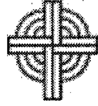

STATEMENT

OF

THE REVEREND FREDERICK AIGNER, Ph.D.
PRESIDENT/CEO OF LUTHERAN SOCIAL SERVICES OF ILLINOIS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

THE SOCIAL AND ECONOMIC EFFECTS OF THE METHAMPHETAMINE
EPIDEMIC ON AMERICA'S CHILD WELFARE SYSTEM

PRESENTED ON

APRIL 25, 2006

Good morning Chairman Grassley, Ranking Member Baucus, and distinguished members of the Committee. It is an honor to appear before you today to discuss the impact of methamphetamine use by parents upon the children that we serve in Illinois' child welfare system. I thank you for this opportunity. My name is the Rev. Dr. Frederick Aigner and I serve as President and CEO of Lutheran Social Services of Illinois. Lutheran Social Services of Illinois (LSSI), founded in 1867, is a statewide, not-for-profit social service agency of the three Illinois synods of the Evangelical Lutheran Church in America (ELCA). LSSI serves people through an array of services, including child welfare services, at more than 100 program sites throughout the state. In Illinois, as in many other states, much of child welfare is contracted by the state to private agencies such as LSSI.

LSSI's services include counseling, mental health, substance abuse treatment, residential treatment for children and adolescents, Head Start, child care services, services for at-risk families, programs for adults and children with developmental disabilities, foster care and adoption, pregnancy counseling, housing and services for older adults and individuals with disabilities, nursing care and programs for prisoners and their families. Last year, LSSI touched the lives of 65,637 people.

LSSI is a member of Lutheran Services in America (LSA). LSA is an alliance of national Lutheran church bodies and their health and human service organizations. LSA has more than 300 members providing services throughout all 50 states and the Caribbean. Its members deliver over $8 billion in services to over one out of every 50 people in the United States. The network of organizations serves the elderly, children and families, people with mental and physical disabilities, refugees, victims of natural disasters, and others in great need. Through these efforts, LSA is on the front lines of building self-sufficiency and promise in millions of lives.

The methamphetamine crisis first came to the attention of LSSI's southern Illinois office in 2002 and rapidly consumed the attention of child welfare staff in that region. This office serves 14 counties with a geographic area the size of Rhode Island and Connecticut combined. The devastating effects of methamphetamine use are largely responsible for a 260 percent increase in the foster care caseload in the past three years. Half of the new cases coming to LSSI's southern Illinois offices over the past three years involved methamphetamine. What is very striking is the fact that as late as January 2002, LSSI's foster care program had only one family where methamphetamine was an identified issue. That is how suddenly and quickly the problem came to families in southern Illinois.

Because our agency provides child welfare services statewide, we have experienced the gradual migration of methamphetamine abuse north over the past year. LSSI's offices in Rock Island, Galesburg, Peoria, Champaign, Dixon and Rockford have all served families in which parental methamphetamine use brought the children into custody. Methamphetamine use came to Illinois from Missouri, which led the nation in

methamphetamine arrests in 2003. We believe that Illinois has the potential to mimic Missouri's experience as the problem spreads north.

In east central Illinois, child welfare agencies are becoming increasingly involved in cases of methamphetamine abuse. These cases often come to the attention of the authorities in the larger metropolitan areas where rural residents come to buy supplies. For instance, two parents from a rural area were arrested in the parking lot of a major chain discount store after personnel were alerted by noticing a large purchase of cold medication. The parents' toddler and a preschooler were in the car. The trunk of the car contained the remaining ingredients to manufacture the methamphetamine. The children were removed from their parents' care and placed in a foster home. The parents ended their relationship but both entered substance abuse treatment. The mother successfully completed her treatment and remained drug-free. Realizing that she had made some poor choices while living away from her family, she and the children returned to her home state where she has a family support system. While the father completed treatment, his substance abuse issues resurfaced. Unfortunately, he died from an overdose. There is both success and tragedy in this story. The children were exposed to the dangers of methamphetamine and had to experience separation from their parents for their own safety and well-being. The mother was able to turn her life around and recognize what she needed to do to be a successful parent. Because of methamphetamine abuse, these very young children will grow up without their father.

Another family in rural eastern Illinois put their two pre-teen children at risk with a methamphetamine lab in their home. Their home burned to the ground as a result, and the children were removed from the care of the parents and placed in foster care with relatives. Rehabilitation from methamphetamine abuse is very difficult, and these parents were unable to successfully complete treatment. Ultimately, their parental rights were terminated and the children were adopted by their relatives.

Unlike other regions of the country which have seen a decrease in the amount of methamphetamine produced in local laboratories and an increase in methamphetamine imported from Mexico, the methamphetamine used in southern Illinois still comes for the most part from local laboratories often located in the home. Methamphetamine made in home labs uses "anhydrous ammonia," which is readily available in this rural area. Therefore, children are frequently around methamphetamine labs and are subject to toxic chemicals and risk of explosions. These factors also create a danger to first responders, such as child welfare workers. Because of the effects of methamphetamine on the users, domestic violence, child abuse and child neglect are very common. Sexual abuse of children also becomes more prevalent.

Young parents were manufacturing methamphetamine in their home in a small southern Illinois town. The father accidentally spilled ether while manufacturing methamphetamine and opened the house window and the resulting odor alerted a town police officer patrolling the neighborhood. This resulted in a methamphetamine lab raid and the parents' four children were taken into protective custody and placed in an LSSI foster placement. There were two-month-old twins, a one-year-old and a two-year-old.

All the children were malnourished, and the twins, a boy and a girl, were exposed to methamphetamine during gestation by their mother. One twin, the girl, is healthy and normal in development. The male twin, however, was very restless and had poor motor functions and was suspected of having mild cerebral palsy. Tests were done on this child and it was determined that his symptoms most likely were a result of methamphetamine exposure.

Last year a single mother in her early twenties, who was using methamphetamine, had her two-month-old infant placed in LSSI's foster care program. The child came to our agency when a babysitter called the state child abuse hotline because the mother did not pick up the child. The Department of Children and Family Services placed the child in protective custody. Despite our agency's best efforts, we were unable to locate the mother for almost three weeks while her beautiful and healthy baby girl was in a foster home. The mother finally contacted our foster care worker and explained that she had been bingeing on methamphetamine. She said it took her that long to finally realize that she had lost her child and her life was in shambles. She subsequently moved away from her friends and the community in which she lived and moved backed to the town in which her family lived several miles away. She actively sought outpatient substance abuse treatment. After a few months of outpatient treatment and regular visits with her child, she requested that her drug abuse counselor place her in a residential program. Despite the fact she had moved back home, there was methamphetamine use in that community as well. She explained to her counselor that she was struggling every day with her cravings for methamphetamine even though she had been testing clean for drugs while in outpatient treatment. She was sure if she did not go to inpatient treatment that she would relapse. Fortunately for this mother, she finally saw the impact methamphetamine was having on her life and her child and is now very close to being reunited with her daughter. However, she still always feels the urge to go back to methamphetamine and states she has to live with this craving.

I wish the last story typified most of our agency's methamphetamine abusing parents, but it does not. Even this success story shows how methamphetamine can consume a person to where little matters to them other than the drug, including their own children. The problem of parental methamphetamine abuse in the child welfare system needs more intensive and effective interventions.

Parents who are methamphetamine abusers have not shown a strong motivation to quit using and engaging in treatment, even though their children are in foster care. As you have heard, methamphetamine is unique among drugs in that the increase in dopamine levels is so much higher than it is with other drugs that addiction is rapid, insidious and overwhelming to the user. If the goal of child welfare is permanency for the child with the best outcome being reunification with the parent, it becomes obvious that treatment for the parent must be rapid, intense and is resource dependent. Evidence from the state of Oregon shows the efficacy of having substance abuse counselors as part of the treatment team working directly in the child welfare office. This addresses two issues:

1. The substance abuse counselor is an internal part of the treatment team

2. The substance abuse counselor fully understands how child welfare works and the critical timelines for permanency mandated by the federal government.

Lutheran Social Services of Illinois has experience with this mode of treatment. We run a state-funded program for intact families with substance abuse issues in Chicago. This program includes substance abuse counselors as part of the team on-site. There needs to be a national child welfare movement to this model with federal dollars to support it.

To effectively work with families impacted by methamphetamine use, there needs to be education and training. Substance abuse counselors need to better understand the unique problems of methamphetamine abuse in child welfare such as risk to children, short timeframes for parents to make changes and large number of female abusers. This treatment team should be trained in dynamics and best practices involving the treatment of methamphetamine addicts. The private sector has advocated for Title IV-E funding to support agency training. It is time to make this a reality.

As the number of children in foster care has fallen nationally, the children served have become more difficult to serve. Children whose parents are methamphetamine abusers exemplify this reality. There needs to be recognition of this fact at the federal level by providing adequate funding to the states to lower caseloads. Illinois supports a ratio of one to 15 children. In reality, a caseload ratio of one to ten would be reasonable.

Thank you again for the opportunity to speak to you. I appreciate your efforts and support for children experiencing abuse and neglect throughout our country.

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