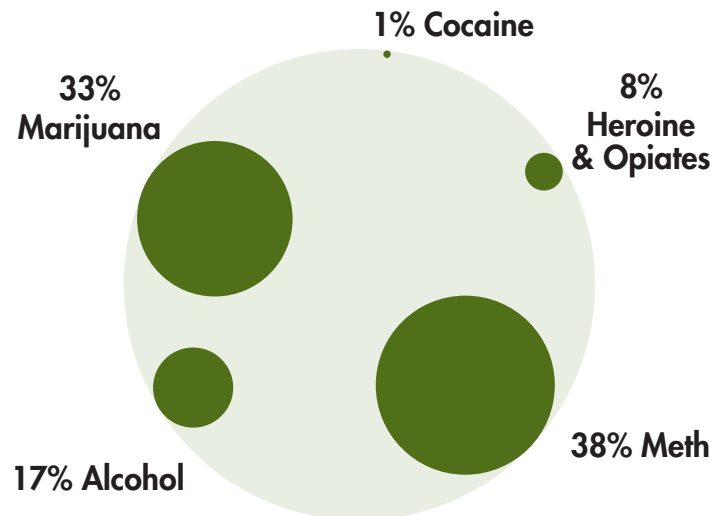
2 “Meth Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers.” Authors Otero, C., Boles, S., Young, N. and Dennis, K., Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, April, 2006.

3 “The Meth Epidemic in America: Two Surveys of U.S. Counties.” National Association of Counties, Washington, D.C., July 5, 2005. <http://naco.org/Template.cfm?Section=Surveys&template=/ContentManagement/ContentDisplay.cfm&ContentID=17216>

4 “The DASIS Report: Primary Methamphetamine/Amphetamine Admissions to Substance Abuse Treatment: 2005.” Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Rockville, MD., February 7, 2008. <http://www.oas.samhsa.gov/2k8/methamphetamineTX/meth.pdf>

5 “Ongoing Child Protective Services (CPS) with Methamphetamine Using Families: Implementing Promising Practices.” Authors DePanfilis, D. and Hayward, R.A., University of Maryland School of Social Work Center for Families, for the National Resource Center for Child Protective Services: A Service for the Children’s Bureau, August 2006. http://www.nrccps.org/PDF/Ongoing_CPS_with_Meth_Using_Families_Implementing_Promising_Practice10302006.pdf

● Meth surpasses alcohol and marijuana as drug of choice in the regional partnership counties



This graph represents adult clients primary drug of choice. Data came from the CalOMS (California Outcomes Measurement System) assessment tool where the clients give a self-report of their drug use.

Source: Butte County RPG Semi-Annual Progress Report, Reporting Period IV: September 30, 2009, through March 31, 2010.

6 “Methamphetamine use behaviors and gender differences.” Authors Brecht, M. L., O’Brien, A., Mayrhauser, C. V., and Anglin, M. D. Addictive behaviors, (2004), 29, 89-106.

7 “Female methamphetamine users: social characteristics and sexual risk behavior.” Authors Semple, S. J., Grant, I., and Patterson, T. L. Women & health, (2004), 40(3).

8 “Status of methamphetamine users 2-5 years after outpatient treatment.” Authors Rawson, R., Huber, A., Brethen, P., Jeanne, O., Gulati, V., Shoptaw, S., et al. Journal of addictive diseases, (2002), 21(1), 107-119.

9 “NIDA InfoFacts: Methamphetamine.” NIDA. (2005). <http://www.drugabuse.gov/pdf/infofacts/Methamphetamine05.pdf>

10 “Psychiatric symptoms in methamphetamine users.” Authors Zweben, J. E., Cohen, J. B., Christian, D., Galloway, G. P., Salinardi, M., Parent, D., et al. The American journal on addictions, (2004), 13, 181-190.

Defining the Problem

Too often, the provision of child welfare services and substance abuse treatment is uncoordinated and fragmented due to the following challenges:

- difficulty in engaging and retaining parents/caregivers in substance abuse treatment
- differing perspectives and policies between child welfare workers and substance abuse treatment providers
- lack of appropriate comprehensive, family-centered treatment services for families involved in both the child welfare and substance abuse treatment systems
- difficulty in identifying families suffering from alcohol or other drug addiction. Without data regarding usage rates, it is difficult to provide rationale for needed funding and services.

This was the rationale of the Promoting Safe and Stable Families (PSSF) program for targeted grants—to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse.

Regional Partnership Grant: Activities and Accomplishments

In September 2007, four Northern California counties came together as the Northern California Regional Partnership for Safe and Stable Families with the mission “through timely services, family involvement and the collaboration and coordination of our multi-agency partnership, we will improve the permanency outcomes for children affected by methamphetamine and/or other substances.”

The overall goal of the Northern California Regional Partnership, comprised of Butte, Lake, Tehama and Trinity counties, was to coordinate services among Child Welfare Services (CWS), Alcohol and Other Drugs (AOD) Programs and the court system in order to improve access to services for families. Through enhanced cross-system partnerships, early assessment, diagnosis and treatment, the counties sought to improve outcomes for families.

Of initial concern when preparing for this grant was the lack of concrete information regarding drug use among clients in the child welfare system. Because of challenges with data reporting (namely, that CWS/CMS does not have a data code for alcohol or drug use), it was very difficult for these counties to provide specific information regarding parental drug use other than anecdotally. Thus, the four-county partnership placed a priority on improving the ability of each county to appropriately track parental drug use.

In addition, each county differed in the sophistication of screening for alcohol and drug use among new clients as well as providing clients with timely referrals and access to AOD treatment.

Major accomplishments of the partnership

Cross-system collaboration

Prior to the meth grant, representatives from both child welfare and alcohol and drug services reported these agencies often had tenuous relationships with each other. Their communication was often inconsistent, sometimes even tense. Often they felt they had competing goals, CWS focusing on the child with AODS focusing on the parents. As a result of the meth grant, relationships have significantly improved. Each county has an oversight committee in place to address policies, changes, concerns and development of new ideas between CWS and AODS. These meetings occur regularly (differs in each county) and include the CWS and AODS administrators, supervisors, social workers and counselors. There is also cross training between AODS and CWS staff that includes policy development and best practices such as motivational interviewing.

Early assessment of alcohol and drug addiction with timely referrals for services

The primary undertaking of this grant was the co-location of an alcohol and drug counselor or specialist position at the Child Welfare Services offices in each of the four counties. This co-located position (varied per county if position was held by CWS or AODS) was to provide immediate AOD assessments of clients upon their entry into the child welfare system. Furthermore, this position was intended to enhance the collaboration between child welfare and alcohol and drug services.

To fulfill the goal of early assessments, each county has now implemented a standardized process for every client of child welfare. In Trinity County, upon the filing of the petition in court, the parent is immediately scheduled an appointment with a co-located alcohol and drug counselor who completes the Addiction Severity Index (ASI) assessment. Within a week of the assessment, an intake appointment is scheduled at AODS and a treatment plan is developed.

In Tehama County, the enhanced CalOMS (California Outcomes Measurement System) assessment tool is completed with parents. Parents in CWS are given priority intake at AODS and are seen within one week of referral. The Butte County Child Welfare office has formally partnered with its respective Alcohol and Drug Services to provide a co-located AOD counselor in each CWS office who provides on-site, immediate alcohol and drug screening and referrals to appropriate resources using the evidence-based guiding principles of the SAFERR model.

Early engagement groups

Early engagement groups have been utilized by the regional partnership as a means of providing new clients with important information to help them understand the Child Welfare Services process and to begin reunification.

Families are immediately referred to the Early Engagement group as part of their required service components, often attending their first class prior to disposition. Group leaders provide an overview of CWS process (court process and legal aspects), work through issues of grief and trauma (their own and their child's) as well as addressing resistance or denial upon entering the CWS system so parents are fully able to participate in CWS service components and court process.

There is not a standard required number of parent engagement classes each parent must attend; instead, it is individually based (one parent may attend four classes whereas another may attend ten). On a broad level, positive outcomes of these early engagement groups include increased involvement of fathers in the reunification process, and cost saving for the county through a reduction in the number of anger management courses typically referred to clients.

Motivational interviewing

Staff in child welfare and alcohol and drug services, including supervisors, have received intensive training in motivational interviewing (MI), a practice that has been rated high by the California Evidence-Based Clearinghouse for Child Welfare in the areas of Motivation and Engagement and Substance Abuse Treatment. MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI has been shown to be effective in improving substance abuse outcomes by itself as well as in combination with other treatments. MI is a therapeutic technique that helps people identify their readiness, willingness and ability to make the change.

Family team meetings

While all four counties are using slightly different models of family team meetings (FTMs), they have all implemented some version. Family team meetings are held prior to the disposition hearing in order to develop a case plan; participants include the ongoing social worker, parents and anyone who the parent wishes to be present, including service providers, group facilitators, AODS and community partners. During the FTM, results from the AOD assessment are discussed. Many positive outcomes have developed from these FTMs, one of which is the involvement of the AOD specialist/counselor in the case planning process. FTMs have increased overall coordination of services in partnership with the family.

Nurturing parents

The Nurturing Parent Programs® aims to treat child and adolescent maltreatment, prevent its recurrence and build nurturing parenting skills in at-risk populations. The Nurturing Parenting Programs have been field tested with families at risk for abuse and neglect, families who have already been identified by local social services as abusive or neglectful, families in recovery for alcohol and drug abuse, and a variety of other high-risk families. The California Evidence-Based Clearinghouse for Child Welfare rates the Nurturing Parenting Programs as Promising Research Evidence with a High Relevance to Child Welfare. In the words of the program developer, this program is:

....a psycho-educational program that assists parents in strengthening their own recovery, facilitating recovery within their families and building a nurturing family lifestyle. A core goal of this program is to nurture parents, thereby enhancing their ability to nurture their children...They [parents] build skills that strengthen their recovery, explore their own development as adults in recovery and examine similarities and differences in the development of their children.¹

Developmental screening tools

These activities and accomplishments are described in the following newsletter article, "Implementing Developmental and Social-Emotional Screening Tools for Infants and Young Children."

Conclusion

Though some of these activities were at least partially in place before the grant was awarded, because of the funding received from the grant, not only have new programs been implemented but others have been expanded; in addition, the grant life, which was originally a three-year award, has now been expanded another year because of the value to families and children in these four counties.

1 "Research and Validation of the Nurturing Parent Programs." Research Report. Author Bavolek, S. J. (2002). Asheville, NC: Family Development Resources, Inc.

Implementing Developmental and Social-Emotional Screening Tools for Infants and Young Children

The Northern California Regional Partnership counties have taken steps to implement a standardized screening protocol for developmental delays and/or disabilities and social-emotional issues in children under the age of five. Currently, all four counties have selected the Ages and Stages Questionnaires (ASQ), an evidence-based screening tool developed by a multidisciplinary team at the University of Oregon Center on Human Development.

Developmental delays and behavior issues have been documented heavily in research as impeding placement stability, reunification and permanency. Furthermore, children with special needs are at higher risk of abuse and neglect.

Research now shows that the use of professional judgment alone is not enough to identify developmental delays or behavioral concerns in infants and toddlers. Because developmental and social-emotional delays can be subtle and can occur in children who appear to be developing normally, most children who would benefit from early intervention are not identified until after they start school. Even pediatricians fail to detect delays more than 70 percent of the time when they rely on clinical judgment alone.

Studies show that when professionals use reliable and valid screening instruments, they are able to identify 70 to 80 percent of children with developmental delays.

All County Letter (ACL) 06-54 requires that child protective services refer children under age three who are “involved in a substantiated case of child abuse or neglect to receive early intervention services funded under Part C of the Individuals with Disabilities Education Act...” 42 U.S.C. 5106a (b)(2)(A)(xxi).

The Ages and Stages tools

- parent- or caregiver-completed screening tools that encourage parental/caregiver involvement
- series of questionnaires for parents of children ages one month to five and a half years old
- tools to accurately identify children at risk for developmental or social-emotional delay



What the screening tools measure

The Ages and Stages Questionnaires® Third Edition (ASQ-3) were developed to screen infants and children (ages two months to five years) for developmental delays.

The ASQ-3 measures the following:

- communication
- gross motor skills
- fine motor skills
- problem solving
- personal-social

The Ages and Stages Questionnaires®: Social-Emotional (ASQ:SE) were developed to screen infants and young children for social or emotional difficulties, identify behaviors of concern to caregivers and identify any need for further assessment (it is not a diagnostic tool for identifying children with serious social or emotional disorders).

The ASQ:SE measures the following:

- compliance
- communication
- adaptive functioning
- autonomy
- affect
- interaction with people
- self-regulation

ASQ in the North State

In September 2009, Lake County implemented a policy that all children under the age of five who are substantiated for maltreatment be screened using both the ASQ 3 and ASQ:SE. To date, 19 caregivers (15 foster parents, three biological parents, and one grandparent) of 24 children have participated in this screening.

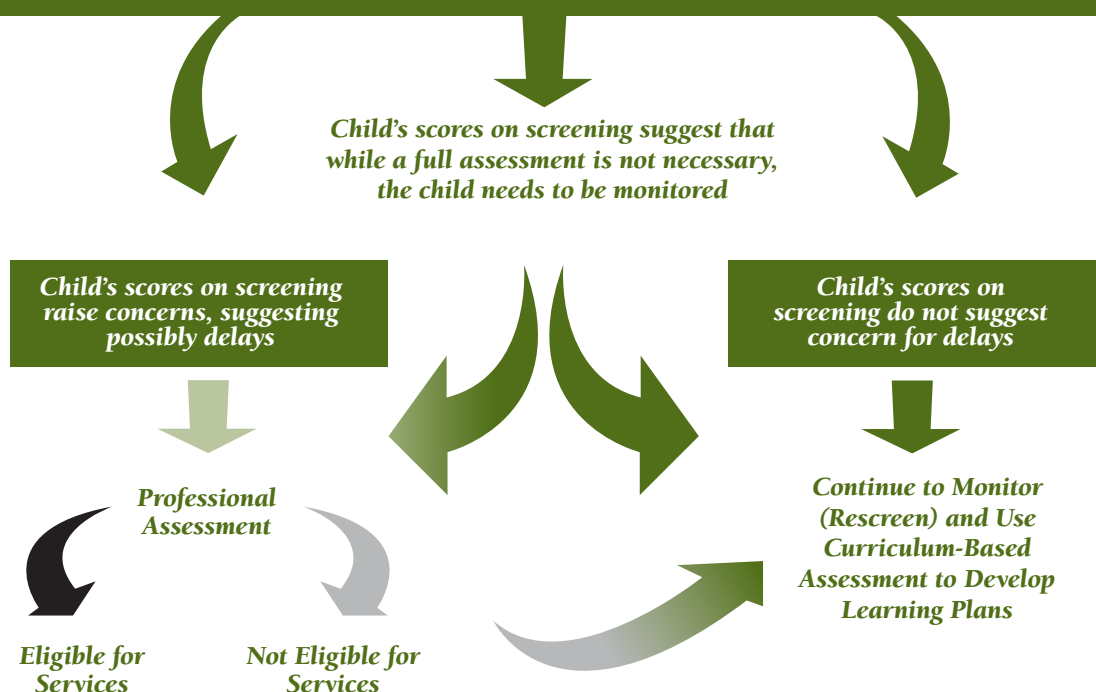
Sixty-seven percent (16 out of 24) of the children were found to need further developmental assessments. Of these children, most are pending receipt of services and getting a formal assessment.

- two children are receiving services
- one guardian refused services for two children
- two children were determined to not need services
- ten children are pending formal assessments



Guidelines Based on Screening Results

Initial screening for developmental and/or social-emotional delays



Agency considerations when implementing a screening protocol

- **Determine which other agencies are screening children**
 - What ages? What domains? What tools?
 - Is it possible to coordinate training efforts?
- **Coordinate services**
 - decrease duplication
 - save resources
- **Determine referral sources**
 - establish a relationship or interagency agreement
 - establish referral and feedback procedures

For more information

For more information on the Ages and Stages screening tools, contact the Northern California Training Academy. Further resources can be found online:

Brookes Publishing Co.
www.brookespublishing.com
(800) 638-3775

Official website:
www.agesandstages.com

Periodic updates available at:
www.brookespublishing.com/asqupdates/

ASQ-3 and ASQ:SE Training Materials by Jane Squires, Jane Farrell, Jantina Clifford, Suzanne Yockelson and Elizabeth Twombly; Paul H. Brookes Publishing Co., 2009.



"I've been involved with criminal type cases and juvenile and dependency cases for 30 years. I was a cynic to the idea of the meth grant to begin with because I had a pretty extensive prosecution background and it seemed like the only thing that would fix the program was to remove them from society and lock them up. I thought the meth grant was a soft approach that sounded good on paper but maybe didn't really work, but now I'm seeing it really work. Now, with this collaboration, I see different people in six months than the people that came in. The looks on their faces are different, their attitudes are different, and their joy of life is back, which is really nice to see. There's a few who fall off the wagon once in a while, but for the most part, there's substantial change. Way more of a change than we're getting from locking people up."

~ **Richard C. Martin**, Presiding Judge,
Lake County Superior Courts,
Dependency Drug Court

Using SAFERR as a Guide to Meth Grant Activities

The Northern California Regional Partnership for Safe and Stable Families utilized the SAFERR (Screening and Assessment for Family Engagement, Retention and Recovery) model as a guide throughout the planning and implementation process of the grant activities. SAFERR is both a model and a guidebook, developed by the National Center on Substance Abuse and Child Welfare (NCSACW), a training and technical assistance resource center established jointly by the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration and the Office on Child Abuse and Neglect of the Administration for Children and Families. Both agencies are part of the U.S. Department of Health and Human Services.

SAFERR was initially developed as a response to the need for Child Welfare Services to have adequate tools to screen parents for potential substance use disorders in order to make critical decisions about children's safety.

Its use as a guide for the meth grant partnership was expanded based on the following premise:

...when parents misuse substances and maltreat their children, the only way to make sound decisions is to draw from the talents and resources of at least three systems: Child Welfare Services, Alcohol and Other Drugs Services and the courts.

The SAFERR model provides invaluable information to improve collaboration and communication across the three systems so that workers will get the information they need and families will feel they have a chance at changing their lives.

The SAFERR model is based on these principles:

The problems of child maltreatment and substance use disorders demand urgent attention and the highest possible standards of practice from everyone working in systems charged with promoting child safety and family well-being.

Success is possible and feasible. Staff in child welfare, substance abuse and court systems have the desire and potential to change individual's lives and create responsible public policies.

Family members are active partners and participants in addressing these urgent problems.



Recommendations for practice

According to important work by the National Center on Substance Abuse and Child Welfare, the following recommendations for the three systems have been made:

Child welfare system understands...

- the basics of substance use and how use affects child development
- how to screen for substance use
- the local treatment system and how to help families remain in treatment
- the implications of tensions between substance use recovery and Adoption and Safe Families Act (ASFA) rules

Alcohol and drug system understands...

- how substance use puts children at risk and how child welfare must respond
- child maltreatment reporting requirements
- how to screen for child safety

Court system understands...

- the basics of substance use and child development
- its role in requiring substance use and child development assessments
- its authority to prompt or require collaboration

Collaboratively, all three systems...

- establish joint policies and procedures for sharing information
- establish case plans
- develop shared indicators of progress
- monitor progress and evaluate outcomes

Child welfare, alcohol and drug, and court systems have collaborative policies, protocols and tools to...

- screen for substance use and child maltreatment
- assess for substance use and child maltreatment
- communicate across systems
- develop and implement collaborative case plans
- monitor progress and evaluate results

At a minimum, child welfare staff should understand...

- how and why people develop substance use disorders
- types of substance use disorders
- how addiction affects a person's ability to function (particularly as a parent)
- how people are screened and assessed for substance use disorders
- types of treatment available to families
- the role of relapse in the recovery process
- how treatment improves family stability, employment and other outcomes

In developing case plans, alcohol and drug treatment and child welfare staff should share the following:

- treatment plans and requirements including drug testing requirements
- child welfare case plan activities and objectives
- family service interventions
- plans for ensuring child safety
- parent and child visitation plans
- permanency goals and plans



"I have no family, so all the support I had was from CPS and AOD."



Amber's Story: When Everything Wrong Goes Right

Not long ago, Amber Reed's life was characterized by drug addiction and unstable relationships. The young woman had no job, no education and no family except for the baby she struggled to care for. Then in March of last year, CPS stepped in and changed everything.

Unlike some clients who struggle with meth and other drug addiction, Amber was prepared to face the consequences of her actions without resistance. Her one year-old son was placed in foster care, and Amber was given the option to stay in her small home town of Red Bluff, Tehama County, for treatment or enter a residential treatment facility in a neighboring county. She elected to go to Oroville, Butte County, for 30 days of drug rehabilitation.

Back in Tehama County after getting a fresh look at "clean and sober," Amber continued her journey through the child welfare system. Her road to reunification was a smooth one, due in no small part to the quality of services and support she received from county child welfare and alcohol and drug services. As one of the participating counties in the Northern California Regional Partnership, Tehama received funding to hire a drug and alcohol counselor at CWS, allowing for much faster assessment of parents who enter the system.

"I have no family, so all the support I had was from CPS and AOD," Amber says. "They helped me out tremendously in every way possible."

Amber even describes Dependency Drug Court as a wonderful program, one that focuses on more testing and more accountability. "They kept you to a high standard," she says proudly.

According to Ginny Kinney from Tehama County Department of Social Services, Amber's successful recovery from meth addiction was aided by the benefit of residential treatment, and, in addition, she was fortunate to have her child placed with an exceptional foster parent who supported and mentored her in her reunification efforts. "In fact, I am told they are still in contact with one another," Kinney adds.

Now, only one year after seeking treatment for drug addiction, Amber at age 24 has earned her high school diploma, completed her first semester of college and gotten her own apartment and vehicle. But, most importantly, she has gotten her son back. Amber says she's thrilled to be putting her life on the right track and is enjoying parenting what she describes as a "typical two year-old."

Amber admits seeking help is a scary and overwhelming undertaking. But she says, "If you actually open your mind up to giving AOD a chance, it will work out...and it will change your life."

A Look at Lake County's Efforts at Cross-System Collaboration

The Regional Partnership for Safe and Stable Families enabled CWS, AODS and the courts in Lake County, Calif., to effectively communicate and collaborate in an effort to better serve families. These efforts were made possible by implementing the Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) model. A case study about a client named Tennille chronicles the evolution of the relationship among these county entities over the past three years as a result of the partnership's efforts.

"Tennille's was one of the first cases that mended our relationship with AODS," says Sherry De LaTorre, a CWS social worker in Lake County, "because we started having conversations and working together."

Prior to Tennille's case, AODS seemed to perceive the social workers as a threat from which they had to protect their clients, De LaTorre explains. "But with all of us now meeting together and talking together, we all got a better perspective of what each of us does and how we all support the family."

De LaTorre notes that the weekly team meetings often helped to keep things on track because the different units had different kinds of access and accountability. "AODS can't go out to the home and make contact, so they can't really go and figure out what's going on. So, if there's a problem and we don't find out about it and help the client through, sometimes it's too late."

Robin Rosen, Tennille's Alcohol and Drug Services counselor, also values the changes Lake County agencies have made in working with clients with abuse problems. Rosen says there is still much to be learned about how to "phase" clients through the program, but the agency collaboration has definitely been beneficial. "We used to get

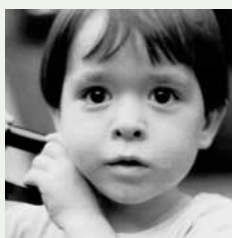
really protective about our clients," she says. "As AODS and substance abuse counselors, our job is to help our clients work on self-esteem, self-worth, recovery, being clean and sober, dealing with high-risk situations, dealing with denial, and breaking through all of that stuff. When you only have one side of the story from the clients, you're not dealing with what really happened in the removal of the children. But now we're really coming together and saying 'look, we're ALL here to help you reunify.'"

The collaborative efforts among agencies sometimes had unexpected benefits, as Rosen noticed in the case of the ASI Index, a form that determines addiction severity. "The ASI is designed so that you ask questions in a certain way and in a certain manner and you get some form of the truth, but you're just going on client disclosure," says Rosen. "Now, CWS is doing the ASI initially, and they have more information about when the child was removed, so I get a much more complete picture of the police report, the test results and history of the client and his or her addictions. It just kind of keeps everyone on the same page."

Tennille, now clean and sober, was able to reunify with her children, and she is grateful for the collaborative efforts made and the services she received: "I'm so thankful that my kids were taken because that was an opportunity to change my whole life. And I have all these people that are willing to help me and be here for me. I know that 10 years down the road I could walk into AODS and CWS or even drug court and say, 'Hi' or 'I'm having a bad day,' and just talk to them, and they'll be here for me."

Tennille's case clearly illustrates that successful collaboration across agencies can make all the difference for positive family outcomes.

To view the video about Tennille's story and Lake County and to read the full case study, go to www.humanservices.ucdavis.edu/academy/resource and select "Methamphetamine Regional Partnership." You can also order a copy of the video for training purposes—just call (530) 757-8643 or email academy@ucde.ucdavis.edu to make your request.



Promising Practices in Collaborative Work with Meth-Affected Families

According to Diane DePanfilis and R. Anna Hayward in their article “Ongoing Child Protective Services with Methamphetamine Using Families: Implementing Promising Practices,” meth addiction treatment is relatively new; therefore, there isn’t extensive research on treatment program effectiveness. But some approaches are proving to be promising.

Based on a review of promising programs, intervention for meth-affected families involved with child welfare should include the following four components: 1) a process for assessing safety and implementing appropriate safety plans, 2) substance abuse treatment for addicted parents, 3) parent- and family-focused interventions, and 4) child-focused interventions.

A Process for assessing safety and implementing safety plans

The following outlines the responsibility of the CPS worker:


1. recognize meth or other drug related symptoms
2. collect information about meth use, abuse, addiction as part of risk assessment and safety evaluation
3. develop and manage safety plans to address the influences that jeopardize a child’s immediate safety
4. conduct family assessments that evaluate the specific effect of meth abuse or addiction on parenting adequacy and the effects of these circumstances on children
5. develop change-oriented case plans that address the impact of meth abuse or addiction
6. select and coordinate meaningful interventions provided by addiction counseling and other agencies
7. evaluate progress of parents and children in recovery

When caregivers have a history of meth use, relapse should be expected. Thus, at least weekly in-home contact is essential to assure that all components of the safety plan are fully implemented and that everyone is meeting agreed-upon obligations.

Substance abuse treatment for addicted parents

Substance abuse treatment is required in order to reduce the risk of maltreatment in affected families. From preliminary research, the same treatment models that have shown effectiveness in cocaine treatment seem to also have promising outcomes in meth treatment. These effective programs have some combination of the following components: outpatient treatment, information/education for families on substance abuse, relapse prevention, family involvement, individual therapy, group sessions, self-help (12 step program participation), urine toxicology monitoring, up to 12 months of case-management, home visits, assistance with transportation and referrals.

The research also shows that substance abuse treatment outcomes are enhanced when the social and health needs of parents and their children are addressed. Furthermore, allowing children to enter care with addicted parents may have positive benefits for parenting, child behavior, family functioning, employment, substance abuse and criminal justice involvement. Finally, because of the specific symptoms of withdrawal from meth, some experts suggest that treatment programs also include cognitive and educational interventions.



Parenting skills interventions may be effective as long as they are tailored for this specific population and match parenting needs and child behavior problems.

Parent- and family-focused interventions

Separate from substance abuse treatment, other types of parent- and family-focused interventions are needed to address the effects of meth on families and to reduce other risk factors for child maltreatment. There are three types of interventions that are particularly effective. Social support interventions address parents' social isolation and connections with drug-using social networks. Positive social support intervention may consist of individual support (in the form of parent-aides or home visitors), may be a component of parent education and support groups, or may be provided as part of a multi- service intervention.

Parenting skills interventions may be effective as long as they are tailored for this specific population and match parenting needs and child behavior problems.

Finally, interventions to address a family's concrete needs are critical before family functioning issues can be successfully addressed. Parents who use meth often have multiple needs beyond substance addiction including the need for food, clothing, housing and other basic needs.

Child-focused interventions

Living with a meth-using parent may result in a range of consequences for children including problems with their physical and mental health, development and social skills. Because of the serious health risks associated with meth exposure, a comprehensive medical examination for children should be conducted to assess any effects of exposure to drugs or toxic chemicals. Ongoing medical care will likely be necessary if there has been toxic exposure.

Developmental evaluations of children of meth users are a necessary part of any intervention. If the evaluation reveals any specific delays or child mental health and behavior problems, the treatment plan should include appropriate interventions.

Social skills interventions have consistently been shown to be effective in helping children achieve a range of positive outcomes such as decreasing aggressive and antisocial behaviors and increasing problem solving and conflict management skills. Child-focused therapies that address Post Traumatic Stress Disorder as well as other mental health needs can help children increase social competence, improve peer relations and enhance problem-solving skills.



Conclusion

When working with families in child welfare impacted by meth addiction, social workers must plan interventions that are comprehensive, intensive and long term in order to prevent relapse, strengthen family functioning and address serious child mental health and behavioral consequences that may be present as a result of parental use, abuse or addiction to meth. Because of the complex needs of these families, interdisciplinary collaboration is required to manage changes in conditions and behaviors over time.

This article was excerpted from: "Ongoing Child Protective Services (CPS) with Methamphetamine Using Families: Implementing Promising Practices." Diane DePanfilis and R. Anna Hayward. National Resource Center for Child Protective Services, a Service for the Children's Bureau. August 2006.



Report on Sacramento and Mendocino Counties' Partnership Grants

Also receiving grant funding for this project in Northern California are Sacramento and Mendocino Counties, both of which have accomplished a great deal in the past three years.

In Sacramento County, the Divisions of Children's Protective Services, Alcohol and Drug Services, along with Juvenile Dependency Courts and other associated agencies have implemented an Early Intervention Family Drug Court. The goal is to provide a number of services to infants and children from birth to five years old, and their families, who have been exposed to meth or other substances.

Services are comprised of comprehensive, family-based treatment including recovery management, voluntary supervision by child protective services and judicial oversight for parents' compliance with the treatment plan—with the goal of allowing families to remain together as parents go through the program. Children receive services including developmental assessments and interventions to address any impact of prenatal exposure to drugs. The families receive intensive aftercare services to ensure their sobriety.

According to Sharon Dipirro-Beard, the Dependency Drug Court coordinator in Sacramento County's Department of Health and Human Services, Alcohol and Drug Services Division, this early intervention project has been a wonderful addition to their Dependency Drug Court. It has meant that families who struggle with substance abuse are identified early on and get the help they need before the problems become entrenched. This program has built on the success of the current collaboration among Child Protective Services, AOD and the court system. It has given families a breadth of services and child welfare staff the support they need when working with families struggling with substance abuse. The biggest challenge has been dealing with the program cuts that have resulted from the state and county budget crises in the last two years.

Mendocino County's Child Welfare Services agency has created a Family Dependency Drug Court (FDDC) in collaboration with the Mendocino County Superior Court, the Alcohol and Other Drug Programs, and the Administrative Office of the Court. The FDDC serves families with open child welfare cases when parents are struggling with substance abuse issues, including meth abuse. The FDDC links families with case management; individual, group and family substance abuse treatment; intensive judicial oversight; incentives and sanctions; parenting education; and reunification support.

Becky Wilson, the project director and deputy director for Mendocino County's Department of Health and Human Services, Child Welfare Services, when asked what's working replied, "All of it!" She said that children are spending less time in foster care and families are getting more intensive services. She also said that families who go through the FDDC program are guaranteed alcohol and drug treatment services which, given all the cutbacks to these services among others, is a wonderful benefit for participating families. Wilson said that what makes it work is the collaboration among the agencies and the fact that the judge is very involved. The judge really gets to know the families, and the clients appreciate that. Initially, the challenge was to build a working collaborative. As Wilson said, everyone had the commitment and good intentions, but ideas of how to work together in the client's best interests were often different. Now the challenge is the state and county budget crises. But Wilson said that client comments like the following tell her and the rest of the FDDC collaborative that their work is effective: "All the agencies working together to keep you on track...that keeps you going."



rap-Up on the Regional Partnership Efforts

Surprising results and overcoming challenges are the common themes of the four counties' implementation of the Regional Partnership for Safe and Stable Families guidelines. Although each of the organizational profiles and dynamics of Lake, Butte, Trinity and Tehama Counties are unique, just as each family involved in child welfare has a unique story, the benefits and results of the meth grant mandates have many similarities. For instance, all four counties report that relationships among CPS, AODS, the courts as well as various community partners have greatly improved. Identifying a workable process for communication and common goals has dramatically changed the level of trust and collaboration in providing the best in services for meth- and other drug-affected families.

A surprising outcome of this new spirit of collaboration is that other community partners have become involved. Lake County's Healthy Start program is now acting as a liaison to advocate with schools. Butte County finds that changes have trickled out to other services such as CalWorks. Trinity County Child Protective Services is seeing more direct collaboration on mutual cases in its relationship with Behavioral Health and Alcohol and Other Drug Services. In Tehama County, social workers depend on the AOD specialist not only for screening and referrals, but also for frequent case consultation and her expertise of drug addiction. For all, a fundamental change in attitude and how business is conducted has been a hallmark of the grant implementation.

To be sure, there have been challenges along the way. Discussing them during the quarterly steering committee meetings with grantees, program managers, IDEA Consulting and the Northern California Training Academy has become an all-day event.

As the three-year grant nears its official close on September 30, 2010, strategizing sustainability for funding grant activities and the grantee-appointed positions has become the counties' primary focus.

There are many more stories of individual, familial and organizational changes. All in all, the counties found incredible results in having been involved in the meth grant partnership and find that the benefits have reached beyond drug-affected families to all the families involved in child welfare in these four Northern California counties.

Additional Resources

WEBSITES

Child and Family Futures

An organization that works to improve the lives of children and families, particularly those affected by substance use disorders. It provides the technical assistance to recipients of the federal regional partnership grants.

www.cffutures.org

Children's Bureau

A bureau of the Administration for Children and Families that works with state and local agencies to develop programs that focus on preventing the abuse of children in troubled families, protecting children from abuse and finding permanent placements for those who cannot safely return to their homes.

www.acf.hhs.gov

MethResources.gov

Federal website with meth resource information by state.

www.methresources.gov

National Center on Substance Abuse and Child Welfare

Has the goal to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems by assisting local, State and tribal agencies.

www.ncsacw.samhsa.gov

PUBLICATIONS & REPORTS

Children's Voice, A bimonthly publication of the Child Welfare League of America addressing a variety of child welfare topics including substance abuse issues.

www.cwla.org/voice/

"Meth Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers," by Cathleen Otero, Sharon Boles, Nancy Young and Kim Dennis; April, 2006. Center for Substance Abuse Treatment, U.S. Department of Health and Human Services.

"Ongoing Child Protective Services (CPS) with Methamphetamine Using Families: Implementing Promising Practices," by Diane DePanfilis and R. Anna Hayward; August 2006. University of Maryland School of Social Work Center for Families. PDF available at www.nrc cps.org/PDF/Ongoing_CPS_with_Meth_Using_Families_Implementing_Promising_Practice10302006.pdf

"The Economic Cost of Methamphetamine Use in the United States, 2005" by Nancy Nicosia, Rosalie Liccario Pacula, Beau Kilmer, Russell Lundberg and James Chiesa; 2009. RAND Corporation, Drug Policy Research Center, sponsored by the Meth Project Foundation and the National Institute on Drug Abuse. PDF available at http://rand.org/pubs/monographs/2009/RAND_MG829.pdf

ANNOUNCEMENTS

Training opportunities from the Academy...

Children of Incarcerated Parents Series

This series, beginning September 2010, will prepare social workers to facilitate visits between children and an incarcerated parent. Final seminar will include a field trip to Folsom State Prison. First class will be held September 21-22 in Davis.

Evaluating Program Effectiveness in Child Welfare Agencies

This symposium will examine the role of research in child welfare agencies including how to use data sets, logic models and conducting research in rural and tribal communities. Topics will be customized for each event and will focus on the unique challenges and opportunities in conducting research in surrounding local communities.

September 10 in Eureka

September 17 in Chico

Standardized Core Training Series for Child Welfare Social Workers

In Davis

September 7-9

December 7-9

October 5-7

January 4-6, 2011

November 2-4

Tools for Supervisory Excellence

Location TBA

September 14-15

February 15-16, 2011

October 19-20

March 15-16, 2011

November 9-10

April 12-13, 2011

December 8-9

May 10-11, 2011

January 11-12, 2011

Special thanks to the county directors in the Northern California Regional Partnership for Safe and Stable Families for their continued efforts to improve outcomes for children and families in the region:

Cathi Grams, Butte County Department of Employment and Social Services

Carol J. Huchingson, Lake County Department of Social Services

Charlene Reid, Tehama County Department of Social Services

Linda Wright, Trinity County Health and Human Services Department

In Our Next Issue

Look for more articles, research, success stories and resources in our next issue of *Reaching Out*. The next issue will focus on "Innovations in Child Welfare Practice."

About the Northern California Training Academy

As part of the Center for Human Services at UC Davis Extension, the Northern California Training Academy provides training, technical assistance and consultation for 29 Northern California counties. The counties include rural and urban counties with various training challenges for child welfare staff. The focus on integrated training across disciplines is a high priority in the region. This publication is supported by funds from the California Department of Social Services.

About The Center for Human Services

The Center for Human Services at UC Davis Extension began 30 years ago as a partnership between the University of California, Davis and state government to address the needs of rural counties in developing skills for their social workers. Through professional training, consultation and research, the Center has grown to serve human services organizations and professionals throughout California and across the nation in such practice areas as child welfare, tribal social services, probation, developmental disabilities and other mental health issues, early childhood education, adult protective services, public assistance eligibility, corrections and more.

Northern California Training Academy

UC Davis Extension
University of California
1632 Da Vinci Court
Davis, CA 95618

Phone: (530) 757-8643

Fax: (530) 752-6910

Email: academy@ucde.ucdavis.edu

Web: www.humanservices.ucdavis.edu/academy

101 199

**UC DAVIS
EXTENSION**

CENTER FOR HUMAN SERVICES