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

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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

TUESDAY, APRIL 25, 2006

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:35 a.m. in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Snowe, Smith, Baucus, and Wyden.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. We will get started. I appreciate everybody's patience. There is some conflict with other committee meetings, so maybe all members will not come. I appreciate Senator Baucus.

We have cooperated on these hearings and most every hearing we do. It is a good working relationship. We come here today to discuss a very important problem that faces his State, my State, and a lot of States, particularly west of the Mississippi. That is the issue of methamphetamine.

The purpose of our hearing is best exemplified by the title of our hearing, "The Social and Economic Effects of the Methamphetamine Epidemic on America's Child Welfare System." It is worth noting that this is the first hearing that the full committee has had on this issue relating to child welfare in nearly 10 years.

Discussions of issues relative to child welfare are of course long overdue. If time permits, I hope to hold another full committee hearing on child welfare issues, particularly as they relate to Promoting Safe and Stable Families. That is a program that has to be reauthorized by Congress this year.

Today we will hear about the awful toll that methamphetamine abuse and addiction is taking on families, communities, and our Nation's social services infrastructure, particularly as it relates to children. Methamphetamine is possibly the fastest-growing drug threat in America.

According to a survey from the National Association of Counties, 58 percent of the counties report that methamphetamine is their largest drug problem. Methamphetamine is highly addictive, and the effects last longer than crack or cocaine. Methamphetamine is relatively easy to make and cheap compared to other drugs.

According to the 2003 National Survey on Drug Use and Health, over 12 million Americans have tried methamphetamine. Methamphetamine-making operations have been uncovered in all 50 States, but the most widespread abuse has been concentrated in the western/southwestern and Midwestern United States.

Numerous reports indicate that methamphetamine abuse is on the increase, particularly among women of childbearing age. This is having an impact on child welfare systems in many States.

Again, referring to a survey of the Association of Counties—and the title is "The Impact of Methamphetamine on Children"—that report says, "Methamphetamine is a major cause of child abuse and neglect." Forty percent of all the child welfare officials in the survey reported increased out-of-home placements just because of methamphetamine in the last year of that survey.

Many child welfare agencies are struggling to cope with the unique challenges associated with parental addiction to methamphetamine. Children living with a methamphetamine-addicted parent are often exposed to toxic chemicals such as ammonia, iodine, hydrochloric acid, starter fluid, and drain cleaner used during the production of the drug.

Because of the parent's high lasting for hours, and because the drug binges can persist for days, children are often left neglected to fend for themselves. Additionally, one of the effects of methamphetamine is a dramatic increase in user's sex drive. As a result, children are often exposed to pornography and sexual abuse.

While this hearing today will highlight the strains that the methamphetamine epidemic is perpetuating on the child welfare system, it is important to note that our Nation's child welfare system is already overburdened. The system is under-staffed and undertrained. Children linger too long before securing a safe and permanent home.

More funding could be available for adoptive assistance and family reunification services. Administrative funds could be used more efficiently. Data collection is insufficient. Finally, the child welfare financing structure is antiquated, inflexible, and prevents States from responding to a variety of challenges.

So I am hopeful that, working on a bipartisan basis, the Senate Finance Committee can address additional flaws in our current child welfare system that impede progress to ensuring every child's well-being.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman, for calling this hearing. I appreciate it very, very much. It is very helpful; it is needed, frankly. We have to do all that we possibly can to stamp out and discourage meth use. It is affecting very much of our country.

A medieval poet once wrote, "When the orphan sets a crying, the throne of the almighty is rocked from side to side." Today we will hear that our Nation is being rocked from side to side. We will hear of the weeping that methamphetamine is bringing to American children.

Every year here in America, 900,000 children fall victim to abuse or neglect, 900,000. That is as many people as live in the entire State of Montana. A child who suffers abuse is more likely to grow up to inflict abuse on others. About one quarter of children who suffer abuse will end up engaging in delinquent behavior.

We have good reason to believe that methamphetamine exacerbates child abuse and neglect. Look at the homes where children of methamphetamine abusers live. They are eating meals at a stove with the cooking of the harmful drug. Their toys share a space with dangerous chemicals. Their forks and spoons share the sink with pots used to cook methamphetamine. I might say, I have seen children whose enamel is decayed because of passive methamphetamine smoke in a household.

Today we will hear real life stories of what these kids face. We will hear from victims of methamphetamine abuse, and we will hear from people trying to protect the children. Methamphetamine abuse has increased dramatically in recent years. It has reached all corners of America.

Methamphetamine has become the scourge of many rural communities. Last week when I was home in Montana, I talked to a lot of kids about meth. I had a couple of assemblies, a couple of high school assemblies. I have had many of these over the last year.

In one in particular I was even more struck because, at the end of the assembly, four separate high school students walked up to me to tell me that their mom or somebody in their household was on methamphetamine. In fact, one gal cried on my shoulders because her mom was on methamphetamine, and she was taken away from her mother, and she could not find her siblings.

It is frightening, it is graphic. I am very impressed, though, with the series of ads now running in Montana. They are graphic, and they depict frightening accounts of methamphetamine abuse. They are a series of ads run by a businessman in Montana named Tom Siebel. I really appreciate Mr. Siebel's work. He is fighting methamphetamine with his own money. He has spent about $10 million in Montana producing the ads, and he is running the ads on television.

In fact, at the high school assemblies, I asked for a show of hands if they had seen these anti-methamphetamine ads, and man, they are graphic, they are really graphic. Every hand went up in the assembly.

I asked, are these ads effective? Are they deterring the first-time users of methamphetamine? Virtually every hand went up in the high school. There are about 2,000 kids at one high school, and at another there are about 700, 800 kids.

So there are people taking steps that are making a difference here, and I think these are the kinds of steps we have to continue to take.

Montana kids also tell me that one of the most powerful motivators for kids not to use methamphetamine is testimony from those who have been affected by it, by their peers—somebody they know and can trust who has been on methamphetamine and tells them what it does to them, what it did to them.

We can look forward to exactly that kind of testimony here today. We are here for people who share their stories of struggle and ultimate victory over methamphetamine addiction.

You will also hear the devastating effect that methamphetamine is having on the child welfare system. Methamphetamine abuse has thrown thousands of children into the safety net of child protective services.

Montana's child protective service agencies are struggling. Kevin Frank from the Montana Department of Public Health and Human Services will tell us what Montana case workers face every day as they try to provide for children from methamphetamine-abusing homes.

I very much look forward to the testimony. Thank you all for being here very, very much. I look forward to the day when methamphetamine is no longer what it is, and when methamphetamine will no longer bring children to cry. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

We thank our first panel already at the table, because first of all they have traveled a long way to come here. Secondly, I presume it is not easy for families to talk about, as they will testify to, personal issues. So we thank you very much for your courage. More importantly, we thank you for coming so far to share with us.

So I would welcome you. Allison Bruno is from my State of Iowa. We have Aaronette and Darren Noble and Aaronette's son, Joseph, from Missouri. All are here to share with the committee their experiences being in the grip of this terrible drug.

I commend them for their courage in appearing before the committee and for their willingness to share difficult and personal aspects of their problems with addiction. Some have concluded that methamphetamine addiction is untreatable, and recovery impossible. Allison and the Noble family proved these characterizations untrue.

As we learn about the wake of destruction that this drug leaves in its path, we can find hope and solace in their stories. We can celebrate their recovery, and of course recognize the redemption available through work, love, and family.

We will hear from them in the way I introduced them, so we will start with Allison, and then Mrs. Noble, Mr. Noble, and then Mr. Binkley.

So would you start, please? And make sure the red light is on, and that you speak in the microphone. Thank you.

STATEMENT OF ALLISON BRUNO, MOTHER IN RECOVERY FROM METHAMPHETAMINE ADDICTION

Ms. BRUNO. Hello.

The CHAIRMAN. Hello.

Ms. BRUNO. Thank you for your time today. My name is Allison Bruno, and I am 22 years old. I have two daughters. Alexis is 5, and Lillian is 22 months. I was born in Waterloo, IA.

My mother and father were both addicts. They got divorced when I was really young. I did not really see much of my dad as I was growing up. As I think back on my life right now, I think that I was predisposed to be an addict.

I had all the addict behaviors when I was young, and I did not know anything else but that. I started drinking, smoking cigarettes, and smoking marijuana regularly when I was 11 years old. My mom was an active user, so she always had friends over and they were always doing drugs, and drinking and stuff.

I walked in on them one day smoking methamphetamine, and my mom offered me some. I was 13 the first time that I did meth, and I truly believe that I was addicted from that day forward. I did meth until I was 15. At 15, I found out I was pregnant.

I quit smoking meth and doing drugs when I was pregnant, but I picked up right where I left off after I had my daughter. It never crossed my mind that I was not being a good mother, because the only thing I had ever known was addicted mothers.

As an addicted mother, I really lacked the proper skills that most people take for granted. I did not learn how to cook, clean, make money, manage money, or take care of kids. When my daughter was 8 months old, I met a man who cooked meth, and I started using IV meth.

I would leave my daughter with her dad, who was not an addict, for days and weeks at a time without seeing or hearing from her. I felt like I needed meth to survive. I did not want my daughter to be exposed to what I was doing, and I was ashamed of my addiction, but I had no idea how to stop.

I was 18 and I got kicked out of my mom's house. I became homeless at that time, and I just floated around from house to house using meth. I was using meth at that time so I did not have to think or feel. I did not have a place where I could bring my daughter to for visits, and I felt tremendous guilt and shame for that.

I got arrested at 18 for possession of a controlled substance and was released the next day. I went to a single adult treatment facility in Waterloo shortly after my arrest, but the program was not very comprehensive. There were no therapeutic services that allowed me to understand the underlying reasons for my addiction.

Not having my daughter with me in treatment was especially hard for me. I thought that, since I could not see her, I might as well just leave. I did leave, and I continued to use until Christmas of 2002.

On Christmas Eve, I was granted a visit with my daughter for Christmas Day. The guilt of not having any gifts for my daughter and not being there for her got to me so bad that I signed myself into treatment.

By the grace of God, I ended up at a family-based treatment program, the Heart of Iowa Women and Children's Treatment Facility in Cedar Rapids, IA. At the Heart of Iowa, I got to have my little girl with me again. Finally we were together.

I had groups every day from 8 a.m. to 8 p.m., while my daughter was in day care or counseling. After 2 weeks, I moved to an apartment owned by the Heart of Iowa. I was taught how to cook, clean, and raise my little girl.

As part of the Heart of Iowa, I was in residential treatment for 4 months, a halfway house for 4 months, and after-care for 2 months.

I now have 3 years and 4 months clean from drugs and alcohol. I am attending Kirkwood Community College and majoring in human services. I had another child in recovery, and I am engaged to be married.

Today I proudly say that my children are the light of my life. My 5-year-old daughter started kindergarten this year, and she is doing wonderful. I am involved in the PTA, and my children are involved in sports and gymnastics. I regularly attend 12-step meetings and the support group, Moms Off Meth.

Because of family treatment, I broke the cycle of addiction in my family. My children will have a different childhood than mine, and I will continue to be a loving, responsible, and healthy mother to them.

My life is truly beautiful today, and I have never been as happy as I am now. Thank you. [Applause.]

The CHAIRMAN. Mrs. Noble?

STATEMENT OF AARONETTE NOBLE, MOTHER IN RECOVERY FROM METHAMPHETAMINE ADDICTION

Mrs. NOBLE. Good morning, Senators. Thank you for the honor of speaking with you today. My name is Aaronette Noble. I am here with my husband and my son, Joey.

I am a wife, a mother, and a recovering addict. I grew up in an alcoholic home. I smoked marijuana for the first time at the age of 7. I first drank alcohol at the age of 14, and I began using cocaine and methamphetamine at the ripe age of 17.

No one plans to have this disease of addiction take over their lives, and no one plans to end up in prison for methamphetamine abuse, and no one plans to give birth to a tiny baby born with drugs in her system.

No one plans to have their children tell them they do not want to have anything to do with their mother. No one plans for these things. I know I did not.

When I was using meth, I felt dead most of the time. All I did was breathe in and breathe out. I had no motivation. The world was a very dark place. I had no hope or faith in anything or anyone.

Every day I would wonder why I just did not die. I was so angry at God, at the world, and mostly at myself. My teeth and my hair were falling out, and other people had custody of my children. My husband and I were homeless and sleeping in our car.

Did I believe that family treatment could help me with all that was wrong in our lives? How could it? I had tried single adult programs, but I never succeeded in staying clean. The programs were very short-term. They were only 90 days at most.

I was not helped as a mother who had shame and guilt because of my addiction. My children were not provided services, and we could not heal together as a family.

After years of prison and inappropriate single adult treatment programs, my addiction to meth got worse. I gave birth to a daughter born addicted to meth. She was removed from my custody by child welfare.

At that point, however, a miracle happened. My children and I were referred to a comprehensive family treatment program. We

entered into Bridgeway Counseling and the Division of Family Services.

My husband had made a commitment to do the same. Bridgeway had just opened a men's residential treatment center next to the women's center. We were the first married couple to be in that treatment center at the same time. It helped to know that we were doing this apart, but also together.

Our addiction tore our family apart, so we needed to find a solution as a family. I received services I did not even know I needed. I saw a psychiatrist who helped me with my depression. I could sleep better and think more clearly. It was like someone turned a light on in my head. I could see colors, things tasted and smelled different, my mind was not constantly racing anymore.

At Bridgeway, we started family therapy. I got counseling for domestic violence and for sexual abuse from past relationships. I did not even think I had issues in these areas until I finally opened up to my counselors and was truthful with myself.

We took parenting classes, went to meetings, and attended church. The Division of Family Services brought our baby to Bridgeway for Darren and I to see. She is a beautiful little girl with big blue eyes that can see right through you.

I want her to only see good things in me today, and that is what she does. She gives me strength and courage.

After 30 days of doing Bridgeway's residential program, my family and I transitioned into Bridgeway's intensive outpatient program. The beginning of our sobriety was not easy, but maybe it should not be.

Maybe we needed to work and struggle. We entered into a shelter, and I came to Bridgeway during the day. We then as a whole family lived in a used trailer that we had bought for $500. I have to tell you, we love that trailer. It is our first sober home as a family.

My husband and I voluntarily joined a family safety drug court with the Division of Family Services that has been great. It has given us more structure and support, and it has given us incentives to move forward. The Division of Family Services, we are able to interact with them more often.

We call a drop line every day, so that gives us more structure, I do believe, in staying sober. It has allowed them to have an even bigger part of our lives.

We have nothing to hide anymore. We only wanted our family back together. We only wanted to stay sober. We only wanted to make our children smile as often as we could. We also continue to receive the family-based treatment services of therapy, family counseling, and parenting classes at Bridgeway.

My beautiful girl with the big blue eyes has been reunited with us now. She has been with us for 5 months. I am sure those of you who are parents can feel the light having all of your children next to you brings to your life. The light is with me today, it is here with me today in Washington, DC, and it is with me every moment.

I know that being a parent is not a right, it is a privilege. It is mine and Darren's privilege to be parents today. No one plans to tear their world apart and the world of their children apart.

Today, because of available family treatment, I can plan every day to put their world back together. This is work, but it is the best kind of work. It is a struggle, but it is the best kind of struggle.

We continue to go to meetings, we continue to meet with the court, we continue to make sober friends, and we began for the first time to be sober heroes to our children.

The CHAIRMAN. Thank you very much. [Applause.] Mr. Noble?

STATEMENT OF DARREN NOBLE, FATHER IN RECOVERY FROM METHAMPHETAMINE ADDICTION

Mr. NOBLE. Good morning, Senators. I would like to thank you for the chance to speak here. Aaronette and I are proud parents of two children, Casey, who is 6, and Summer, who is 15 months old. Summer is here with us today. I am also a proud stepfather of Joey Binkley.

Aaronette said a lot of my story. I would just like to touch on meth. Meth struck our family hard. It tore our whole family apart. I tried to seek recovery. It would not do me any good. I wanted to be able to focus on myself. I had my family out there. It takes 100 percent to get recovery. When I had family out there, my wife and my children, I could not focus on that. I could not let go of that feeling.

It did not work for me. Aaronette would try, and the kids were suffering, too. I always thought I was being a parent, but I was not. The children were the ones being the parents. They were watching over us. They knew what we were doing. Even though we thought we kept it away from them, they knew.

They always wanted to go places with us, they would not let us get away alone. They knew what we were going to do, so they wanted to be there.

I used to get home, and Casey would hide my keys to keep me from leaving. I thought it was because she wanted to be with me. She was being my mother, telling me to stay home, that I did not need to leave, because she knew what I was going to do.

But then the time came when I was arrested for manufacturing methamphetamine, and I went to prison. While I was in prison—I was locked up for 3 years and 10 months—I used to talk to Joey over the phone and tell him how it was going to be different when I came back. I was away from the drugs.

I actually thought it was going to be different. I thought my life was different. I did not seek recovery, I was just away from it. When I came out of prison, I came right back to what I left from. My same life, it never missed a beat. Everything had changed a little bit, but I came right back to the same situation; I went right back to the same things.

I stayed away from manufacturing meth because I thought, that is what sent me to prison, making meth. Not doing meth, but making it sent me to prison, so I stayed away from making it, but continued on my life.

I let Joey down, nothing changed, same old family. Then my daughter, my daughter was born while I was in prison. I got attached to her, and all that lost time, here I am doing meth. I am thinking I am spending quality time with her, but I am high and I am out there.

I do not remember that time, first getting out of jail and being with her. All of that time is lost. I thought those were precious moments of getting back to my daughter, but it is lost.

Aaronette had gotten pregnant with Summer, and we could not get away from it. We tried and tried, but we could not. I tried leaving her, because I knew I could not quit, so I would leave her, my family, to try to get her to quit.

She was not getting any help, so how was that going to keep her from using? She was going to keep using. So then I would just come back because she is still using while she is pregnant. We did not know what to do.

Summer was born, and they took her away from us. I decided I was going to quit when she got out of the hospital and we got home. Well, we did not quit. We figured we would quit once we got to the courts and we had to quit. Well, then we got there. They could see right through us. We were not quitting.

So we ended up getting kicked out of the program, and she was getting put up for adoption. We talked to people, and they allowed us back in. They allowed us to get back in this program.

They put us into a family treatment center where we all went together. We all got healthy together. Our family could not be broken up and made healthy. Our family had to go get healthy together. Once we were all safe, we were able to focus on ourselves and get better.

For us, where we are today, it has been a process. It just did not happen overnight.

The CHAIRMAN. Thank you very much. [Applause.] Mr. Binkley?

STATEMENT OF JOEY BINKLEY, SON OF A MOTHER IN RECOVERY FROM METHAMPHETAMINE ADDICTION

Mr. BINKLEY. Hello. As you know, I am Joseph Binkley. I am the son of Aaronette Noble. I am 18 years old, and I am a senior at Ritenour High School in St. Louis, MO. For most of my life, I had no idea that my mother was addicted to drugs and alcohol. But looking back now, I can see some points in which things were not right.

I had no idea until about the end of elementary school, beginning of middle school, that there was a problem. I kind of noticed whenever I would go to friend's houses and see how their mother would act, how their mother was, and mine was not the same.

She had gone into treatment, she had gone to jail, and things were not changing. One time when she went into jail, I stopped talking to her. I completely broke away because I did not want anything to do with that. I had no trust in her anymore.

Up until about a year ago, whenever Summer, as I am sure you guys hear her screaming in the back, until she was going to go into a foster home, I knew at that point, that was when I needed to step in and help do something for the family. I know that if I were to ever get taken away, then I could not have been the normal, upright citizen, student as I am right now.

I know that the family treatment at Bridgeway really helped bring us together and solve our problems. I know that you had some statistics about how kids who live in these families do so bad. I would just like to say that I am not one of them.

At this point right now, I have a high grade point average of 3.8. I have perfect attendance for the last 4 years of high school. I am involved with many groups, such as Leadership. I am a DJ for our school radio station. I am involved with RCO, I play varsity baseball, I am with the school's big brother/big sister program. I am a teenage health consultant. I'm in Mu Alpha Theta. I was even on the homecoming court earlier in the year.

[Applause.]

Mr. BINKLEY. Even at work, I have excelled. I worked at, it is a little diner called Chuck-O-Burger on St. Charles Rock Road. I was working there for less than a year, and my responsibility and my hard work allowed me to be a manager there. So now I am a part-time worker, and I manage.

At the beginning of the year, I applied to Southeast Missouri State University, and was accepted. So I plan to go there. Well, they only gave me two scholarships, so I am trying to find some more funding for that. But my plans are to become a teacher in some field of science. Right now I am thinking physics. [Applause.]

The CHAIRMAN. Thank you. Did you finish?

Mr. BINKLEY. Yes.

The CHAIRMAN. All right. Good. Well, it is a nice story. All of your stories are nice in the ending. Getting to where you are today is not so nice, but you are helpful to other people by coming here to explain.

Now, let me tell you, we have a period of time for members to ask you questions. You do not need to feel intimidated. Just answer as best you can. If there are any problems that you have in answering of questions, we can provide a process by where you can answer questions in writing, and our staff will help you with that.

Let me say to you on the second panel, because members have conflicts and cannot all come, sometimes you do get questions in writing, but since you have not been involved with that process, we will be helpful to you in responding to members who cannot come.

So I will take 5 minutes, then Senator Baucus, then Senator Smith, and then Senator Snowe, and if others come, we will have further questions.

I am going to start with you, Allison, and thank you for your honesty, your courage, all of you. Let me say up front, thank you for your honesty and courage.

In regard to your testimony, you mentioned, I believe, Moms Off Meth.

Ms. BRUNO. Yes.

The CHAIRMAN. And I hear that this is a support group and has been very helpful to you. Maybe describe just a little bit for the committee how that support group works. But if you could give us some idea of how many women participated, at least while you were there, and then if there is any indication you can give us, how many mothers maybe tried to seek the same sort of family-based treatment that you did, and whether or not you consider this successful. I assume from your standpoint you do see it as successful. But just some sort of general comments along those lines.

Ms. BRUNO. Okay. Moms Off Meth is a support group for women who are mothers. It is not really just for methamphetamine; it is for any sort of addiction that mothers have.

It is basically we sit around a table and we just help each other get through our issues and our problems. We help each other learn how to advocate for ourselves.

Like with the social service system, people who have been through it can help the other mothers go through the steps to get through the DHS system. There are like 20 to 30 people in the group that I attend. It is just a loving group of women that can get together and help each other work out their problems.

We do a lot of great things there. That is why I am here today, is through them. I love that group.

The CHAIRMAN. Well, along the lines of describing, for instance, did you run into people on the staff saying that they are able to take care of the needs of mothers like you? Or is there just a long waiting list? Is there a lot of interest in getting into the program?

Ms. BRUNO. The treatment center?

The CHAIRMAN. Yes.

Ms. BRUNO. Oh, yes. There are three family treatment centers in Iowa, and only one of them is actually residential treatment where families can get treatment all day and get counseling and therapy.

There is a tremendous amount of women who need to get in that program. There are 30 to 40 beds there, and that is all the women they can have at one time. There are people who come into Moms Off Meth who are trying to get into these programs, and there are waiting lists that are so long, 2 weeks, 3 weeks, a month.

They need this. I cannot say that I would be clean if I did not get into that program right away. If I had to go back out on the street and wait for the bed to open up, I probably would not have made it.

The CHAIRMAN. I will go to Mrs. Noble now. You told us about a treatment experience you had that was earlier than the one that was successful for you.

Why do you believe that that first treatment that you sought did not work for you and your family?

Mrs. NOBLE. Because the single treatment, a lot of it was just for today, keep it simple, one day at a time. At that point in time, I knew all that. I knew all the just for today's. I had to find out what kept me using.

It was not like I used for a year. I had been using most of my life. I needed to find out within myself what kept me using. So with this family-based treatment program, they had services.

My mom and dad were alcoholics, too, and I came from a very dysfunctional family, so I did not know how to be a parent. They had a parenting class. Like I said, domestic violence, domestic sexual abuse. I mean, I did not even know I had problems in most of these areas.

Right before the hour was up talking to a counselor, I was in tears. So I had to go deal with me, what made me keep using, or I could apply the just for today's and keep it simple and all that in my life. My family was there. That burden was off of me.

I could look out the window and see my husband at the man's place. So I knew that he was okay. I knew my kids were okay, because they were there. That way I could focus more on me and my issue.

It is an individual problem, but you turn it into a family problem that is a community problem. So that is why.

The CHAIRMAN. Senator Baucus now. We just had a vote start. I will go vote now, and then Senator Baucus goes to vote after I get back.

Senator BAUCUS. Yes, I will ask questions now.

The CHAIRMAN. Yes. Go ahead. So I will just be temporarily gone. If Senator Baucus gets done, Senator Smith then Senator Snowe.

Senator BAUCUS. Thank you very much, Mr. Chairman. It is those blue eyes, they look right through you, you are right.

I would like to know, and I will start with you, Ms. Bruno. What works best in prevention? Looking back on your experience, is there a time when, I am thinking of these ads. You have not seen these ads, I am sure. There are some TV ads running in Montana. They are on billboards, they are radio ads, they are really graphic, high shock effect.

Ms. BRUNO. Yes.

Senator BAUCUS. I am wondering if you, when you were younger—you said I think you were born into a dysfunctional family—had seen those ads, do you think that might have made a difference, or not? What kind of prevention works?

Ms. BRUNO. I think for me if I would have seen, I mean, I never really saw any. I did not know what methamphetamine was. I just was from a dysfunctional family. People just did things that were not normal.

I think that if there were more people who came out and talked about their addiction and talked about the things that were going on, to let me know that the things that were going on in my home were not normal, they were not the things that were supposed to go on.

Senator BAUCUS. At what age did you start doing methamphetamine?

Ms. BRUNO. I started doing methamphetamine at 13.

Senator BAUCUS. So what if in school there had been lots of discussions about what methamphetamine is, and the problems that it causes? Would that have helped, do you think?

Ms. BRUNO. I think it would have. We have the DARE program.

Senator BAUCUS. Right.

Ms. BRUNO. All I can remember is the DARE song. I do not really remember anything that we learned. I think if there was a little more explanation on what the drug could do to you, I think that would have helped me.

Senator BAUCUS. Let me ask you, Mr. and Mrs. Noble. What might have worked in your lives to prevent you from doing methamphetamine, deterring you from doing methamphetamine in the first place.

Is there anything when you look back in your lives? Ms. Bruno mentioned something may have worked for her, perhaps.

Mr. NOBLE. For me, I believe I was born an addict.

Senator BAUCUS. And you were born an addict why?

Mr. NOBLE. From my genes.

Senator BAUCUS. All right.

Mr. NOBLE. From my family. It was passed onto me from my family. I was an addict without the drug. All you had to do was

apply the drug to me, and I was going to be an addictive person, unlike some people who can experiment with drugs and not use, can go out and do methamphetamine one time and never touch it again in their lives.

Me, I go out and do methamphetamine one time, I'm going to do it every day, and I'm going to be an addict. But for me, to publicize methamphetamine, like you say, is a good way. Today I feel recovery is out there a lot more.

The first time I went through treatment was in 1987 when I was 15. It was not very popular back then; it was just starting to get started. Very few young people were involved in it, so I did not stay involved in it. That was before I started getting into harder drugs, into methamphetamine.

I think the way the world is going today, treatment just needs to be more accessible to people. Just like she said.

Senator BAUCUS. Let me ask that question, then. What kinds of treatment work? You are all clean?

Mr. NOBLE. Yes.

Senator BAUCUS. How tempted are you when you see drug paraphernalia?

Mr. NOBLE. Oh, not at all. I have no cravings. When I think about drugs, or what I used to use or any situation that has to do with that, I think of the negatives. The negatives pop in my head.

Senator BAUCUS. And the treatment really worked?

Mr. NOBLE. Yes.

Senator BAUCUS. It helped create that situation?

Mr. NOBLE. Yes.

Senator BAUCUS. You do not want to go back to that at all?

Mr. NOBLE. Yes.

Senator BAUCUS. All right.

Mr. NOBLE. We changed our whole lives around. Our whole lives are different today than what they were before we went into that treatment center. We do not associate with anybody. If they use, they are not part of our lives anymore.

We changed, we did a complete process of our whole lives. When we came out of treatment, we did not have a home. We did not find a place to stay where we knew people. We went and found a place where we did not know people.

Senator BAUCUS. Right.

Mr. NOBLE. We started going to meetings in that area. We met new people, met new friends, started going to church. It took our kids being behind us, supporting us.

Senator BAUCUS. Mrs. Noble, you wanted to say something about what treatment really works. Or what prevention.

Mrs. NOBLE. I was going to say that, you know, maybe if the family treatment was available for me when I was younger, you know, my mom was involved in it once, like my son, I believe that will break the cycle of addiction, that will prevent it. By having my kids involved in the family treatment at such an early age that will educate them.

When I first started doing methamphetamine, I did not know that it was batteries, ephedrine, all the stuff that it was, ammonia. I mean, any one of those chemicals would kill you.

Senator BAUCUS. Right. Mr. Binkley, you were able to stay away from it, is that right?

Mr. BINKLEY. Yes.

Senator BAUCUS. How? Why?

Mr. BINKLEY. Well, I would have to believe I stay away from it because I had an example at home that showed me what not to do. Having the police around, people going to jail, that kind of negative feeling, people around the neighborhood talking about it. That kind of thing—I did not want to be anything like that.

That is why I have never smoked, I have never drank anything. I just do not think that those are the right things to do. I have learned a little bit at school what it can do to you. Though I was never really shown much, I always thought that I do not want to have those kind of, not just physical ailments, but more the emotional ailments also.

Senator BAUCUS. Great. Thank you. Senator Snowe may have something that she wants to say here, too.

Senator Snowe?

Senator SNOWE. Thank you. I want to thank all of you for your moving and courageous stories and your willingness and courage to be here to describe your personal experiences and the long road back.

Clearly it is an indication to us that we should not abandon help in any way in terms of the resources that can be provided that can make a difference. I think that is really the key for us, what works in the final analysis, and starting early.

Obviously this started early in your own lives and became generational. So starting with you, Ms. Bruno, what education prevention services could have helped to intercede at any point in your young life? Again, you started taking methamphetamine at the age of 11?

Ms. BRUNO. Thirteen.

Senator SNOWE. Thirteen. So what could have happened in the school systems, for example, that could have made a difference? Anything?

Ms. BRUNO. Within the school system, like there were days where I would dress myself in kindergarten and stuff like that, and would not eat breakfast and stuff like that.

I think that if some type of intervention would have happened when I was young that involved my mother, maybe things would be different. Maybe if the child welfare system got involved when I was a kid, when I was young, things would be different. My mom could have gotten clean maybe.

As far as the school system, I think they should have recognized, or they could have recognized. Maybe it was not so recognizable back then, the things that could happen.

Senator SNOWE. The child welfare system did not recognize it in your own family?

Ms. BRUNO. Oh, no, no. The child welfare system got involved in my family after I had my daughter. I have a little sister who is 9 now, and they got involved with my mom there.

She was still an active user and alcoholic, and still nothing happened with my little sister. She did not get removed either until

I went to treatment. Then my mom gave her to my aunt. My mom actually got clean 6 months after I did.

Senator SNOWE. Was that a motivating factor? The whole custody question, do you think with your mother, for example?

Ms. BRUNO. Oh, yes.

Senator SNOWE. Yes.

Ms. BRUNO. Yes. She saw me going through family treatment, and she saw that things were working for me. I think she did not think there was any hope for her since she has been addicted so long. She felt so much guilt.

But she ended up going to a family treatment center, too, and that is where she recovered.

Senator SNOWE. All right. Mrs. Noble, you mentioned the fact that it is residential treatment because you did not have to worry about your husband and your son and so on.

What could have happened earlier for you in your life do you think? Where could it have all started where you could have benefitted from some assistance in the system?

Mrs. NOBLE. DFS did get involved in my life when Joey was probably like 9 or 10, but they did not follow up or anything. So I think I even had signs of using on my body from IV using. They totally ignored it.

I go back again on family treatment. Having the family involved at as early an age as possible I believe is a big factor in that.

Senator SNOWE. So we have to intervene early?

Mrs. NOBLE. Early.

Senator SNOWE. Early on.

Mrs. NOBLE. Like I said, most people do not even know. You can say oh, well, methamphetamine has ammonia in it. But if you do not see it, you do not see these things that people are making methamphetamine with. You do not associate with it.

Senator SNOWE. So it is key obviously to start early in breaking the cycle.

Mrs. NOBLE. With family treatment, I do believe that if my mom had been involved, and my mom went to rehab a few times, but it never involved the family.

Actually, like Joey said, he did not talk to me for like 4 years besides yes and no. With the family treatment, it brings the family back together, and that is what this country needs, more family back together.

Methamphetamine is breaking up families, and that is what we need.

Senator SNOWE. So if we provided more support in that respect in maybe grants——

Mrs. NOBLE. Yes, ma'am.

Senator SNOWE [continuing]. Because that is one of the bills that Senator Rockefeller and I have introduced in providing more grants for substance abuse to help families.

Mrs. NOBLE. Because like I said, it is an individual problem, but then it becomes the family problem, which becomes a social problem in the community as well.

If we could get more education, more treatment, family treatment centers.

Senator SNOWE. To bring the family together. And you would agree, Mr. Noble, on that question?

Mr. NOBLE. Yes.

Senator SNOWE. As a family. Does that make a difference?

Mr. NOBLE. Yes. It made a difference in my family.

Senator SNOWE. All right.

Mr. NOBLE. One thing I would like to add to that is to prevent it, for me, I would be able to notice the signs with my children. I am healthy now, so I will be able to take the right steps, which I know the steps myself.

But also people who are not addicts and do not have this problem in their lives, they need to be educated because they think they are smart. But when their child goes out and becomes this, when it gets into his life, he also gets that ability to snow over his parents on what they are seeing and telling them different stories.

They can really put it off on somebody who does not know anything about it for a long time. So families need to be educated before it comes into their lives, too.

Senator SNOWE. Thank you. And Mr. Binkley, you are an inspiring story. We really congratulate you.

Mr. BINKLEY. Thank you.

Senator SNOWE. It is very moving, all of you, to be here today to share that, and to tell us what works, what does not work, and what we need to do to help make a difference in other people's lives. You are certainly helping to make a difference by telling your stories. Thank you for the courage of being here. Thank you.

The CHAIRMAN. Thank you, Senator Snowe, for taking over. I appreciate it.

Senator SNOWE. Any time.

The CHAIRMAN. Is Senator Smith coming back? All right. So then I will go ahead. I had a couple of questions, and then if Senator Baucus does not have any more questions, we will go on to the second panel.

I will go to Mr. Noble. From your perspective as a father, and also as a person who is addicted, in your seeking support in the support system, do you believe that the intervention of the child welfare services was an effective intervention in your family?

Mr. NOBLE. Oh, yes. It changed my life. They open up doors in all areas, getting us into the Bridgeway Family treatment, the parenting classes, telling us things. We are trying to get our daughter back, and they would give us a goal. When we did our part, they backed that up. What they said, they backed up.

So we got from 4-hour visits to 8-hour visits to overnights to weekends. Before you knew it, we had her with us by doing our part, and them keeping their word. That meant a lot to us.

When we would do this, something which was actually small, it would mean so much to us from what they were doing back to us, and they kept their word.

The CHAIRMAN. Did the criminal justice system coordinate with the child welfare system? The services system? Child welfare services system?

Mr. NOBLE. I am not understanding.

The CHAIRMAN. Well, in other words, you coming out of the criminal justice system, was there an effort there to work with you in the child welfare systems? Or was it entirely separate?

Mr. NOBLE. No. Actually it was totally separate.

The CHAIRMAN. Okay.

Mr. NOBLE. Can I explain that to you?

The CHAIRMAN. Yes.

Mr. NOBLE. At the time of trying to get into the family services, into the family treatment center, I was getting a lot of grief from my parole officer. She wanted to send me back to prison.

I told her, I am trying to get into this treatment center, this family thing. She was like, she did not care. I guess when she wrote to the board to send me back, they replied back that it would be suitable for me to go into this family treatment before I got sent back to see how I would do.

The CHAIRMAN. And Mr. Binkley, could you tell us how long you and your family spent at the Bridgeway Treatment Center, and what made it such a successful experience for your family as you saw it as a son within the family?

Mr. BINKLEY. I am not really good with time. I would say it was almost a year, about, dealing with the Bridgeway program, and just seeing that everyone was together and everyone was working together to gain a goal to get clean, to have a healthy family. I think that is what made it work.

The CHAIRMAN. Let me ask, does anybody know if Senator Baucus has any more questions? Okay. Well, we are going to thank you very much for your appearance. I cannot say anything more than thank you for being brave.

Also, I cannot speak for other people, but I would see from the standpoint of other people seeing what you have gone through, both to raise questions about the use of drugs, and more importantly, to see that help as you received it can be very successful.

Thank you for being a good example. Thank you.

[Applause.]

The CHAIRMAN. Now, can we have the second panel, please? Our first witness is Kevin Frank. Senator Baucus would like to introduce Mr. Frank, so I am going to start with Dr. Nancy Young. She is the director of Children and Family Futures at the National Center for Substance Abuse and Child Welfare. Then Rev. Fred Aigner will speak as a practitioner on the meth crisis and options available to ensure the well-being of children.

So Mr. Frank, I am going to start with your testimony. Then when Mr. Baucus comes, I will allow him to speak about you. Go ahead.

Mr. FRANK. Thank you, Mr. Chairman. You kind of threw me a curve ball there, I thought you were going to start with hers.

The CHAIRMAN. Well, maybe I should. Yes, let us do that. Can you start off, Dr. Young, please?

Dr. YOUNG. Absolutely, yes.

STATEMENT OF DR. NANCY K. YOUNG, Ph.D., DIRECTOR, CHILDREN AND FAMILY FUTURES, INC., NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE, IRVINE, CA

Dr. YOUNG. Thank you for the opportunity to share some information with the committee. If you have the hard copy of my written testimony, I want to walk through a couple of charts that I put in the front of that.

First is a table that shows the number of new users by specific substances in our country. You will see that there has been a similar rate of increase in new methamphetamine users and new cocaine users over the past decade.

The second chart then shows that same data of the new users, which are kind of a leading indicator of drug use problems in our country.

The second chart then also has that bold triangle that shows the foster care caseload in the country. You see that, while there are variations by State and by community, overall in our country since 1999 there has been an ongoing decrease in the number of kids who are living in out-of-home care.

I think that paints a picture of how complex the issue of substance use disorders are with the child welfare system. It is not a single drug kind of issue. It is not something that just happened when methamphetamine came along. It is something that we have been working on in the country for quite some time, and certainly had a lot of efforts during the cocaine and crack epidemics of the late 80s and early 90s.

I think some of the lessons from that era are things that we need to be able to apply to this era of methamphetamine use.

The next chart then shows those numbers of people that are using methamphetamine that have increasingly been diagnosed or met criteria for substance abuse or dependence. That is one of those alarming kinds of statistics that over just the last 2 years, the methamphetamine abuse and dependence have doubled among those who are using methamphetamine.

So if you go back to that leading indicator of who is using, and then this next set of data about when do folks start to have problems related to that use, you see what is happening with our country, which brings up then the need for treatment and the need for services based on meeting that criteria for abuse and dependence.

I want to point out also that there is a very big difference between the cocaine and crack epidemic from the late 80s and 90s and what we are seeing today. The percentage of individuals who are using, current users of methamphetamine by race and ethnicity, shows our native populations in our country are more impacted by methamphetamine—our native Hawaiians and our native Americans. We need to pay attention to that as we are thinking about what happens for children in the child welfare system.

But particularly alarming, if you look then at a lagging indicator, if you will, those who actually get into treatment, you see that the rate of pregnant women who are entering treatment with primarily methamphetamine problems has greatly increased over the last 5 or 6 years.

That is the good news. We want women who have substance use disorders who are pregnant to be in treatment, but it also calls into

question what is happening for the children. Perhaps those who may have been prenatally exposed during that period, knowing how many, what kinds of services is really one of the critical issues for the country about that issue.

Next I want to point out what the overall treatment gap is in the country. If you look at the 19 States that are represented by senators on this finance committee, they represent 6.5 million people who needed treatment for substance use disorders and did not get it. That is in the 19 States represented on this committee.

Overall, there are about 17 million people who needed and did not get treatment for alcohol addiction, and another 6.5 million who needed treatment for drug addiction and did not get it.

So what is the good news here? There are communities around our country that have put programs together. They have been working on it for quite some time and have addressed the substance use disorder problem in their child welfare system.

I want to point out the data that are on the graph from Sacramento County. Over the last decade, they have put in place several different system reforms so that parents at the very first interaction with the child welfare system get access to comprehensive services.

They get recovery management services, they immediately get access to the kinds of supports that are needed by families. It is unique in Sacramento, and it has taken awhile for them to get there. But half of the parents whom they are working with in the child welfare system who are in the evaluation data have primary methamphetamine problems. But if you look at the reunification rates, if you look at the treatment completion rates, there are not significant differences between those who have methamphetamine problems and those who are addicted to other substances.

So again, it calls into question some of the media in terms of methamphetamine being untreatable. That is not what the scientific literature would support, it is not what the evidence supports. Thank you very much for your invitation today.

The CHAIRMAN. Thank you. I want to introduce Mr. Frank, and then we will have Mr. Frank's testimony, and then Rev. Aigner.

Senator BAUCUS. Thank you, Mr. Chairman. Kevin Frank is the Regional Administrator of the Department of Health and Human Services at Child and Family Services in the State of Montana, supervising all child protective services and activities in 11 counties in Montana.

In those 11 counties, and I might say, Mr. Chairman, here in Washington, DC, they think they know what rural America is. They do not know what rural America is, frankly, Mr. Chairman, until they come out to those 11 counties that Kevin is involved with. That is really rural.

I might say, just in passing here, it is kind of interesting, back more than 10 years ago, President Clinton came up with his health care plan. Hillary, now Senator Clinton, came to Montana, and, when she got off the airplane in Montana, her first words were, this is not rural, this is hyper-rural, this is mega-rural.

That is the kind of territory that Kevin supervises. He has been working for the State for 15 years, and he knows his subject very

well. He is extremely able. We are very proud of him. He is a third generation Montanan, so he knows what he is doing. Kevin Frank.

STATEMENT OF KEVIN T. FRANK, REGIONAL ADMINISTRATOR, DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES, CHILD AND FAMILY SERVICES DIVISION IN SOUTH CENTRAL MONTANA, BILLINGS, MT

Mr. FRANK. Thank you very much. Good morning, Mr. Chairman; and Senator Baucus, thank you for that introduction. Members of the committee, it is my great pleasure to be here today.

By now nearly everyone in America has at least heard of methamphetamine, and over time, many communities have come to the sobering realization that methamphetamine affects everybody, and in a big way. From farmers to law enforcement officials, landlords to social service professionals, victims of methamphetamine-related crimes exist in families across the entire socioeconomic spectrum.

No other illicit drug in recent history has garnered such attention, and unfortunately many have discovered the nearly limitless capacity of methamphetamine's authentic reputation for rampant personal destruction.

In Montana, we were once able to point to the large urban areas of the country as having the most drug-associated ills for which we were proudly immune. We are no longer able to make such claims.

As Senator Baucus mentioned, I grew up in Montana, as did my parents and grandparents, and things have changed.

Methamphetamine affects nearly all aspects of the citizens and systems in our society, but nowhere are the immediate and residual effects of methamphetamine more brutally visible than through the eyes of child protective services social workers.

Social workers entering the child welfare field today can fully expect to be exposed to toxic chemicals, expected to know how to physically handle a contaminated child, must have a heightened awareness of their own physical safety, and through it all are expected to withstand rigorous cross-examination from defense counsel in court proceedings.

A social worker can also fully expect to be confronted by an adult whose behaviors may range from maniacal to near comatose, and verbal and physical threats of assault against case workers are common.

With regard to older youth, in the past when we received reports of incorrigible adolescents or teenagers contributing to what could lead to reciprocated violence between the parents and youth, we might suggest family counseling combined with the mental health assessment. Today it is increasingly common for both the parent and the youth to be experimenting with or addicted to methamphetamine.

In questioning parents, some will immediately confess to drug use, along with the desire to get clean. Others will deny use, even when confronted with drug test results, and still others will flatly tell us or a police officer, just take the kids.

Child welfare workers get into this business to help families, but methamphetamine is a multiplier that exponentially increases all things bad that may have otherwise been preventable or manageable in families showing more traditional signs of risk.

Caseworkers are accustomed to fast-paced, near-chaotic work environments where the rewards are few, and the personal demands great. Methamphetamine poses unprecedented challenges to child welfare agencies given the risk factors involved. Over 65 percent of all foster care placements in Montana are directly attributable to drug use, and of those, methamphetamine is a primary factor 57 percent of the time.

Sadly, 80 percent of all foster care cases involving methamphetamine in Billings will result in termination of parental rights. Hundreds more children who are not directly involved in the child welfare system are living with grandparents or other relatives due to methamphetamine-related incarceration or absenteeism of their parents, and methamphetamine use among residents of the seven Indian tribes in Montana far exceeds epidemic proportion.

There is hope. The first being through education and awareness. Montana has been blessed with responsible local media outlets that consistently and accurately report on all aspects of the meth issue, and we enjoy a great deal of partnering and collaboration with many diverse organizations from all levels of the public and private sectors to get the word out about methamphetamine.

Also there are a handful of family drug treatment courts in Montana, the first in Billings which started taking clients in June of 2001. The significance of the drug court model is very simple, but also very powerful. It invokes the historically recognized and revered institutional authority of the District Court to both punish and praise.

It custom-tailors that to one individual at a time. For most of the parents whom we see, it is the first time they have ever had a conversation or any type of a positive relationship with a judge. Most of our clients are in need of a total person transformation due to multigenerational dysfunction.

Drug court participants are subject to high-level personal accountability while treated with respect and dignity in a holistic and practical approach designed to reintegrate them back into society, and, in my opinion, it is one of the most honorable applications of the court system.

For those who complete the year-long commitment, it is often the most life-changing year of their lives, marked with graduation celebrations that are so packed with emotion, they are enough to keep child welfare workers motivated for months when they go back to the grind.

So in closing, let me say that any successful approach to combating methamphetamine must involve authentic, cooperative, working relationships between community players and a holistic approach with individual clients.

Thank you very much for this opportunity to address the committee. This concludes my testimony, and I welcome your questions.

The CHAIRMAN. We thank you, Mr. Frank. Now, Rev. Aigner.

STATEMENT OF REV. FREDERICK AIGNER, Ph.D., PRESIDENT AND CEO, LUTHERAN SOCIAL SERVICES OF ILLINOIS, DES PLAINES, IL

Rev. AIGNER. Good morning. Good morning, Mr. Chairman. Just by way of reference, I am grateful for your relationship with Roger Goodman.

The CHAIRMAN. Oh, yes.

Rev. AIGNER. Who prized his relationship with you. Thank you for your accessibility. We are grateful. Member Baucus, good morning.

Senator BAUCUS. Good morning. How are you?

Rev. AIGNER. I serve in the President's Office at Lutheran Social Services of Illinois. It is a 140-year old institution. Last year we served 65,637 people, 16 lines of service. Two of the most predominant ones are child welfare, child issues, and then also drug abuse.

Methamphetamine first came to our attention in Illinois through our southern offices. The region down there is rural. I do not know if it is hyper-rural, but it is rural. Fourteen counties the size of Connecticut and Rhode Island together with not a lot of people. That is where in 2002 we had no methamphetamine abuse indicators, and now 3, 4 years later, we have a 260-percent increase in it, and most of it is attributable to methamphetamine.

A Statewide agency, we track it across the State and we see it moving up freeways, so it is Peoria and Champaign, and now Galesburg and the quad cities and Rock Island. I was over there the other day and I saw an ad maybe comparable to the one that Senator Baucus mentioned. It was a policeman. It said, "If you cook it, we will come."

There is such a widespread understanding now, that is what is at stake. You do not have to, cook what? Cook up your methamphetamine at home. It turns out that in the southern part of the State, unlike other places, it is virtually all home labs, virtually all home labs, so we do not have an import issue. That is a non-issue down there.

But as a consequence, children are exposed then in the homes down there to all of the toxicities around that. You heard them portrayed variously by other members of the panel, the previous panel, and also by this panel.

There is this danger that Mr. Frank identified to first responders, which include child welfare specialists. People are very erratic. Whatever their predispositions in the world, they are now amped up on the stimulant, and they are going to be more so. If they keep high for long enough, they are going to be perfectly dysfunctional psychologically, as in fact yours and the other Senator's portrayals suggested at the very beginning.

So domestic violence, child abuse, not to mention of course, neglect, as well as sexual abuse are all very, very common and are pretty much on the minds of our folks as they now go out with a sense of threat to themselves.

I want to tell one story, and then make three suggestions, and then answer your questions if I may, sir.

A young mother left her child with a babysitter. The babysitter called the hotline because mom did not pick up the child, and was given to us to care for her. We tried diligently for 2½ weeks to find

the mom. Finally after approaching 3 weeks, she showed up. She had been on a methamphetamine binge.

What is remarkable in her personal testimony is to me, she forgot she had a baby. That is so remarkable clinically. That is actually unprecedented in our experience, and we work with people with drugs all the time. She forgot she had a baby. When she finally stopped binging and she remembered, of course she was horribly ashamed.

This is a happy story; it had a good ending. She got herself straightened out, and now months later there is a high likelihood of reunification, which is of course what we are always shooting for.

But the fact of the matter is that, in most of our experiences with methamphetamine, it does not have a happy ending, at least 60 percent. It is that difficult.

The people who were here before us—I was in town a couple of weeks ago for the Horatio Alger awards—these were the Horatio Algers of America here, undaunted spirit and optimism in the face of adversity. What is the difference between the Nobles and Allison and Mr. Binkley? All of them have very bright eyes, and all of them had lovely childhoods, and they had adversity, but they were not broken internally, and they were not addicted.

They were not singly, dually, or multiply diagnosed, as most of the people now coming into the system, not these folks, but most of the people coming in now, these are the Horatio Algers. Theirs is the story of America that needs now to be told, and resources have to be found to free them up.

I think that if we do think positively, lots of good things can happen. The fact of the matter is that because it is rural, it very often happens in places where there are not sophisticated drug interventions, drug treatment programs. So the first recommendation I would like to make: we run drug programs in Chicago, but we do not have them in the southern part of the State. I do not know how complete access is in Iowa. It sounded very good from some of the testimony, and Missouri now too, I would assume, as well as California sounds wonderful. Oregon of course has been wrestling with it for a long time.

I would suggest that resources have to be deployed to add drug abuse counselors to the child welfare teams within the offices. They cannot be extrinsic to it. They not only have to be within the offices and working in tandem—and we do not do residential work in the south—but when they go out, they need to actually go out in twos, because the impact of a child welfare specialist on a methamphetamine parent or someone who is trying to clean up, it is so aversive, they immediately want to get high again. They almost have to have a drug counselor there with them on the visit. Well, that doubles the cost for every one of those visits right there.

Furthermore, drug counselors have to be sophisticated about the Federal mandates regarding permanency and the fact that the time lines are inordinately short. Not inappropriately, but relative to methamphetamine, inordinately short. So 9 months and 17 months, they have to be working and intensifying their activities on behalf of our clients in order to bring them along in such a way that fami-

lies can be reunified, which would be the ideal situation. So there was that.

I wanted to mention training. It is for us in our area a relatively new phenomenon. It clearly is not with Dr. Young or with Mr. Frank in your areas. We need lots of training. We have spoken in the past and would lift up again title IV–E.

Title IV–E dollars are largely used for training pretty much through State agencies. The fact of the matter is with 80 percent outsourced to private agencies, it seems a shame that the training dollars that are available to train people are not made available also to the private agencies who are doing the burden of the work in the field. So we would lift that up for your consideration as well.

Finally, even though the number of children in foster care has fallen nationally, the fact is that the children in foster care are increasingly more difficult to serve. As a consequence, I would recommend that case loads drop from—currently in Illinois—15 per worker, to 10. That set of recommendations and the resourcing of it would be hugely helpful for us.

A great opportunity for me and for Lutheran Social Services of Illinois, part of Lutheran Services of America—which by the way delivers $8 billion worth of services and touches the lives of 1 out of 50 people every year—to come and to present to you this day. Thank you for your interest in the methamphetamine crisis.

The CHAIRMAN. Thank you very much. I will start with Mr. Frank.

From your experience with interacting with Federal money, do you believe that there is enough flexibility in the current Federal financing structure for child welfare to allow States to respond to the methamphetamine epidemic?

Then I suppose I ought to start with the reality of the fiscal constraints that we face now. How would you balance the State's need for flexibility with a concern for a more flexible block grant approach, and would reducing or eliminating the entitlement status for various vulnerable children be a good thing, or not?

Mr. FRANK. Well, Mr. Chairman, I think I got most of that. Some of that I can comment on, and some is up to my superiors to formulate a response.

As far as flexibility, the first part of your question, grants certainly offer far more flexibility to the extent that they last, the size of them, than does IV–E. IV–E is an antiquated system. Welfare was reformed, IV–E was not. It is designed to take care of kids who otherwise would meet that traditional financial category and places them in foster care. It is just not a progressive type funding source.

Montana though has tens of millions of dollars wrapped up in IV–E, as its current entitlement program. So if it were to go to a block grant, we would want to definitely have comment on what would that look like. There are experts who know a whole lot more about this than I who would need to weigh in on that.

The CHAIRMAN. All right. Dr. Young, in your testimony you discuss the characteristics of female methamphetamine users. Could you review these characteristics for the committee and discuss the implications, particularly on children.

Dr. YOUNG. Well, I think the thing that comes to mind most profoundly without looking at my notes is the intergenerational issues

of abuse and neglect. The vast majority of women who come to treatment were abused or neglected as children themselves.

So we are addressing two parts. First, the whole family in terms of the parent who comes to treatment, and the needs of the children, but also recognizing that for women, the mental health, the trauma, the domestic violence components that make up her world as she enters this new life of sobriety have to be put in place to be able to deal with that.

We know that there are some unique characteristics of women in terms of methamphetamine itself and using. They tend to begin using younger, they use with a different kind of pattern, a certain number of days. That would mean that if the effects of methamphetamine last over a longer period of time, the risk of neglect—and predominantly who comes to the child welfare system are kids who have been neglected—that risk obviously is increased when a parent is using methamphetamine compared to some of the other drugs.

I think, again, most importantly is looking at that intergenerational piece as a woman who comes to treatment and what else needs to go on in her life in terms of comprehensive services and really looking at the trauma issues that got her there in the first place.

The CHAIRMAN. You speak about two-thirds of the women who are methamphetamine users having been physically abused, and nearly one-third sexually abused.

What is it about the nature of this drug that makes it so attractive to women who have been victims of domestic or sexual abuse?

Dr. YOUNG. Well, I think if we look at the young girls and the data on the young girls that are starting, the media messages and what they tell us about why they are starting to use, it is a pretty effective weight control piece in the very beginning.

Girls get into methamphetamine for a variety of reasons that would not necessarily attract boys for those same kinds of things. I am not sure that it is the methamphetamine that draws a population that also has childhood abuse going on in their family. I think that that is there regardless of what kind of substance.

We know of women who are addicted to alcohol, to cocaine, to other substances, and the amount of childhood abuse and neglect in their lives is similar. It is not just methamphetamine that that comes out in.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. I would just like to explore a little bit the relative value of, say, drug courts and other programs like Bridgeway that came up in the last panel.

I assume that some work better, some situations, than others. But could you talk, both of you, Mr. Frank, a little bit about the drug court. In your experience it is working pretty well. I am just trying to see where we put our resources, because they are not infinite.

Mr. FRANK. Thank you, Senator Baucus. The drug court does work well for a certain population. It does not work for others. It is the best thing that we have going in the way of treatment combined with what we were calling shared family care, what Allison on the first panel referred to as a family treatment program.

Senator BAUCUS. Right. Right.

Mr. FRANK. That is something I am going to go back and talk to my peers and superiors about. I am very interested in that twist on adding that to drug court.

The families we see are at the end of their rope. I mean, they have tried every kind of preventative thing and intervention that may have been tried earlier, short of going to court. So it is just a very difficult population. But drug court is from the treatment standpoint, and it does address the whole family. As the youth, I guess that he is 18 now, down on the end said, drug court will encompass all of the juvenile probation activities.

I think one of you asked about the criminal aspects, and the gentleman replied, that is done separately. There are different evidentiary standards and so forth, but drug court does treat the whole family in court.

Senator BAUCUS. Dr. Young, do you want to talk about that, please?

Dr. YOUNG. Yes. I think the thing that we have to think about in terms of the family treatment courts and developing family treatment courts is it allows us to have accountability in two ways. Accountability for families that have substance use disorders, but it also makes the systems more accountable.

The court then is looking at what is happening in the child welfare case, what is happening in treatment. The models that have been developed that provide those services for all of the families in that particular jurisdiction have been very, very effective in terms of increasing reunifications, increasing treatment completions, getting parents to treatment faster.

There is lots of evidence about what works in family treatment court. However, we have to remember that that is really the back end of the system, if you will. Most of the families that are in child welfare are in those services that are family support services, Promoting Safe and Stable Families, the flexibility about being able to serve families before children are removed.

Once the court comes into a jurisdiction where a child has been removed, that is where most of the family treatment court practice is happening. That is not to say that there are not court-involved families in which the kids are still at home.

Senator BAUCUS. I appreciate that.

Dr. YOUNG. But they are on the back end.

Senator BAUCUS. Reverend, do you have any thoughts, among these various ways, but in terms of treatment, what works?

Rev. AIGNER. It does have to be comprehensive. Actually I apologize, I actually want to speak to this, but my immediate thought has fled as I was following Dr. Young's response. It is escaping me.

Senator BAUCUS. We can come back to you.

Rev. AIGNER. Would you please come back to me?

Senator BAUCUS. Yes, sure.

Rev. AIGNER. Thank you.

Senator BAUCUS. I will tell you, in my very limited experience, the family treatment centers work, and foster programs work. About a year ago, I was in an assembly at a middle school in Billings.

The whole program was fighting methamphetamine. We had some various resource people, law enforcement and others, trying to get kids to understand the problems with methamphetamine. Afterwards, a bunch of kids walked up to me and we chatted a little bit, this and that.

I could tell there was one little fellow standing off on the side. In the corner of my eye, I saw him. I sensed that he had something pretty serious that he wanted to talk to me about.

Sure enough, he was the last person to talk to me. He walked up to me and blurted out, he said, "My mom is on methamphetamine." He started crying. We talked about his grades and how he is doing, the situation. It was rough. He kind of pulled himself together a little bit, but it was tough. He really bawled when he walked away.

But right then at that moment, I decided I am going to mentor this kid, and I have. We correspond a lot, we see each other. I have to tell you, he was placed not too long ago into a family. His mom was taken away from him. He only had really himself. He had no idea where his dad was, but he knew his mom and he loved his mom, but he was taken away from his mom because she was doing methamphetamine.

Anyway, he went to a foster home. A month ago, his mom died of an aneurysm, methamphetamine-related disease. I saw him. I had dinner with him at a Pizza Hut last week. He is really doing well. It is just wonderful to see.

The foster home environment has been really helpful to him. You just see the confidence he is now getting. He has also grown a bit in the last year. He is talking that he might go live with his brother who is overseas in Okinawa. He is on the Internet learning about Japan and other countries.

From my experience, the foster program in Montana is working, at least in this fella's situation. So I just wanted to thank you for all that you do very much.

I do not have any more questions here. Just thank you so much for what you do. Obviously you all care, you care a lot. Based upon the experiences there were up there, there are good results. Just keep at it. Again, thank you very much for taking the time and coming here. Thank you.

The CHAIRMAN. Rev. Aigner, if you think of what you were going to say to Senator Baucus, break in at any time.

Rev. AIGNER. Yes. Thank you. Yes, actually I did think about it. I do not know if I said it exactly as precisely as I wanted the first time around with this young woman.

Yes, it is 7 percent in the country. Other drugs seem to be comparable in many ways, and maybe the treatment patterns will be the same. This drug is so disruptive of the natural order of creation for people, so profoundly disruptive that that is what I was trying to suggest with my example. I had three or four, if you read the written testimony again.

That is often as even the threat of having a child removed does incite and incent a parent to engage it. Our experience is equally often, it does not. That is why we need a lot of help here in the State of Illinois. If you are doing better other places, I commend you. We are actually pretty good at this. Proprietaries want to buy

our drug and alcohol continuum from detox all the way through. We are actually pretty good at this.

I am saying that around methamphetamine, it is new territory for us. It has not been easy for us to engage as fully as we should. So in the example of the courts, the later part is more where we find ourselves than the earlier part. We engage, but as many times as not in one family, the other example, the father commits suicide, the mother regains her health.

That is about it for us so far. So we need the attention, we need the resources. I know we can do better, we are very good at it. But methamphetamine is a pernicious drug.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, thank you for holding this hearing. I think it is an important discussion and long overdue. You and Senator Baucus have long been leaders in the anti-methamphetamine effort.

Dr. Young, I especially appreciate what you have done. Oregon has taken a huge pounding in terms of the methamphetamine problem. I would like to put it I think a little bit differently.

The skeptics, particularly in this kind of budget environment, often come to me and say, Ron, can we really afford these kind of treatment programs? It seems to me the question is really different. That is, can we afford not to have these programs?

My judgment is just from the standpoint, I mean, a really cold-hearted budgetary analysis, the kind of treatment work you advocate makes sense from a dollars and cents standpoint.

Let me tell you how I get to that point, and I would be interested in your reaction. I think the country has a choice. You can spend a boatload of money constantly paying for jails, constantly paying for hospital emergency room visits, constantly paying for this huge array of costs that methamphetamine addicts can incur, or you can have the kind of well-targeted treatment programs you are talking about and break the cycle of methamphetamine addiction all together.

That way, the kids and parents can be back together in a drug-free environment. So my question to you is, even if you do not have a warm heart, and I am not saying that anybody approaches that way, but just from a cold dollars and cents standpoint, doesn't it make sense to look at some of these targeted treatment approaches and say, it sure looks like the costs here are not going to be close to the dollars that you rack up constantly paying for people, a revolving door in and out of a jail cell?

Dr. YOUNG. That is absolutely correct. Time and time again, cost offset studies, cost effectiveness studies have shown that treatment pays for itself a few times over, most recently out of California and their Prop 36.

Again, the treatment effectiveness data as well as the cost effectiveness data are there. But Oregon is a very unique situation. In fact, one of the staff from the Oregon State child welfare agency has said recently that if you look at the case load data of Oregon of the kids coming into out-of-home care, during the time when the methamphetamine epidemic was really exploding there, they had treatment resources.

Mr. Wersher would say we really were getting a handle on what was happening with methamphetamine, and their case loads were coming down. Then they had a cut in funding in substance abuse treatment in Oregon. He says, and you will see in the data and the graphs that were provided, Oregon's case load has gone back up.

He attributes that to not being able to get access to services for families in the State of Oregon.

Senator WYDEN. Well, I am going to do everything I can to kind of take your message and sort of proselytize for your cause. If you can get us some more information to that effect, that would be helpful.

I think the way this has really broken down in terms of a debate with citizens is, are you tough on methamphetamine? And of course I want to be. I want to come down with hobnail boots on these kinds of sophisticated criminals that are dealing in methamphetamine.

We have seen some very sophisticated people. When Senator Smith and I were in Asia, for example, recently we talked to them about the link between Asia and the methamphetamine problem. Apart from the morality of helping families get back together, the data you have in terms of just plain dollars and cents impact show that treatment is smarter from a dollar standpoint than the alternative.

So if you can get us a summary of those studies, I would like to take that message far and wide, because I think it is something that needs to be heard. I thank you all. We are all juggling today. There have been a lot of hearings and demands on our time, but I just thank you for all the work you are doing.

Especially, Mr. Chairman, for calling this hearing. I think a lot of people would look at the topic and say, what is the Senate Finance Committee, this enormously prestigious committee doing looking at the methamphetamine issue? You have laid out exactly why we are, and the costs to our country both in terms of social services, which we do have jurisdiction over, and the costs to our families are compelling.

So I look forward to having more hearings like this and to working with you and Senator Baucus.

The CHAIRMAN. Along that line, if we can work it in, we may have another hearing dealing specifically with the reauthorization.

I am going to just ask a couple of questions, and then we will be done, unless other members come. I am going to ask Rev. Aigner.

On this issue of what is best for the kid, whether it is with the family that gave birth to that child, or whether it is outside the family, in working with these children and families, how do agencies such as yours, Lutheran Social Services, determine whether or not family reunification is possible?

Let me ask three questions. Whether or not family reunification is possible, how do you determine that, and then secondly, in your experience, how often is family reunification successful when a parent is addicted to methamphetamine, and that might be as opposed to being addicted to other things, and do you have suggestions for Federal lawmakers on ways that we can facilitate positive outcomes when family reunification is advisable?

Rev. AIGNER. I take note of the latter. With all clients, you have a treatment plan. It is the participation of your client in that treatment plan that determines whether or not you are going to move back toward family reunification.

It would be participation in the full range of counseling services, parenting services, management of the cravings, and all of that side. It would be engagement in a job and the ability to support, it would be all the normal indicators from the treatment plan.

If they are moving along, then they can appear before the judge and they can be reunified.

The CHAIRMAN. In most cases, are they reunified, or not so?

Rev. AIGNER. In other parts of the State, and with other issues, we have great luck. We have less luck at this point in Illinois with the methamphetamine-related cases.

The CHAIRMAN. Go ahead.

Rev. AIGNER. Yes. So that is the first part of it, if that is helpful. I forgot your second question. Could you just quickly remind me of it?

The CHAIRMAN. The second one, how often is family reunification successful when a parent is addicted to methamphetamine? That might also be in relationship to success or in relation to other addictions other than methamphetamine.

Rev. AIGNER. Yes.

The CHAIRMAN. And you may not have any statistics on that in your own mind. If you do not, it is okay.

Rev. AIGNER. Thanks. We are talking about a spike in a very precise part of Illinois, rural Illinois, in the south, generally outside Chicago, downstate generally.

It seems in the early days to be worse. We are very mindful of Oregon's work. We are very impressed by that, by Dr. Young and her colleagues there, and mindful of the States that have gone before us, Missouri and Iowa, and their engagement of it, and we are trying to learn as fast as we can.

At this juncture, I would still say because it is so early, we do not have a lot of evidence to suggest we can be enormously successful with it at the current level of resources. I guess that is how I would like to phrase it.

The CHAIRMAN. All right.

Rev. AIGNER. We have pretty good success with the rest of them, although it takes a long time. In our culture, the problem is everyone wants shorter, more intensive quick fixes. The fact of the matter is most addictions require years of behavioral management before you have integrated all that has to happen.

The CHAIRMAN. Well, then did you just tell me that the chances of recovery and family reunification are better with addictions other than methamphetamine than with methamphetamine?

Rev. AIGNER. Yes, and perhaps this is in support then of Dr. Young's point. We know those other drugs better. We understand how they work better. We seem to have better luck with those. Yes.

The CHAIRMAN. Okay. Then as we consider reauthorization or any policies here, any suggestions on ways that we as Federal lawmakers can help facilitate positive outcomes when family reunification is advisable, as opposed to adoption or foster care?

Rev. AIGNER. Well, it is a beautiful thought to think that you could take a whole family to a residence and have them all there in proximity and everyone would know that they were there and could be engaged in it as a corporate act.

That seems very much beyond our ability to achieve in the State of Illinois, at least to date. We have women's residences, we have men's residences. We have programs for families, but they are all outpatient programs. They are not inpatient like that.

Part of the problem always, it seems to me in dealing with the Federal Government, has been the decision to not fund any kind of facility. Fund a program, but not a facility.

Well, for us who live with no margin at all, or a negative margin on a yearly basis, we cannot capitalize the creation of a facility. So I can imagine running the residence if we had the capitalization for it, but we do not have that.

It sounds like that would be a really effective way to go. In facilities, you see them every day. It is that kind of intensive treatment that makes the difference. As it is, in a rural area they are spread out. You have to go, and it should be two now, two counselors, the drug-abuse and child-welfare specialists, they have to go these long miles to that home. That is what we have to do where we currently are.

The CHAIRMAN. Oh.

Rev. AIGNER. So anything that you, sir, would understand that you could do I guess to fix that would be helpful.

The CHAIRMAN. Dr. Young, my last question is for you. Describe how methamphetamine works differently in the body and the brain than other addictive drugs. Then for my part, if I could tell you, I make a very short statement about methamphetamine because obviously even though it is a major problem in my State, I do not understand what I just asked you in the sense of what that answer might be.

I describe it as probably more mind altering than any other drug. Now, that may not be true. So if I am wrong, correct me so that I cannot make that statement in the future.

Dr. YOUNG. Well, remember I am a social worker, not a neuroscientist. But I will help you with that if I can from my understanding of what that means.

We know from, if you will, animal models, that they are able to measure the Dopamine, which is a neurotransmitter that gives us pleasure in our brain. We get Dopamine from all kinds of activities that give us pleasure as human beings, and rats get that also.

So when they measure what the Dopamine levels are from eating, from sex, from using particular kinds of chemicals, they can then measure how much of that is there. The amount of Dopamine for methamphetamine far exceeds any of the other substances of abuse.

So it increases the amount of Dopamine that is happening between the neurons in the brain, and it lasts for a longer period of time. That half-life, about how long it will last, creates some of those risks to kids. There is no question about that.

So that is part of the reason that it becomes so immediately such a huge issue for families.

Could I turn to your previous question about the reunification numbers?

The CHAIRMAN. Yes.

Dr. YOUNG. I mentioned Sacramento County because we have been looking at their data for quite some time. They have had about a dozen years now to work on the comprehensive services that need to be put in place between the substance abuse agency, the child welfare agency, and the court.

They now have a coordinated system for the last 2 or 3 years that just works beautifully. It works on time, it works to meet the needs of families.

They have gone from before they put their system in place, they had a reunification rate among families with substance use disorders of about 22 percent. After they put this system in place, that includes recovery management, access to services at the first court date, accountability for the families through the family treatment court, the reunification rates are about 47 percent.

So they have essentially doubled the percentage of families that are reunifying in their county. They have cut the time of kids in out-of-home care dramatically. They estimate that they have saved about $3 million a year in services that would have been expended had they not put this in place.

But what is really important is when we look at that data by primary substance of the parent, there are no differences in the reunification rates among parents with methamphetamine problems than there are from alcohol problems, marijuana problems, cocaine problems.

The only family groups that reunify at a lower rate, at least in that particular county, are heroin addicts. More recently with the 2-year data looking over 24 months of what is happening for children, we have begun to see that there is a difference with heroin and opiate addicts.

The CHAIRMAN. All right. As Senator Baucus said, you have been very helpful. We appreciate it very much. Not only this panel, but the previous panel, and I repeat that for the previous panel because I think that they were brave in coming forward.

But it helps us very much as we think of this issue, particularly its impact upon our social services. Thank you very much, and the committee is adjourned.

[Whereupon, at 12:20 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Lutheran Social Services of Illinois

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.

Committee On Finance
Max Baucus, Ranking Member

NEWS RELEASE http://finance.senate.gov

For Immediate Release
Tuesday, April 25, 2006

Contact: Carol Guthrie
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Statement of U.S. Senator Max Baucus (D-Mont.)
Senate Finance Committee Hearing
"The Social and Economic Effects of the Methamphetamine Epidemic On Americas' Child Welfare System"

A medieval poet once wrote that: "When the orphan sets a crying, the throne of the Almighty is rocked from side to side." Today, we will hear that our nation is being rocked from side to side. We will hear of the weeping that methamphetamine is bringing to American children.

Every year, here in America, 900,000 children fall victim to abuse or neglect. 900,000 children — that's as many people as live in the entire state of Montana.

A child who suffers abuse is more likely to grow up to inflict abuse on others. And about a quarter of children who suffer abuse will end up engaging in delinquent behavior.

We have good reason to believe that meth exacerbates child abuse and neglect. Look at the homes where the children of meth abusers live: Their evening meals share the stove with the cooking of a harmful drug. Their toys share space with dangerous chemicals. Their forks and spoons share the sink with pots used to cook meth.

Today we'll hear real-life stories of what these kids face. We'll hear from victims of meth abuse. And we'll hear from people trying to protect their children.

Meth abuse has increased dramatically in recent years. It has reached all corners of America. Meth has become the scourge of many rural American communities.

Last week, I was in Montana talking to students about meth. For several months now, Montana kids have seen graphic and sometimes frightening accounts of meth abuse, through a series of ads run by businessman Tom Siebel. I greatly appreciate Mr. Siebel's work. He is fighting meth with his own money. And based on what I hear from Montana kids, the ads are having an effect.

--1 more--

Montana kids tell me that one of the most powerful motivators for kids NOT to use meth is testimony from those who have been affected by it. We can look forward to exactly that kind of testimony here today. We will hear from people who will share their stories of struggle and ultimate victory over meth addiction.

We will also hear the devastating effect that meth is having on the child welfare system. Meth abuse has thrown thousands of children into the safety net of child protective services. Montana's child protective service agencies are struggling to keep up. Kevin Frank from the Montana Department of Public Health and Human Services will tell us what Montana case workers face every day, as they try to provide for children from meth-abusing homes.

I look forward to the testimony of our witnesses. I look forward to the work that we will do together to combat the evil of meth. And I look forward to the day when meth will no longer bring children to cry, here in America.

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TESTIMONY OF
JOEY BINKLEY
SON OF A MOTHER IN RECOVERY
FROM METHAMPHETAMINE ADDICTION

COMMITTEE HEARING: THE SOCIAL AND ECONOMIC EFFECTS OF THE METHAMPHETAMINE EPIDEMIC ON AMERICAS' CHILD WELFARE SYSTEM

COMMITTEE ON FINANCE
U.S. SENATE
WASHINGTON, DC

APRIL 25, 2006

Hello, my name is Joseph Binkley, I am 18 years old and I am a high school senior in St. Louis, Missouri. For most of my life, my mother has been addicted to drugs and alcohol. In my early years I had no idea that my mother had anything wrong with her. I had no idea about drug addiction or the symptoms of it. It wasn't until the end of elementary school that I realized that something was wrong. My mother was acting very strange and she had to be placed into treatment multiple times for drug abuse. I was not able to be with her during those times in treatment. A short time afterwards she went to prison. From that moment, till about a year ago I completely stopped talking to my mother. I did not want anything to do with her, I felt betrayed. I lived with my father during my mother's incarceration. After getting out of prison my mother was still was using drugs.

It wasn't until I learned that my youngest sister was about to be put up for adoption that I felt I had to do something about this issue. I joined my family in the family treatment program at Bridgeway. The family treatment program helped rebuild my family and heal my mother's issues. Throughout the experiences of mother's addiction and recovery, I could not leave my family because that would not have helped me. I feel that I may have done worse without their support.

Surprisingly to most, my at home issues have not affected me academically. Throughout the years, I have maintained a high grade point average. At this moment I have about a 3.8 gpa, perfect attendance, and am involved with multiple groups including: Leadership, DJ for school radio station, RCO, Teenage Health Consultants, Mu Alpha Theta, and Ritenour Big Brother/ Big Sisters. I was just promoted to a managerial position at my job, after less than a year there. I have already been accepted to Southeast Missouri State University with two scholarships. I plan to become a teacher of science, preferably physics.

FAMILY-BASED TREATMENT FOR METHAMPHETAMINE ADDICTION

BACKGROUND

Upwards to 80 percent of families who come to the attention of child welfare are suffering with a drug addiction, and drug-related cases are more likely to result in foster care than other child welfare cases. The dramatic increase in numbers of families using meth is overwhelming child welfare systems across the nation. Approximately 10,600 children in the U.S. were either present at lab seizures or lived where the labs were seized between 2000 and 2003. 2,900 children were removed from their homes during 2002 and 2003 because of neglect or abuse by meth-addicted parents. During the past five years, 71% of counties in California reported an increase in out of home placements because of meth and 70% of Colorado counties reported an increase, according to a recent report on meth by the National Association of Counties.

THE METHAMPHETAMINE EPIDEMIC AS A MOTHER AND CHILD ISSUE

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of women from 1995 to 2003 admitted for methamphetamine treatment has almost doubled - from 6.1% in 1995 to 11% in 2003. Similarly, the number of pregnant women admitted for methamphetamine treatment during this same time period substantially increased from approximately 10% in 1995 to approximately 20% in 2003. In many states hit hard by meth, mothers with minor children have the highest rate of meth use.

A COST-EFFECTIVE APPROACH

When family treatment costs are compared to the costs of incarcerating a substance abusing mother and placing her children in foster-care, the savings to the state and nation are significant. For example:

- Family treatment costs on average between $14,000 to $25, 000 per family per year depending on the state (for example, in Utah family treatment costs $14,600 and in New York approximately $25,000).
- The average cost of one child in the foster care system is $30,000 per year.
- The average cost of state and federal incarceration of a mother is 30, 000 per year.
- The Department of Justice (2002) concluded that lifetime costs of caring for drug exposed children range from $750, 000 to 1.4 million per child.

Additionally, substantial research has been done in tracking the negative consequences on children as a result of parent-child separation. Parent-child separation impairs a child's emotional and cognitive development, as well as triggers the onset of attachment disorders. Children with attachment disorders are more vulnerable to sexual abuse, involvement in the criminal justice system, and substance abuse.

FAMILY TREATMENT AS AN EFFECTIVE RESPONSE TO THE METH CRISIS

Comprehensive, family treatment provides effective intervention services to the whole family—both the substance abusing parent and her children:

- Services include mental health counseling, vocational; preparation and job training, parenting classes, relapse prevention, supportive housing, therapeutic childcare, family therapy, and child-focused academic tutoring and assistance.
- SAMHSA's evaluation of these family treatment programs demonstrate significantly reduced alcohol and drug use, as well as decreased criminal behavior.
- Parental sobriety averaged at 60 percent, at discharge and 6 months post-discharge from treatment.
- Rates of premature delivery, low birth weight, and infant mortality were improved for participating women.
- Treatment costs were offset three to four times by savings from reduced costs of crime, foster care, Temporary Assistance to Needy Families [TANF], and adverse birth outcomes.

Unfortunately, family treatment programs represent less than 5% of the overall treatment services available, and are even less accessible in the many rural states and counties disproportionately affected by the meth crisis.

COMPREHENSIVE FAMILY TREATMENT WORKS

THE NEED FOR FAMILY TREATMENT PROGRAMS

Mothers with substance abuse issues are generally victims of sexual and domestic violence. Often, the underlying reasons for addiction among mothers are untreated post-traumatic stress and/or major depression disorders, precipitated by the injuries of sexual and domestic violence.

When these mothers seek out treatment to heal from their addiction, they face an uphill battle. Families struggling with substance abuse issues are offered few opportunities to find treatment and recovery for themselves and their families:

- The 1996 Uniform Facility Data Set found that only 6 percent of the treatment programs surveyed included prenatal care and 11.5 percent provided childcare.

Parents involved in the child welfare system are especially impacted by the dearth of drug treatment programs available to families:

- Between one-third to two-thirds of parents involved in the child welfare system require substance abuse treatment, yet existing treatment meets less than one third of that need.
- Alcohol and drug-related cases are more likely to result in foster care than are other child welfare cases.
- Only ten percent of child welfare agencies report that they can successfully find substance abuse programs for mothers and their children who require the treatment in a timely manner.

FAMILY TREATMENT OUTCOMES

Although family-based treatment represents a small percentage of the overall treatment available, family treatment programs enjoy consistently high levels of success.

In 2001, the Center for Substance Abuse Treatment (CSAT) evaluated its Pregnant and Postpartum Women and Their Infants Program, which provides comprehensive, family-based treatment for substance abusing mothers and their children. Major findings of this study, at 6 months post treatment, include:

- 60% of the mothers remained alcohol and drug-free.
- Drug-related offenses declined from 28% to 7%.
- 38% obtained employment and 21% enrolled in educational/vocational training.
- 75% of the mothers had physical custody of one or more children.

In 2003, an additional cross-site evaluation of 24 residential family-based treatment programs 6 months after post-treatment revealed successful outcomes for mothers and their children:

- 60% of the mothers remained completely clean and sober 6 months after discharge.
- Criminal arrests declined by 43%.
- 44% of the children were returned to their mothers from foster care.
- 88% of the children treated in the programs with their mothers remained stabilized and living with their mothers, 6 months after discharge.
- Employment rose from 7% before treatment to 37% post-treatment.
- Enrollment in educational and vocational training increased from 2% prior to treatment to 19% post-treatment.

FAMILY TREATMENT AS COST-EFFECTIVE

When family treatment costs are compared to the costs of incarcerating a substance abusing mother and placing her children in foster-care, the savings to the state and nation are significant. For example:

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- The Department of Justice (2002) concluded that lifetime costs of caring for drug exposed children range from $750, 000 to 1.4 million per child.

TESTIMONY OF
ALLISON BRUNO
MOTHER IN RECOVERY
FROM METHAMPHETAMINE ADDICTION

COMMITTEE HEARING: THE SOCIAL AND ECONOMIC EFFECTS OF THE METHAMPHETAMINE EPIDEMIC ON AMERICAS' CHILD WELFARE SYSTEM

COMMITTEE ON FINANCE
U.S. SENATE
WASHINGTON, DC

APRIL 25, 2006

My name is Allison Bruno. I am 22 years old. I was born and raised in Iowa. My mother and father were both addicts. My mom and dad got divorced when I was young and I didn't have much contact with my dad after that. As I think back on my life I now realize that I was predisposed to be an addict. I started drinking, smoking cigarettes, and smoking marijuana on a regular basis at 11 years old. My mom was an active user and she always had her friends over. One day I walked in on them smoking meth and my mom offered me some. I was 13 when I did meth for the first time, and I believe I was addicted from that day forward. I continued to smoke meth until I was 15. At 15, I found out I was pregnant. I didn't use while I was pregnant but I picked up were I left off after I had my daughter.

It never crossed my mind that I was not a being a good mother, because I had only known mothers who were addicts. But, as an addicted mother, I really lacked the proper skills that most people take for granted. I hadn't learned how to cook, clean, work, or manage money. When my daughter was 8 months old, I met a man who cooked meth and I started to shoot up meth. I would leave my baby with her dad, who was not an addict, for days and weeks at a time. I felt like I needed meth to survive. I didn't want my daughter to be exposed to what I was doing. I was ashamed of my addiction but I had no idea of how to stop.

When I was 18, I was kicked out of my mom's house and I became homeless. I was using meth so I didn't have to think or feel. I didn't have a place where I could bring my daughter to for visits and I felt tremendous guilt and shame for that. I got arrested at 18 for possession of a controlled substance and released the next day.

I went to a single adult treatment facility in Waterloo, Iowa shortly after my arrest. But the program was not very comprehensive. There were no therapeutic services that allowed me to understand the underlying reasons for my addiction. Not having my daughter with me in treatment was also very hard. I thought that since I could not see her, I might as well leave. I did leave and I continued to use until Christmas Eve 2002.

On Christmas Eve, I was granted a visit with my daughter for Christmas day. The guilt of not having any presents for my daughter and not being there for her got to me so bad that I signed myself into treatment. By the grace of God, I ended up at a family-based treatment program: the Heart Of Iowa woman and children's treatment facility.

At the Heart of Iowa, I got to have my little girl with me again, finally. Together we were in treatment. I had groups' everyday from 8 am to 8 pm while my daughter was in daycare or counseling. After 2 weeks, I moved to an apartment owned by the Heart of Iowa. I was taught how to cook, clean, and raise my little girl. As part of the Heart of Iowa, I was in residential treatment for 4 months, a halfway house for 4 months and after care for 2 months.

I now have 3 years and 4 months clean from drugs and alcohol. I am attending college at Kirkwood community college and majoring in Human Services. I had another child in recovery and she is happy and healthy. Today, I proudly say that my children are the light of my life. My 5 year old daughter started kindergarten this year and she is doing wonderful. I

am involved in the PTA and my children are involved in sports and gymnastics. I regularly attend twelve step meetings and the support group Moms Off Meth. Because of family treatment, I broke the cycle of addiction in my family. My children will have a different childhood than mine, and I will continue to be a loving, responsible, and healthy mother to them. My life is truly beautiful today. I have never been as happy as I am now.

Written Testimony of Kevin Frank,
Regional Administrator, Montana Department of Public Health and Human Services, Child and Family Services

Before the Senate Committee on Finance
Hearing on "The Social and Economic Effects of the Methamphetamine Epidemic on America's Child Welfare System"
April 25, 2006

Good morning Mr. Chairman, Senator Baucus, and members of the Committee. It is my great pleasure to be here today.

By now, nearly everyone in America has at least heard of meth and over time, many communities have come to the sobering realization that meth affects everybody – and in a big way. From farmers to law enforcement officials, landlords to social services professionals, victims of meth related crimes, and families across the entire socio-economic spectrum, no other illicit drug in recent history has garnered such attention and unfortunately, many have discovered the nearly limitless capacity of meth's authentic reputation for rampant personal destruction. In Montana, we were once able to point to the large urban areas of the country as having the most drug associated ills from which we were proudly immune, but we are no longer able to make such claims. I grew up in Montana - as did my parents and grandparents. Things have changed.

Meth affects nearly all aspects of the citizens and systems in our society but nowhere are the immediate and residual effects of meth more brutally visible than through the eyes of a child protective services social worker.

In years past, a college student studying a child welfare curriculum could expect to work with families in poverty suffering from a variety of social ills. That all is still true, but these same graduates entering the child welfare field now can fully expect to be exposed to toxic chemicals, are expected to know how to physically handle a contaminated child, are expected to know how <u>not</u> to disturb a crime scene, must have a heightened awareness of their own physical safety, and through it all are expected to withstand rigorous cross examination from defense council in court proceedings. The social worker can also fully expect to be confronted by an adult whose behaviors may range from near comatose, to maniacal - and verbal and physical threats of assault against the caseworker are common.

With regard to older youth; in the past, when we received reports of incorrigible adolescents or teen-agers contributing to what can lead to reciprocated violence between the parent and youth, we might suggest family counseling combined with a mental heath assessment. Now, it is increasingly common for both the parent and the youth to be experimenting with or addicted to meth.

In questioning parents, some will immediately confess their drug use along with a desire to get clean; others will deny their use even when confronted with drug test results, and still others will express their inability to resist the drug and their wish to relinquish parental rights to their children hoping to end our involvement.

Child welfare social workers get into this business to help families, but meth is a multiplier that exponentially increases all things bad that may have otherwise been preventable or manageable even in families showing more traditional signs of risk. Child welfare workers are accustomed to fast paced, near chaotic work environments where the rewards are few and the personal demands great, but meth poses unprecedented challenges to child welfare agencies given the risk factors involved. In Montana, we have the unenviable honor of being among two states in the country with the highest number of children in foster care per capita, and the numbers are still rising. Over 65% of all foster care placements in Montana are directly attributable to drug use and of those, meth is a primary factor 57% of the time. Hundreds more children that are not directly involved in the child welfare system are living with grandparents or other relatives due to the meth related incarceration or absenteeism of their parents, and meth use among residents of the seven Indian tribes in Montana is far in excess of epidemic proportion.

But there is hope - the first being through education and awareness. Montana has been blessed with responsible local media outlets that consistently and accurately report on all aspects of the meth issue, and we've experienced a great deal of partnering and collaboration of many diverse organizations from all levels of government, law enforcement, attorneys, hospitals, schools, the Montana University system, civic groups, and various private organizations all working together to combat the meth problem.

With a great deal of leadership directly from our local court judges and with a number of legal protocol issues resolved, the Yellowstone County Family Drug Treatment Court was born in Billings and took their first client in June of 2001. The significance of the Drug Court model is very simple but also very powerful. It invokes the historically recognized and revered institutional authority of the district court to both punish and praise – and custom tailors it to one individual at a time. For most parents, it is the first time they have ever had a conversation or any type of positive relationship with a judge.

The term "Drug Court" or even "Family Treatment Drug Court" belies its name in the sense that it is a total person transformation, as courageously touted by many of its graduates – and it is very demanding. Expectations of personal accountability and responsibility are very high. Drug Court applies and models respect, accountability, and dignity in a holistic and practical manner to reintegrate an individual and family back into society and in my opinion, is one of the most honorable applications of the court system. For those that complete the year long commitment, it is often the most life-changing year of their lives marked with graduation celebrations that are so packed with emotion, they're enough to keep child welfare workers motivated for months when going back to the grind.

In closing, let me say that any successful approach to combating meth must involve authentic, cooperative working relationships between community agencies, and a holistic approach with individual clients.

Thank you very much for this opportunity to address the committee.

This concludes my testimony and I welcome your questions.

U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

Opening Statement of Sen. Chuck Grassley
Hearing, "The Social and Economic Effects of the Methamphetamine Epidemic on America's Child Welfare System"
Tuesday, April 25, 2006

Today's meeting of the Senate Finance Committee is for the purpose of hearing testimony on "The Social and Economic Effects of the Methamphetamine Epidemic on America's Child Welfare System." It is worth noting that this is the first hearing the full Finance Committee has had on an issue relating to child welfare in nearly 10 years.

Discussions of issues relative to child welfare are long overdue and if time permits, I intend to hold another full committee hearing on child welfare issues, particularly as they relate to the "Promoting Safe and Stable Families" program which the Congress must reauthorize this year. Today we will hear about the awful toll that methamphetamine abuse and addiction are taking on families, communities and our nation's social services infrastructure, particularly as it relates to children.

Methamphetamine is possibly the fastest-growing drug threat in America. According to a survey from the National Association of Counties, 58 percent of counties report that meth is their largest drug problem. Meth is highly addictive and the effects last longer than crack or cocaine. Meth is relatively easy to make and cheap, compared to other drugs. According to the 2003 National Survey on Drug Use and Health, more than 12 million Americans have tried meth. Meth-making operations have been uncovered in all 50 states, but the most wide-spread abuse has been concentrated in the western, southwestern and midwestern United States.

Numerous reports indicate that methamphetamine abuse is on the increase, particularly among women of child-bearing age. This is having an impact on child welfare systems in many states. According to a survey administered by the National Association of Counties, "The Impact of Meth on Children," meth is major cause of child abuse and neglect. Forty percent of all the child welfare officials in the survey report increased out-of-home placements because of meth in the last year.

Many child welfare agencies are struggling to cope with the unique challenges associated with parental addiction to meth. Children living with a meth-addicted parent are often exposed to toxic chemicals such as ammonia, iodine, hydrochloric acid, starter fluid and drain cleaner used during the production of the drug. Because the parent's high lasts for hours and drug binges can persist for days, children are often left neglected to fend for themselves.

Additionally, one of the effects of meth is a dramatic increase in a user's sex drive. As a result, children are often exposed to pornography and sexual abuse.

While this hearing today will highlight the strains that the meth epidemic is perpetuating on the child welfare system, it is important to note that our nation's child welfare system is already over-burdened. The system is understaffed and under-trained. Children linger too long before securing a safe and permanent home.

More funding could be available for adoption assistance and family reunification services. Administrative funds could be used more efficiently. Data collection is insufficient. Finally the child welfare financing structure is antiquated and inflexible and prevents states from responding to a variety of challenges.

I am hopeful that working on a bipartisan basis, the Senate Finance Committee can address fundamental flaws in our current child welfare system that impede progress to ensure every child's well-being.

TESTIMONY OF
AARONETTE NOBLE
MOTHER IN RECOVERY
FROM METHAMPHETAMINE ADDICTION

COMMITTEE HEARING: THE SOCIAL AND ECONOMIC EFFECTS OF THE METHAMPHETAMINE EPIDEMIC ON AMERICAS' CHILD WELFARE SYSTEM

COMMITTEE ON FINANCE
U.S. SENATE
WASHINGTON, DC

APRIL 25, 2006

Good morning Senators. Thank you for the honor of speaking to you today. My name is Aaronette Noble. I am here with my husband and my son Joey. I am a wife, a mother, and I am a recovering addict.

I grew up in an alcoholic home. I smoked marijuana for the first time at the age of 7. I first drank alcohol at the age of 14 and I began using cocaine and methamphetamine at the ripe age of 17. No one plans to have the disease of addiction take over their lives and no one plans to end up in prison for methamphetamine abuse. No one plans to give birth to a tiny baby born with drugs in their system. No one plans to have their children tell them they don't want to have anything to do with their mother. No one plans for these things, I know I didn't.

When I was using meth, I felt dead most of the time. All I did was breathe in and breathe out. I had no motivation. The world was a very dark place. I had no hope or no faith in anything or anyone. Everyday I would wonder why I didn't just die. I was so angry at God, at the world and mostly at myself. My teeth and my hair were falling out and other people had custody of my children. My husband and I were homeless and sleeping in our car.

Did I believe that family treatment could help me, with all that was wrong in our lives, how could it? I had tried single adult programs but I never succeeded in staying clean. The programs were very short-term, they were only 90 days at most. I was not helped as a mother who had this shame and guilt because of my addiction. My children were not provided services. We could not heal together as a family.

After years of prison and inappropriate single adult treatment programs, my addiction to meth got worse. I gave birth to a daughter born addicted to meth. She was removed from my custody by child welfare. At that point, however, a miracle happened. My children and I were referred to a comprehensive family treatment program. We entered into Bridgeway Counseling and the Division of Family Services. My husband had made a commitment to do the same. Bridgeway had just opened a Men's Residential Center next to the Women's Center. We were the first married couple to be in treatment at the same time. It helped to know that we were doing this apart, but also together. Our addiction tore our family apart, so we needed to find our solution as a family. I received services I didn't even know I needed. I saw a psychiatrist who helped with my depression and I could sleep better and think more clearly, it was like someone turned on the light in my head and my mind wasn't constantly racing.

At Bridgeway, we started family therapy. I got counseling for domestic violence and for sexual abuse. I didn't even think I had issues in these areas until I finally opened up to my counselors and was truthful with myself. We took parenting classes, went to meetings and attended Church. The Division of Family Services brought our baby to Bridgeway for Darren and me to see her. She's a beautiful little girl with big blue eyes and she can see right through you. I want her only to see good things in me today, and that's what she does. She gives me strength and courage.

After thirty days of doing Bridgeway's residential program, my family and I transitioned into Bridgeway's intensive outpatient program. The beginning of our sobriety was not easy, but maybe it shouldn't be, maybe we needed to work and struggle. We entered into a shelter and

I came to Bridgeway during the day. We then, as a whole family, lived in a used trailer for $500. I have to tell you, we love that trailer; it is our first sober home as a family. My husband and I voluntarily joined a "Family Safety Court" in order to have more structure and more support and allow Division Family Services to be an even bigger part of our lives. We had nothing to hide, we only wanted our family back together, we only wanted to stay sober, we only wanted to make our children smile as often as we could. We also continued to receive the family-based treatment services of therapy, family counseling and parenting classes at Bridgeway.

My beautiful girl with the blue eyes has been reunited with us now; she has been with us for five months. I'm sure those of you who are parents can the feel the light that having all of your children next to you bring to your life. That light is with me today, it is with me here in Washington DC, it is with me every moment. I know that being a parent is not a right, it is a privilege. It is mine and Darren's privilege to be parents.

No one plans to tear their world apart and the world of their children. Today, because of available family treatment, I can plan every day to put their world back together. This is work, but it is the best kind of work. It is a struggle, but it is the best kind of struggle. We continue to go to meetings, we continue to meet with the c ourt, we continue to make sober friends. And we begin, for the first time, to be sober heroes to our children.

TESTIMONY OF
DARREN NOBLE
FATHER IN RECOVERY
FROM METHAMPHETAMINE ADDICTION

COMMITTEE HEARING: THE SOCIAL AND ECONOMIC EFFECTS OF THE METHAMPHETAMINE EPIDEMIC ON AMERICAS' CHILD WELFARE SYSTEM

COMMITTEE ON FINANCE
U.S. SENATE
WASHINGTON, DC

APRIL 25, 2006

Good morning Senators. Thank you for the chance to speak to you as a father in recovery. Aaronette and I are the proud parents of two children, Casey who is six and Summer who is 15 months old. Summer is here with us today. I am also the very proud stepfather of Joey Binkley.

I used meth for 14 years. My wife and I used meth together. We wanted to get help to stop hurting ourselves and our children. I tried treatment. I went to 4 different treatment programs. But each program was set up for single adults. I couldn't bring Aaronette or the children with me. So I couldn't concentrate on the treatment itself. I couldn't stop worrying about my wife still being in the situation that I left. I couldn't stop worrying about what was happening with our children. For treatment to work you need the time and space to think about you. But I couldn't think about me. I could only worry about my family.

After so many years of using meth, trying get clean, and using again, I ended up in prison. In 1999 I was arrested for manufacturing meth. I use to manufacture meth by myself out in the woods. When I went into prison, I weighed 120 pounds. I was not offered treatment in prison and after prison. After serving 3 years and 10 months, I was released.

Life didn't get better for us after prison. Aaronette and I continued to use meth. Our addiction got so terrible that in 2005, Aaronette gave birth to our second daughter who was born with meth in her. Child welfare took our baby girl away. But child welfare, along with the family court program, placed us into Bridgeway's family treatment program. Aaronette went to the women and children's program. I went into the men's program.

I can't tell you how wonderful it felt to do treatment as a family. In the family treatment program, I knew that my wife and children were safe and healing. That really eased my mind. I could focus on my treatment. But I could also heal with my family. At Bridgeway, we did family therapy, couples counseling, and parenting classes. I learned how to communicate with my wife. I learned how to honor her. You see, before our relationship was based on drugs. But now we know how to talk to each other and love each other. We also know how to be parents.

When I was using meth, our daughter Casey looked so scared. Our daughter Summer lived with her Grandmother. Summer was very attached to her grandmother. But today, our daughter Casey has a beautiful sparkle in her eye. She is doing well in school. Our daughter Summer was retuned to our custody five months ago, and she is inseparable from us. We are a family.

We have a support system made up of wonderful people from the family court, Division of Family Services, and the family treatment program. They all worked together to help our family get clean and stabilize. Our social circle is made up of other parents in recovery and people in NA. We are blessed. I am working in construction. We attend church. We still go to therapy. We are a family with faith and hope.

Senator Jay Rockefeller
Written Statement – Senate Finance Committee
The Social and Economic Effects of the Methamphetamine Epidemic
On America's Child Welfare System
April 25, 2006

Mr. Chairman, I wanted to submit a written statement for the record to commend you for convening such and important hearing on our child welfare system and the most recent drug – methamphetamine – to strike our families and hurt vulnerable children. It has been a long time since the committee held an oversight hearing on child welfare, and I truly appreciate your commitment to such vulnerable children and families.

I am unable to personally attend the hearing since I am still recovering from my back surgery.

West Virginia, like too many states, is struggling with the effects of the methamphetamine epidemic – it has troubled our families, our law enforcement officials, and most tragically our child welfare system.

In April of last year, I hosted a round table in West Virginia with law enforcement officials in Charleston to discuss the problems of methamphetamines. I learned a great deal from the officers, including the sad situation of children living with meth labs and suffering because of the addiction of their parents. It is important for the Senate Finance Committee to review how meth is affecting vulnerable children and the child welfare system itself.

Whenever there is a discussion about methamphetamine, people suggest an epidemic. The available statistics are startling. SAMSHA reports that methamphetamine abuse has increased more than 420% for persons 12 years and older during the past decade. In southern West Virginia alone there have been well over 100 laboratory raids since October 2005. According to a July 2005 survey by the National Association of Counties (NACo) the epidemic is no longer just hitting rural states like my own or states such as Iowa or Oregon, meth is moving into suburban and urban areas.

We know arrests are up due to meth, and tragically in many states, including West Virginia, we are seeing press reports of out-of-home placements for children on the rise as well.

The question for today's hearing will be how do we help our law enforcment officials, and our child welfare system. How can we educate and support foster families that take in children devastated by this drug, and how do we support a full and prompt recovery, if possible, for their parents?

Some areas that have been struggling with meth for years have developed innovative programs to combat this drug, and help its victims. What do we know, and what can with share with other states and regions that are just beginning to confront meth related problems. Also, what do we need to learn about meth, and the child welfare system?

This year, Congress should reauthorize the Safe and Stable Families Program, an initiative created in 1997 as part of the Adoption and Safe Families Act to invest in prevention services for families and support for adoption of children from the foster care system. Prior to 1997, less that 25,000 children were adopted from foster care on an annual basis, but today that number is over 40,000. That is real progress toward achieving permanency for children, and it is why we need investment in adoption support.

Today, meth affects our child welfare system. What can and should be done to respond to this new drug that is hurting our families and communities. The Finance Committee hearing today an important effort to education our future deliberations.

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

April 25, 2006

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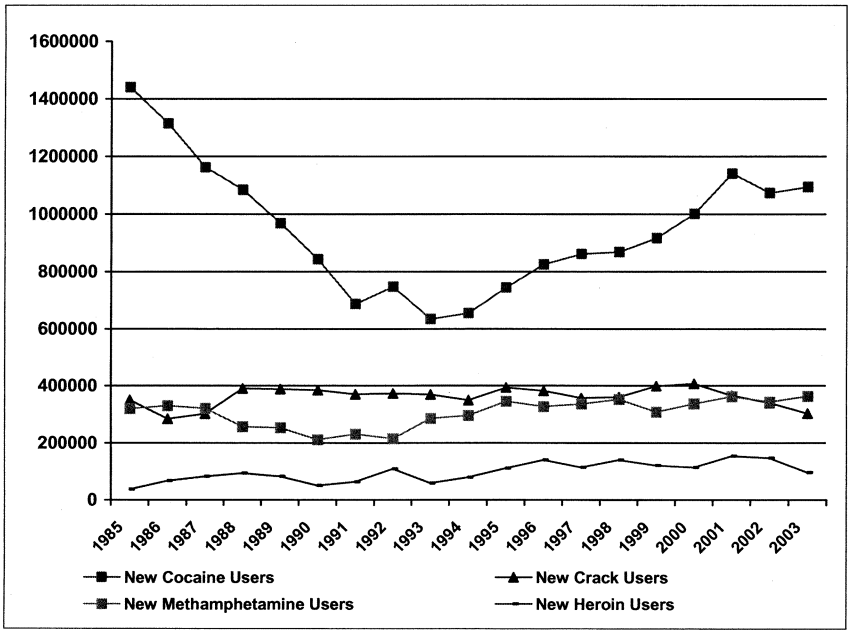
Summary Charts for Oral Testimony

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

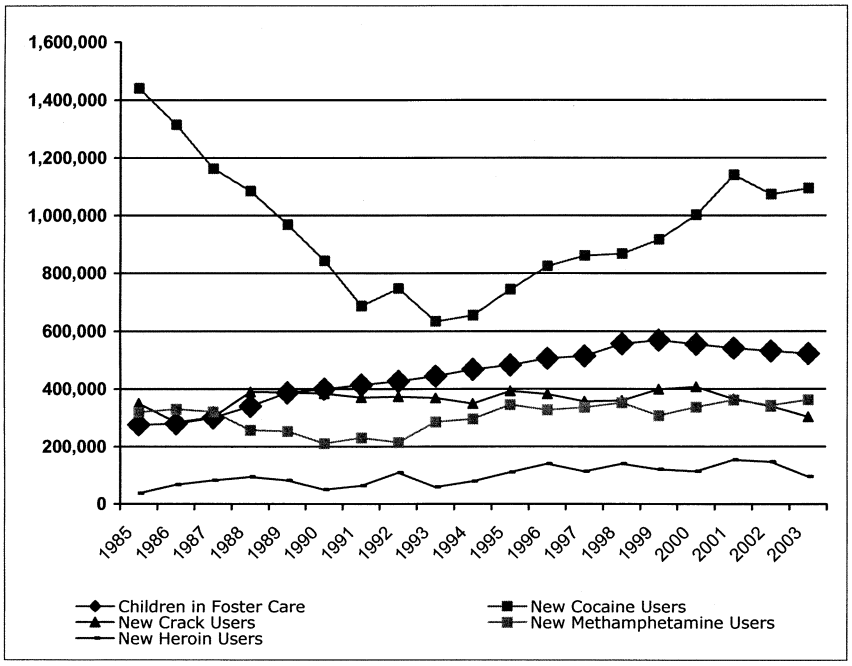


It is important to monitor trends in the new users of specific substances, those that begin using a substance in a given year, as they are a leading indicator of drug use trends and the data can suggest future trends of substance-related health, social and economic consequences for the nation.

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]

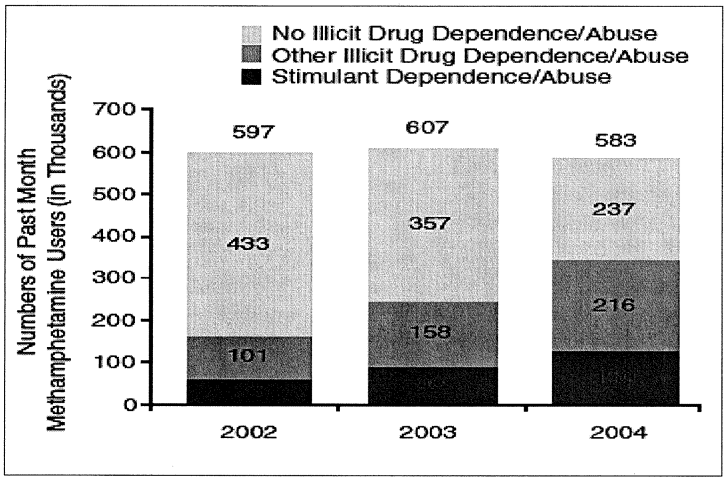


The bold red line in the same chart shows the number of children in out-of-home care on the last day of each fiscal year.

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.

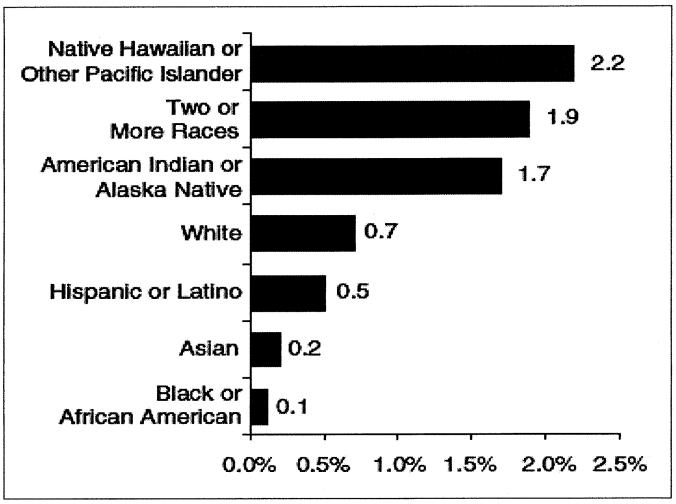
Chart 3: Methamphetamine Use in Past Month among Persons Aged 12 or Older, by Dependence and Abuse: 2002, 2003, and 2004[3]



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.

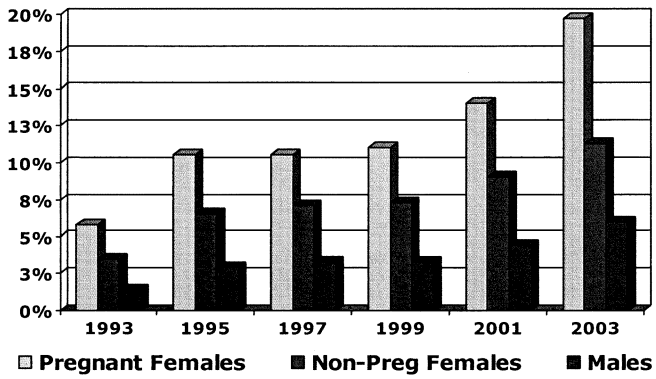
Chart 4: Methamphetamine Use in Past Year among Persons Aged 12 or Older, by Race/Ethnicity: 2002, 2003, and 2004[4]



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)



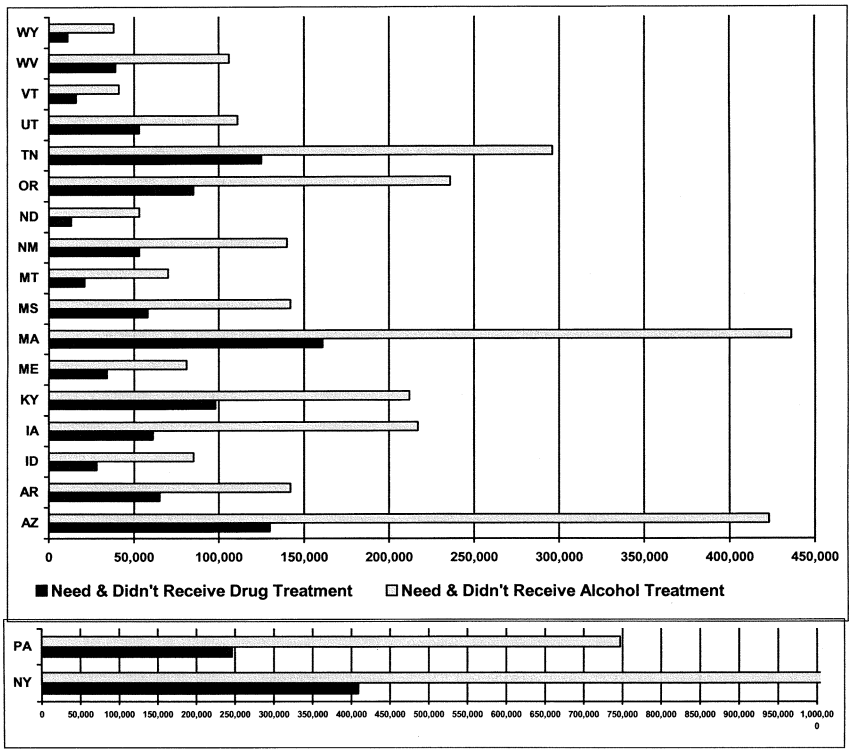
While overall treatment admissions for primary methamphetamine problems are increasing, they are increasing at the fastest rate among pregnant women.

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

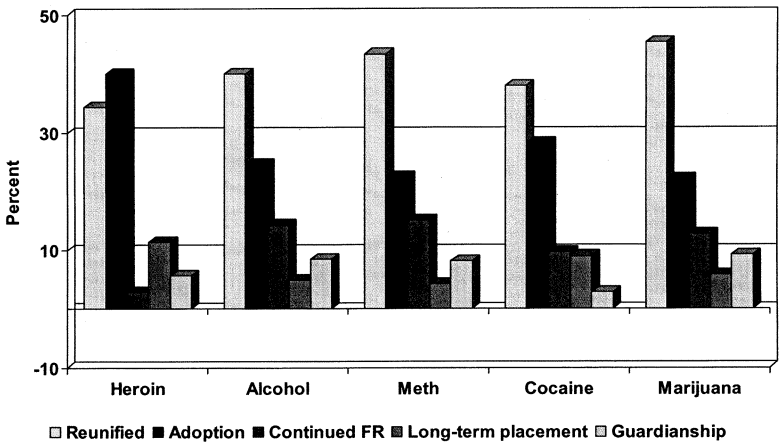
- Needed and didn't receive drug treatment – 6.43 million
- Abused or were dependent on any illicit drug – 7.1 million
- Needed and didn't receive alcohol treatment – 17.37 million
- Abused or were dependent on alcohol – 22.0 million

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.

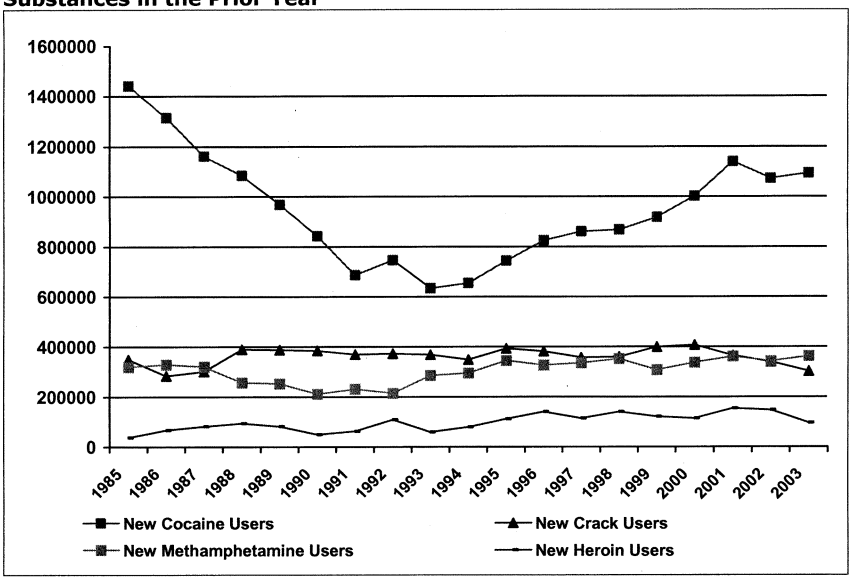
New Users of Methamphetamine[*]

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.

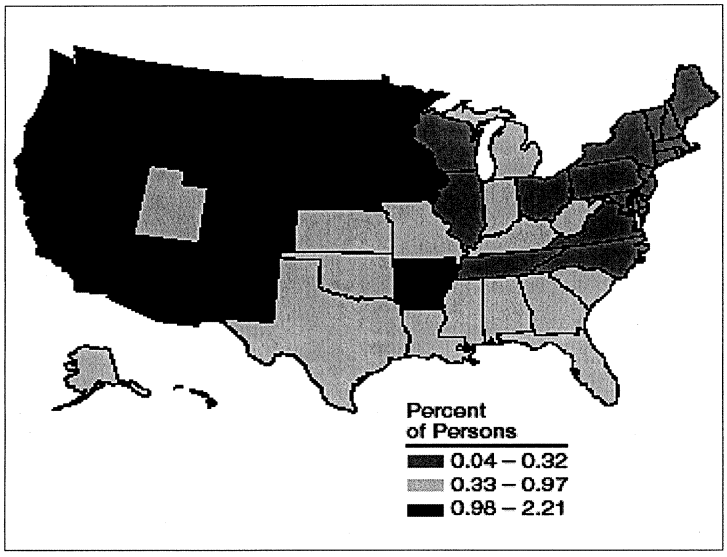
Figure 1: Number of Persons over Age 12 who First Used Specific Substances in the Prior Year[6]



Current Users of Methamphetamine

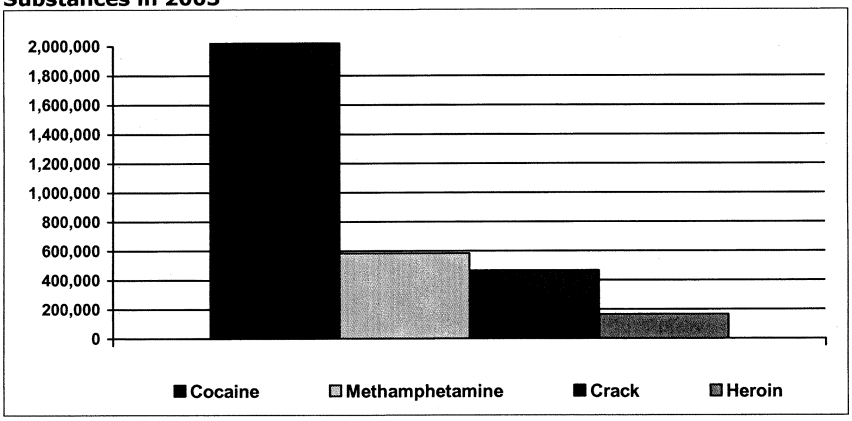
Current users of substances are important to monitor because they are often the population that create health, social and economic costs to our society. The number of current users is estimated by asking people about their use in the prior 12 months and the prior 30 days. Overall, the number of current 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]

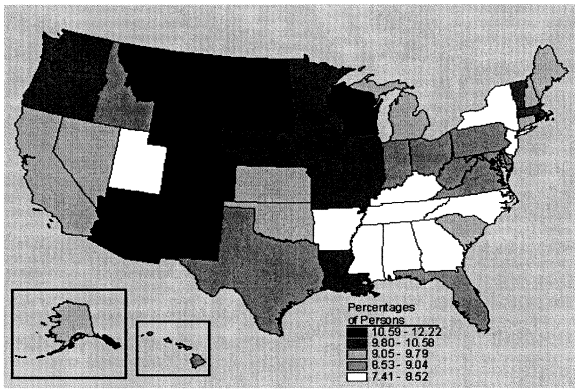
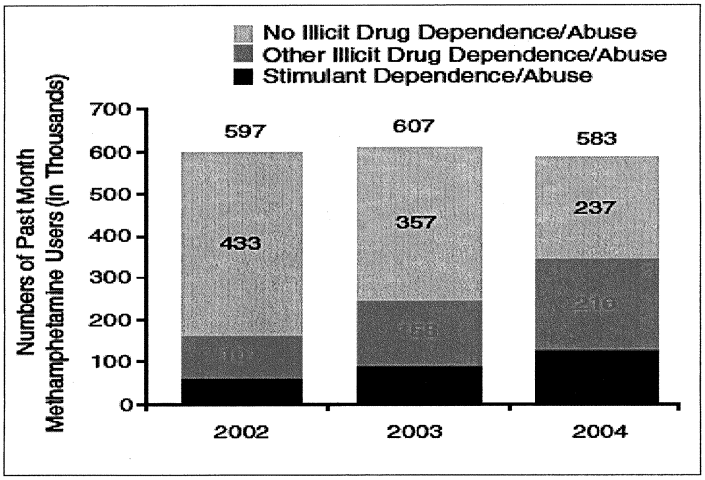


Figure 5 shows a substantial increase in persons experiencing negative consequences of methamphetamine use. While the prevalence of methamphetamine use has remained constant over the past few years, the percentage of current methamphetamine users who met criteria for drug dependence or abuse in the prior 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]



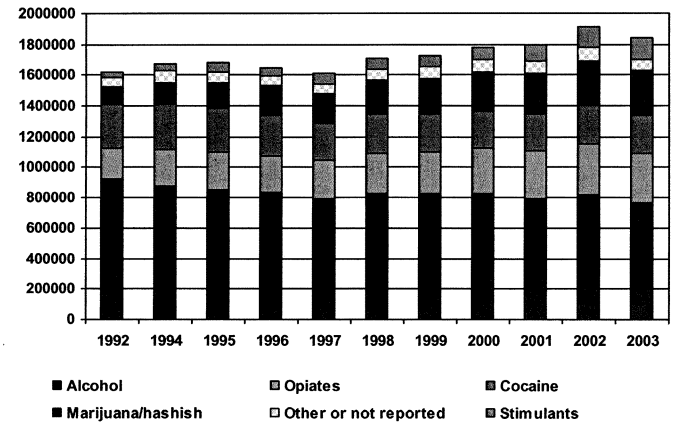
Methamphetamine and Treatment Admissions

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]



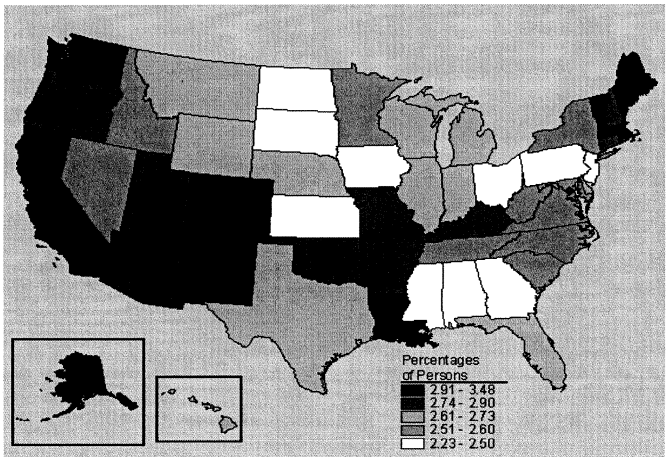
While these 1.8 million persons accessed treatment services, the unmet need for substance abuse treatment continues to be a critical gap in our nation's response to drug epidemics. Based on the survey data from 2003 and 2004, there were an

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]



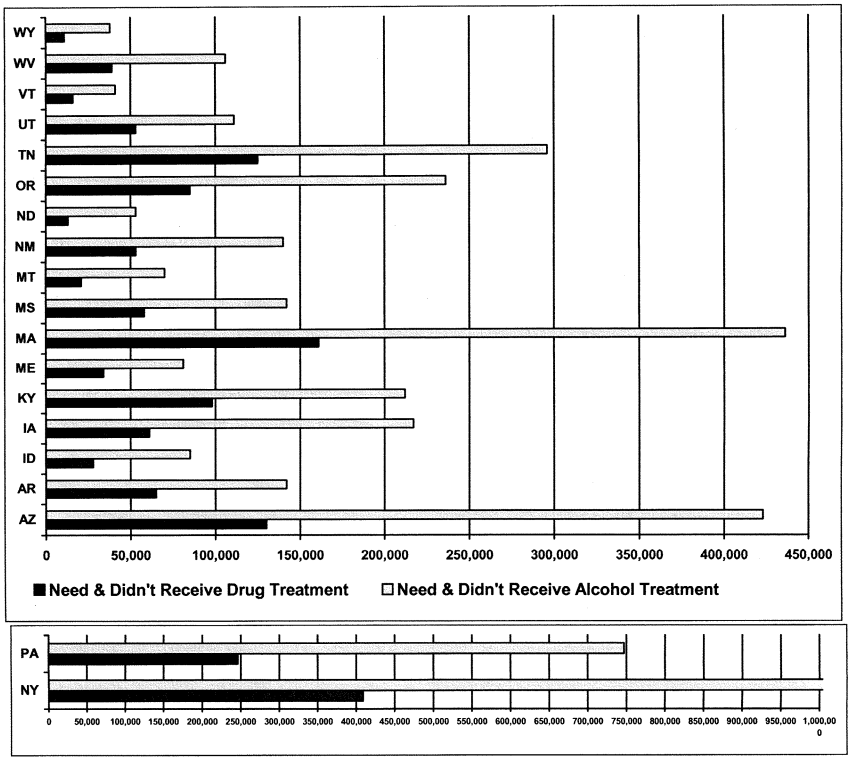
These percentages by State translate to very large number of persons who are not accessing treatment for their substance abuse. Nationally, the numbers are:

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

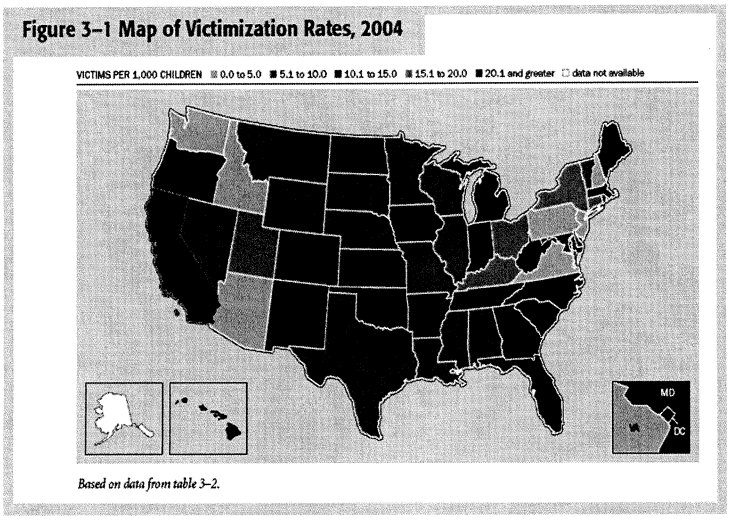
Unmet Need for Substance Abuse Treatment in the United States

- 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

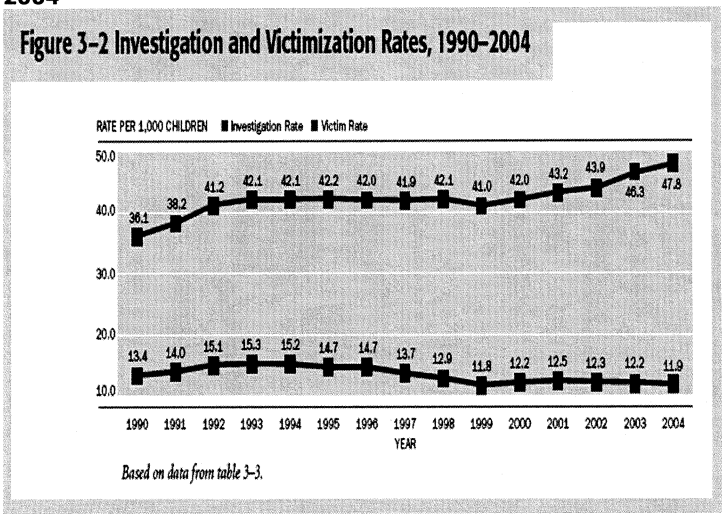
Child protective services (CPS) agencies respond to the needs of children who are alleged to have been maltreated and ensure that they remain safe. Based on a rate of 47.8 per 1,000 children, an estimated 3,503,000 children received an investigation by CPS agencies in 2004. Based on a victim rate of 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]



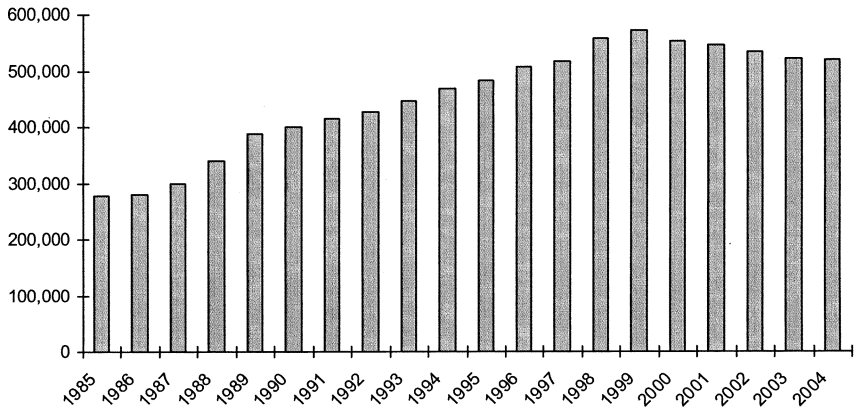
Despite the relatively rapid increase in rates of methamphetamine abuse and dependence, particularly in specific regions across the nation, there has not been an increase in the rate of victims of child abuse or neglect. The rate of all children who received an investigation or assessment increased from 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]



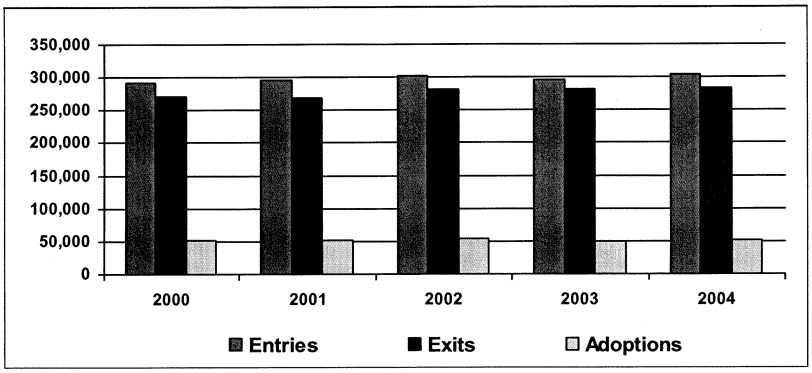
In addition to the recent decreases in the rate of child victims, the population of children in out-of-home care has been on a steady decline since 1999, with approximately 518,000 children in care at the end of the 2004 fiscal year. That decrease comes after a decade in which the number of children 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



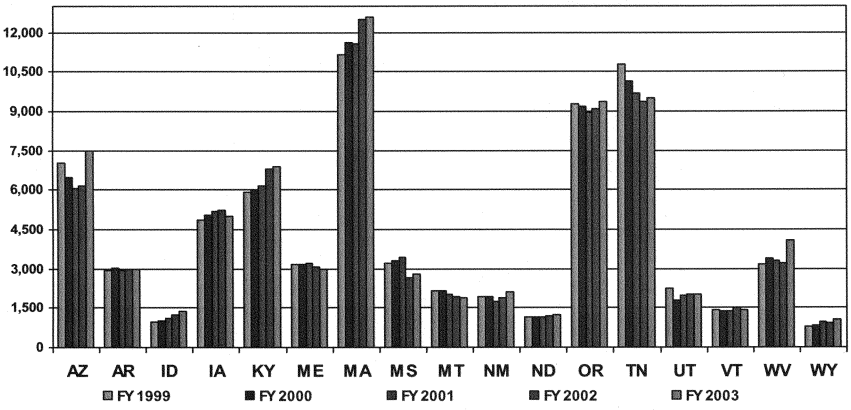
The Adoption and Safe Families Act (ASFA) was signed into law in the fall of 1997 and fully implemented over the following few years. The decrease in the point-in-time estimate of children in out-of-home care results from several underlying factors. The estimated data from fiscal year 2000 and 2004 indicate 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.

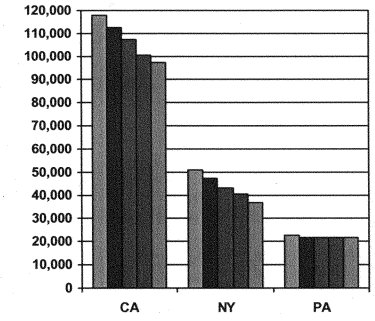
Figure 12: Trends in Foster Care and Adoption, FY 2000 to 2004[18]



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]

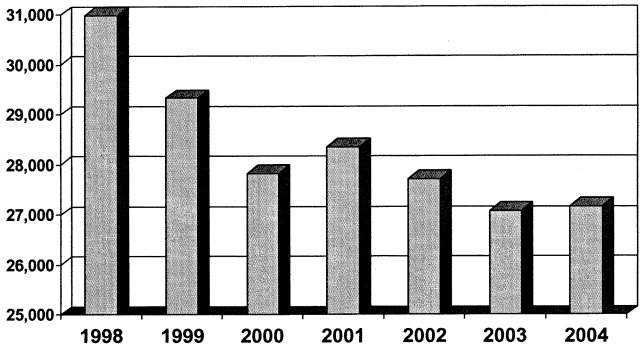




Another State example is shown in Massachusetts. The Federal data show that in Massachusetts the caseload increased through 2003.[20] More recent State-level data show that the trend reversed in 2004 and there were approximately 9,500 children in out-of-home care at the end of 2005. During this time 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]

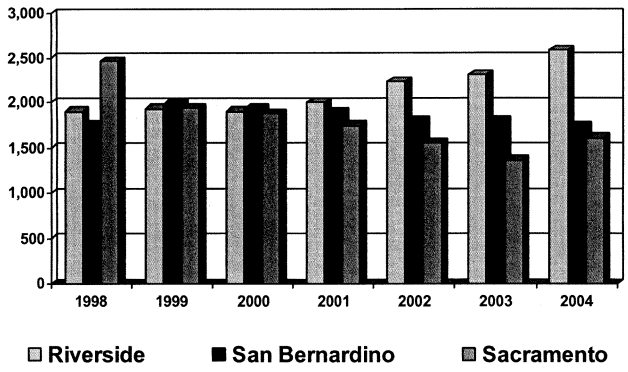
In California, this reduction reflects both fewer children coming into care and more children exiting care over the past six years. Figure 14 shows the decreasing number of children entering care in California (among children who stayed in care for five or more days) with a leveling of that number between 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.

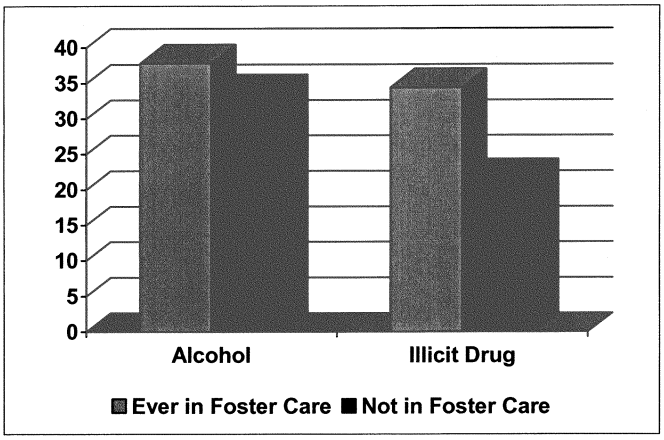
Figure 18: Children Affected in Methamphetamine Manufacturing[56]

	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.

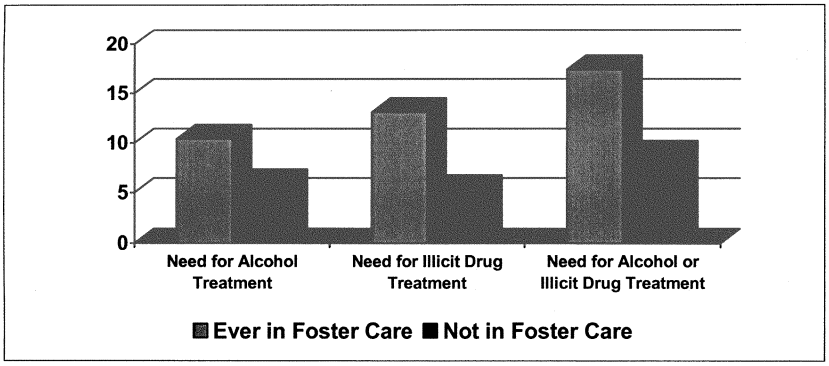
Finally, it is imperative that we address the children who are removed from their parents' custody and placed in protective custody in terms of their needs for prevention and intervention services. The Office of Applied Studies at SAMHSA has analyzed the national survey data to determine the rates of 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.

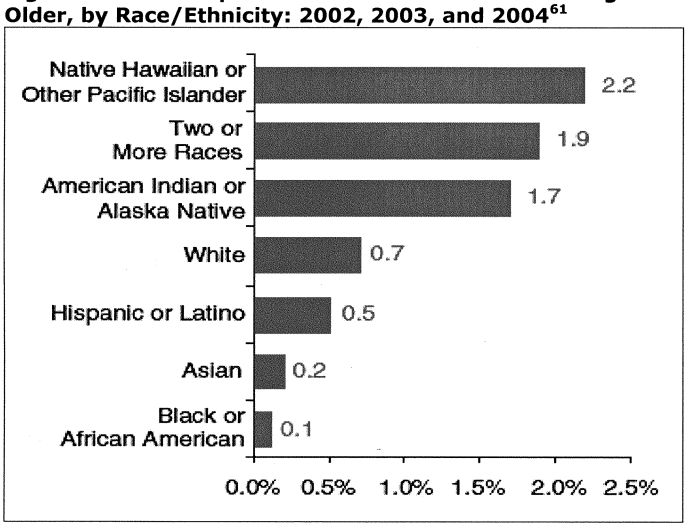
The changes in the brain may help explain the depression, paranoia and memory problems experienced by chronic users of methamphetamine. For example, effects have been documented in the area of the brain that is important for emotional and cognitive behavior; as well as the area of the hippocampus which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

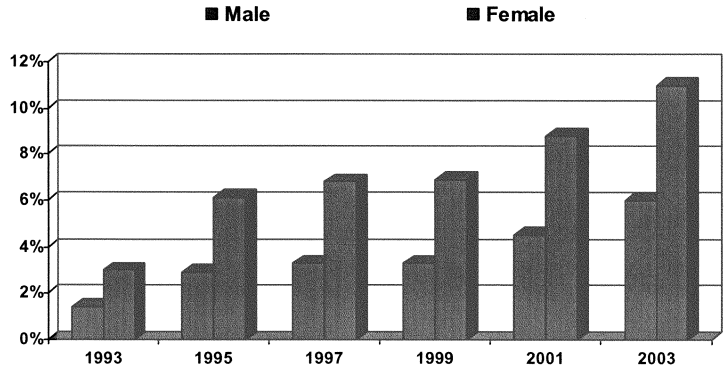
Figure 21: Methamphetamine Use in Past Year among Persons Aged 12 or Older, by Race/Ethnicity: 2002, 2003, and 2004[61]



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.

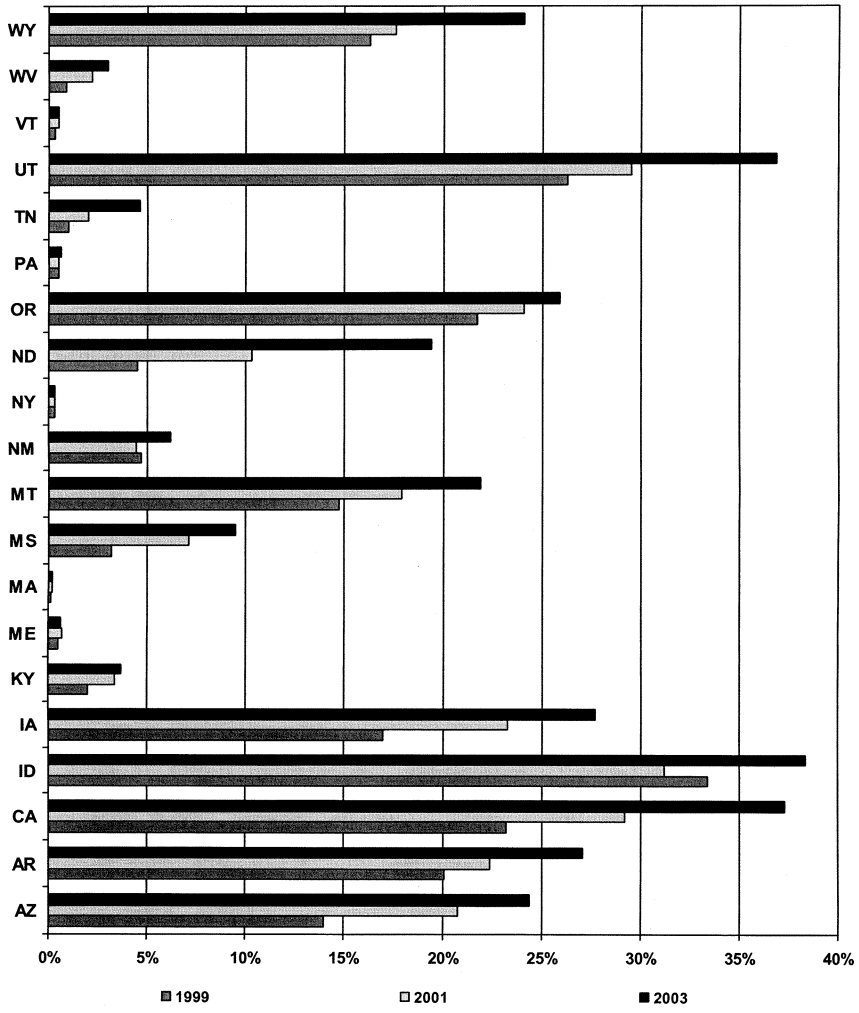
Figure 22: Percent Methamphetamine/Other Stimulants as Primary Substance at Admission 1993-2003, By Gender[62]



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%).

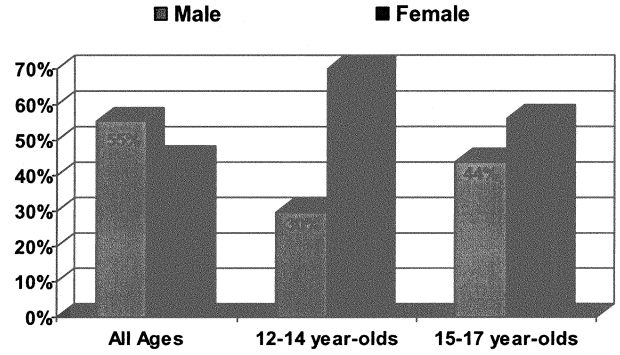
Yet, we should not be misled by these data in terms of the impact of substance use disorders on the child welfare populations in the States with low primary methamphetamine treatment admissions. In the past year and a half, the National Center on Substance Abuse and Child Welfare has begun in-depth technical 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)



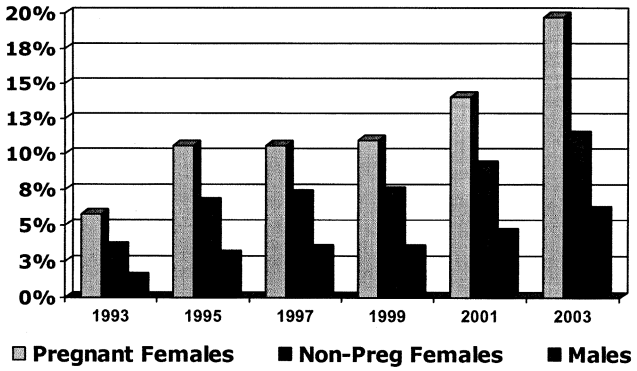
Of particular concern and urgency is the percentage of methamphetamine treatment admissions for adolescents. While young girls represent a smaller number of overall admissions, young girls between 12 and 14 years old represent 70% of youth admitted to treatment for methamphetamine. Figure 24 shows these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

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



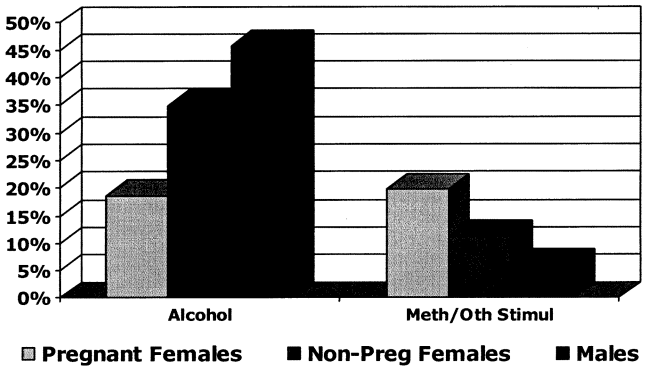
Finally, as Figure 25 shows, methamphetamine admissions as a percentage of all admissions increased from 6% in 1993 to 20% in 2003 for pregnant females, in contrast to an increase from 4% to 11% for non-pregnant females and 1% to 6% for males.

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



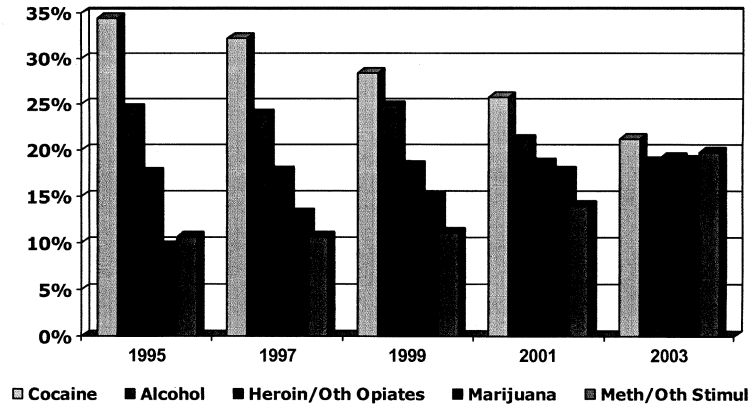
Again, it is important to recognize the larger impact that other substances have on women, the treatment system and child welfare agencies. As shown in Figure 26, admissions for primary alcohol problems represented 46%, 35% and 19%, respectively.

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



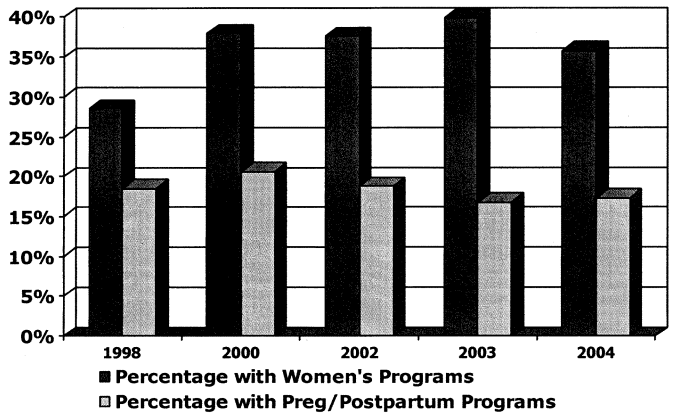
To further explore other substances of abuse and pregnant women, Figure 27 shows that among pregnant women entering treatment from 1995 to 2003, there has been a decrease in those reporting cocaine and alcohol-related problems, relative stability in admissions for heroin, and an increase of 98% for marijuana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

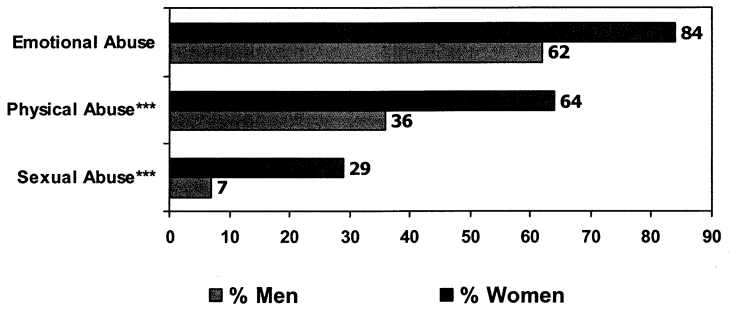
Compared with male methamphetamine users, female methamphetamine users:

- 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

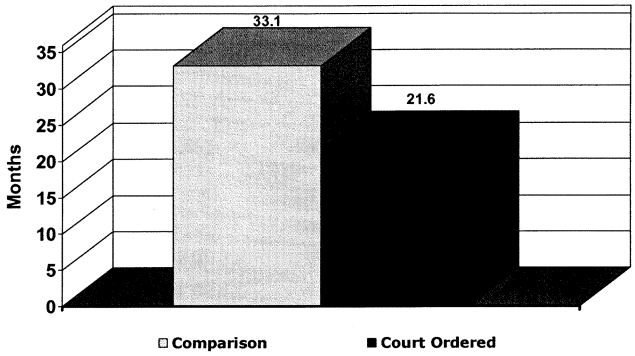
4. **Prioritization of Families in Child Protective Services**—County-wide policy to ensure that families in the child welfare system have priority access to substance abuse treatment services

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).

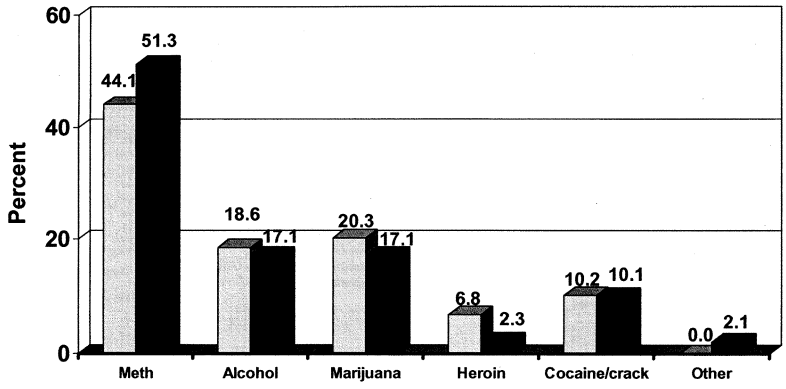
Figure 30: Sacramento County DDC Participants and Comparison Group by Time in Out of Home Care



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.

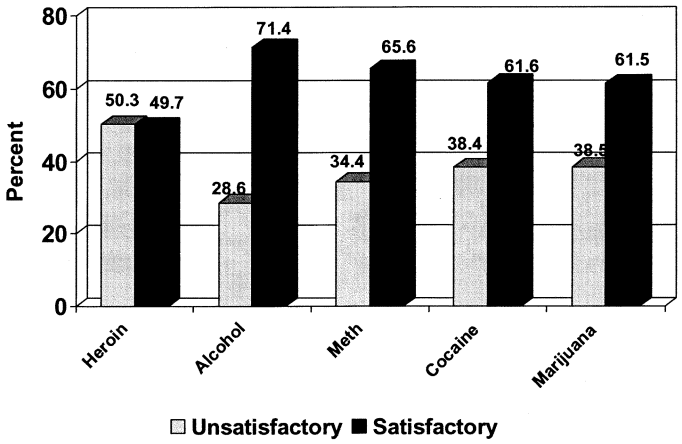
Figure 31: Sacramento County DDC Participants and Comparison Group by Primary Drug Problem



p<.05

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

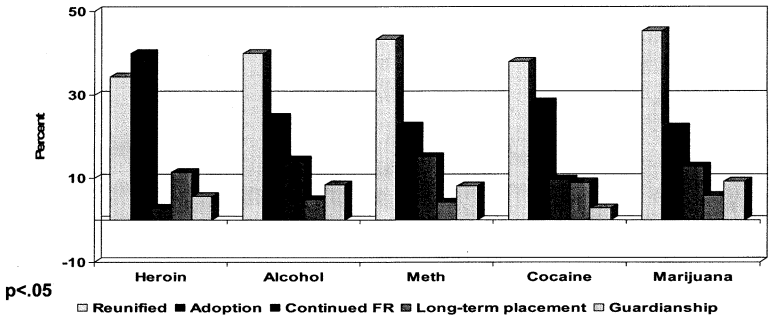
Figure 32: Treatment Discharge Status by Primary Drug Problem



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.

[5] Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Estimated Number of Persons Needing but Not Receiving Treatment for Illicit Drug Use in Past Year based on National Survey on Drug Use and Health 2003, 2004. Retrieved from: http://www.oas.samhsa.gov/2k4State/vars.htm. April 14, 2006.

[6] 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

[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

[8] 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

[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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COMMUNICATIONS

METHAMEPHETAMINE
AND ITS
SOCIAL AND ECONOMIC IMPACT ON CHILD WELFARE

UNITED STATES SENATE
THE COMMITTEE ON FINANCE

APRIL 25, 2006

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The Child Welfare League of America (CWLA),on behalf of its 900 public and private nonprofit, child-serving member agencies, thanks the U.S. Senate Finance committee for holding this hearing on the issue of methamphetamine (meth) use and its impact on the child welfare system. We appreciate that this Committee, through the leadership of Chairman Grassley and Senator Baucus has set aside time in the Committee's very busy schedule to highlight the impact of meth use on communities across the country and on the child welfare systems that serve them. CWLA looks forward to future hearings and discussions on the range of child welfare issues that challenge this nation—including the reauthorization of the Promoting Safe ands Stable Families program.

CWLA also recognizes Chairman Grassley's recent efforts concerning the implementation of regulations in regard to Medicaid's targeted case management (TCM) and its availability to children in foster care. The Chairman's letter dated April 5th to the Secretary of Health and Human Services, attempts to clarify how states can use TCM through Medicaid in light of recent legislative changes. Medicaid targeted case management serves as an important tool to ensure children in care gain access to clinical and medical services that are essential to their permanency. CWLA looks forward to working with your office and all members of the committee to ensure that any future regulations will aid, not hinder, such a goal.

The Issue of Parental Substance Abuse on Children

Any discussion concerning the manufacture, use, and addictive nature of meth and the child welfare system highlights a more general, but critical concern CWLA holds regarding a key strategy for improving the safety and well-being of children and the effectiveness of the nation's child welfare system. Alcohol and other drug addictions devastate the lives of hundreds of thousands of American children and their families each year.

Among these families, those who are involved in the child welfare system often face additional difficulties with addictions and require access to appropriate substance abuse treatment.
A common thread in child protection and foster care cases is the high percentage of children, their parents, or both who have a substance abuse problem. Substance abuse, a major factor in child abuse and neglect, is associated with the placement of at least half of the children in the custody of child welfare agencies.[1] Some estimates indicate that substance abuse is a factor in nearly two-thirds of substantiated cases of child abuse and neglect, and in two-thirds of cases of children in foster care.[2] Furthermore, children whose parents use drugs or alcohol are three times more likely to be abused and four times more likely to suffer from neglect.[3]

As this Committee examines the impact that meth production and use play on child welfare systems, we should remember that substance abuse is a treatable public health problem with cost-effective solutions. Even meth-focused treatment is effective, despite claims to the contrary. Implementing a treatment strategy for meth addiction that is time appropriate and includes a cognitive behavioral approach and motivational interviewing can produce recovery rates for meth addiction similar to other substance addictions.[4] Congress should craft policies that recognize these interventions as important components of a comprehensive drug policy and as a key to effectively treating all substance abuse addictions.

Good assessment, early intervention, and comprehensive treatment are key to determining when and if a child can safely stay at home or be reunited with his or her family.[5] SAMHSA data indicates that women who participate in comprehensive substance abuse treatment longer than three months are more likely to remain alcohol and drug free (68%) than are those who leave treatment within the first three months (48%).[6] SAMSHA data also shows that 75% of those women receiving comprehensive substance abuse treatment have physical custody of one or more children six months after treatment discharge.

In 1997, this Committee guided through to passage the Adoption and Safe Families Act (ASFA) (P.L. 105-89). ASFA was designed to promote the safety and permanence of children by expediting the timelines for decision-making in seeking a permanent home for children. ASFA requires that the courts review the plan for a child's permanent living arrangement within 12 months of the date a child enters foster care. It also requires that if a child is in foster care for 15 of the most recent 22 months, that a petition to end a parent's rights to the child must be filed, unless certain exceptions apply. To ensure permanency decisions can be made for children whose families face alcohol and drug addictions, special steps must be taken to begin services and treatment for the family immediately upon a child's entry into foster care or after the family regains custody of their children.

Resources for substance abuse treatment for families are in chronically short supply. There is a national shortage in all types of publicly funded substance abuse treatment for those in need, especially for women with children. Even prior to the rapid spread of meth, all states reported long waiting lists. Alarmingly, over two-thirds of parents involved in the child welfare system need substance abuse treatment, but less than one-third gain needed treatment.

In recent years Senators Olympia Snowe and Jay Rockefeller, along with other cosponsors, have proposed legislation (Child Protection/Alcohol Drug Partnership Act) that would assist states in addressing this shortfall through a range of state activities to improve substance abuse treatment. These activities must be directed to families with substance abuse problems who come to the attention of the child welfare system. We urge the committee, as part of its review both of the current meth crisis and comprehensive child welfare reform, to examine this legislative proposal which was developed through a broad coalition of groups and experts.

The Impact of Methamphetamine Manufacture and Use on Child Welfare

In recent months several congressional committees have held hearings in Washington and around the country on the unique challenges and threats that meth imposes on all aspects of the community. Much of the initial focus centered on the law enforcement issues regarding meth use and production. CWLA restates earlier comments offered to Congressional committees that the Finance Committee may find useful:

Increasing use of meth has challenged the abilities of child welfare agencies (tribal, state, and private) to protect children. Child welfare agencies are forced to focus more of their time and resources on children impacted by meth and, as a result, essential child abuse and neglect prevention and support funds are diverted to providing foster care. In rural areas, where meth use and production has led to greater devastation, stresses on the child welfare system can also surface through the increased need for foster parents complicating the unique challenges rural areas already face in recruiting foster families. These challenges increase when caseworkers must find appropriate foster parents willing or having the ability to accept children removed from

meth-involved families. Some potential caregivers may fear contamination or have concerns regarding some children's behavioral problems that may require intensive therapy following removal.

Children face many hazards while living in meth labs and are often the victims of maltreatment. In homes where drug addiction is present, necessities such as food, water, supervision, shelter, and medical care may only be an afterthought. Children can also be exposed to dangerous chemicals and the risk of explosions. As of 2003, fires or explosions occurred in 15% of meth labs.[7]

Studies have shown that meth production environments produce immediate and long-term health risks. Exposure to the precursor chemicals used in the manufacturing of meth can result in pulmonary irritation and pulmonary edema; severe corneal irritation; upper respiratory tract damage resulting in permanent lung damage; and bronchospasm, vocal cord dysfunction, and lung fibrosis among healthy adults.[8] For children, these effects are multiplied. The complete and lasting long-term health effects for children exposed to meth environments are not fully known at this time, however, recent reports from physicians and psychologists reveal significant concerns about the physiological and psychological conditions of children exposed to these environments.[9]

Between 2000 and October 15, 2005, methamphetamine lab seizures by local or federal law enforcement affected 15,192 children.[10] Early reports reveal that nearly 3,800 children were exposed to toxic chemicals, 96 were injured, and 8 died because of meth labs.[11] This does not account for the other meth-affected children who entered foster care through reports of abuse or neglect, or those who were never reported to state officials. The figures are considered underreported, as many states are only beginning to collect data representing the presence of children in a lab site. While it is important to document the number of meth labs seized, they account for only a small level of meth available in communities. The passage of recent legislation aimed at preventing the home manufacturing of meth has resulted in fewer meth labs, but the National Drug Threat Assessment reports the increased production in and distribution from Mexico has easily offset this.[12] Recent data indicates more than 80% of the nation's meth supply is being imported to the U.S.[13]

Child welfare workers report that the needs of children removed from meth labs are pronounced and extreme following prolonged periods of neglect. Outside of the immediate physical health concerns, these children may exhibit greater social, educational, emotional, and behavioral challenges than other children who enter foster care.[14] The lack of parental attention has not allowed the children to achieve appropriate levels of development and a child may face confusion and doubt in terms of whom they can trust. These children have difficulty associating with peers and lack guidance in their everyday actions.[15]

The Impact of Methamphetamine on the Child Welfare Workforce

We urge the committee to pay special attention to the child welfare workforce when addressing meth. We feel it is always critical that any reforms or modifications aimed at improving child welfare pay special attention to the workforce that must be fully staffed, trained, and supervised. This also applies to the impact of meth. The exposure to the toxic mixture we list in this testimony is a risk not just to the families but also to the child protection and other child welfare personnel who come into these sites. Comprehensive solutions require addressing the need for training and protection for these workers.

Child protection workers are often among the first to investigate potential meth labs based on reports of neglect or abuse filed by schools, neighbors, or others. Child protection workers who perform investigations face extreme risk of physical safety due to users' heightened sense of paranoia, which can result in assaults against workers. Also, unknowing workers are at risk of chemical contamination as they enter the home. As a result, several state legislatures have enacted provisions within the past year that set strict protocols for child protection workers to follow if they suspect a meth lab is present. For example, a responder who suspects a meth lab should immediately leave the area, without informing potential suspects, and inform law enforcement of the situation.

The Impact of Methamphetamine in Select Communities

The social and economic impact of meth has spread from a few rural areas to a majority of states. Meth has filtered into a significant portion of the communities represented by members of this committee, as the following chart reflects. Of the 17 states that the committee members represent, *4,739* children were directly impacted from federal or state meth lab seizures from 2000-2005.[16] This represents nearly one-third of all the children nationwide who were impacted over the same period. Again, these numbers are only a fraction of the children who enter into out-of-home care due to parental meth use.

Children affected by meth lab seizures for 2000-2005*[17]

	2000	2001	2002	2003	2004	2005	Total
AR	53	120	207	230	173	57	840
AZ	57	59	60	82	44	20	322
IA	37	61	91	115	103	25	432
ID	14	16	14	21	10	4	79
KY	33	34	42	55	79	67	310
MA	*NA*	2	*NA*	2	0	*NA*	4
ME	*NA*	0	*NA*	*NA*	6	0	6
MS	18	44	104	80	63	19	328
MT	5	17	37	20	7	2	88
NM	7	27	43	64	18	6	165
ND	5	52	57	18	14	1	147
OR	117	225	133	99	82	19	675
PA	0	1	2	8	5	7	23
TN	59	160	224	296	287	41	1067
UT	17	23	29	17	22	0	108
WV	0	10	8	20	37	31	106
WY	3	2	19	9	4	2	39
Totals	**425**	**853**	**1070**	**1136**	**954**	**301**	**4739**

**Totals reflect reports as of 10/15/05*

Even with recent trends documenting that "mom and pop" meth lab operations are decreasingas because state and federal legislative action are limiting the sale of precursor chemicals, meth use is not fading away. Substance abuse treatment admission rates for meth increased 420% between 1992 and 2002.[18] The most recent available treatment rates reveal significant portions for meth treatment in each of the committee members' states.

2003 State Admission Rates with methamphetamine/amphetamine as primary substance of abuse[19]

	Total of All Admissions	Meth/Amphetamine admissions
US	*1,841,522*	*135,737*
AR	13,369	2,958
AZ	15,879	1,625
IA	27,197	5,330
ID	3,122	818
KY	31,149	696
MA	52,202	101
ME	13,057	51
MS	9,140	561
MT	7,234	1,040
NM	3,835	155
ND	2,045	240
OR	45,461	7,548
PA	63,992	254
TN	7,796	301
UT	13,226	3,430
WV	1,247	21
WY	5,816	891
Totals	**315,767**	**26,020**

The Impact of Methamphetamine in Tribal Communities

On April 5th, the Senate Committee on Indian Affairs held a hearing on meth use and its impact on Indian country. Members of the Finance Committee represent sizable tribal populations, we emphasize that solutions need to include tribal governments.. CWLA mentions this not only because many of these tribes are your constituents, but also because we believe this country must make a more diligent and concentrated effort to provide tribal governments greater access to vital child welfare services.

Existing data on meth use affecting tribal communities is startling. The National Survey on Drug Use and Health shows that 1.7% of the American Indian/Alaska Native population reported meth use in the past year.[20] This rate is only behind that of Native Hawaiians (1.9%) and those of two or more races (1.9%).[21] Less than 1% of White, non-Hispanics reported using meth in the past year[22], even though they account for 72.7% of those entering treatment with meth as a primary focus.[23] Native Americans represented only 2.2% of those entering treatment due to meth use.[24]

CWLA'S Recommendations

CWLA strongly recommends federal legislation that is focused on the growing meth dangers in this country and the impact of parental meth use on children. Much of the recent focus and attention on the meth problem has focused on the law enforcement response and action. Legislation is needed to strengthen the capacity of child welfare agencies to protect children from abuse and neglect where meth is involved, enhance services for children removed from these homes, and increase prevention efforts for abuse and neglect. Congress can address these issues in several ways:

- **Pass the Child Protection/Alcohol and Drug Partnership Act with new resources for states and tribes to provide the substance abuse treatment.**
  The Child Protection/Alcohol and Drug Partnership Act would provide new resources for a range of state activities to improve substance abuse treatment for families in the child welfare system. State child welfare and substance abuse agencies, working together, would have the flexibility to decide how best to use these new funds to enhance treatment and services. This bipartisan legislation, sponsored in previous sessions by Senators Olympia Snowe and Jay Rockefeller and others from both parties, would enhance efforts to address substance abuse treatment as it affects child welfare systems. As part of this, Congress must ensure that tribal communities are partners in this effort in both planning and funding.

- **Reauthorize Promoting Safe and Stable Families with enhanced funding.**
  We urge Congress to reauthorize the Promoting Safe and Stable Families program before it expires at the end of this fiscal year. We appreciate the increase in mandatory funding and continue to work toward restoring this important program's full funding, which was set at $505 million in 2001. The need for increased funding for family reunification, family preservation, family support, and adoption support is great and the challenges of meth use only increase this need.

- **Preserve access and support for Medicaid Targeted Case Management and other services.**
  We commend Chairman Grassley's efforts to preserve access to targeted case management for children in foster care. We call on all of Congress to preserve this service and reject any proposal that would reduce the matching rate. In addition, CWLA urges Congress to reject any legislative or regulatory changes that would deny access to children in the child welfare system to needed rehabilitative services provided through Medicaid.

- **Maintain, strengthen, and broaden the access to Title IV-E training funds.**
  As the challenge of parental substance abuse increases in many parts of the country, child welfare workers (including tribal, public, and private agency workers) need to be well prepared. A small but important source of child welfare training is provided through Title IV-E Training dollars. Currently, federal funds cannot be used to provide training for private agency workers or court personnel who are involved in providing services and making decisions for abused and neglected children. Neither is this funding directly available to tribal programs, as emphasized earlier. This source of funding could enhance worker training if Congress were to amend the law as some recent legislative proposals have suggested, increase the appropriations available in response to the current epidemic, and expand the access to include all governmental and non-governmental agency staff that are required to intervene.

- **Pass the Indian and Alaska Native Foster Care and Adoption Services Amendments to provide tribal access to Title IV-E funds.**
  Legislation currently before the Senate, S. 672 the Indian and Alaska Native Foster Care and Adoption Services Amendments of 2005, introduced by Senator Gordon Smith and co-sponsored by other members of this Committee, would allow tribal governments direct access to Title IV-E Foster Care and Adoption Assistance. While not specific to the substance abuse problem, these federal funds are the single largest federal source of support to our nation's child welfare system. The Senate Finance Committee actually passed this

legislation in 2005, but the vehicle it was attached to did not pass. These funds subsidize foster care placements and adoption assistance. Tribes currently do not have access unless they can work out mutual agreements with state governments. The child welfare systems of tribal communities are massively underfunded, and this issue needs urgent Congressional action.

Conclusion

CWLA commends the Committee for its focus on addressing the impact meth plays on children, their families and the agencies that serve them. The dangers of meth to children and its social and economic impact on the child welfare system are such that it demands the immediate Congressional attention. As Congress acts on the overall impact of meth manufacture and use, it must also incorporate child welfare concerns in its legislative efforts. A real solution must establish enhanced treatment programs, allowing individuals to receive the help needed. Effective practice modalities must be established for child welfare workers that protect their safety. Education efforts must begin for our children, youth, and tribal communities that detail the dangers associated with meth and seek to curb future use. These efforts must also be targeted at those areas that are not currently experiencing a problem. Above all else, services and protection for the children removed from meth homes must be secured and strengthened. CWLA looks forward to working closely with this Committee to further promote the safety and security of the nation's children.

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2,500 Police Chiefs, Sheriffs, Prosecutors, other Law Enforcement Leaders, and Violence Survivors Preventing Crime and Violence

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

United States Senate
Committee on Finance

Submitted for the Record
April 25, 2006

1212 New York Avenue, Ste 300 • Washington, DC 20005 • (202) 776-0027 • Fax (202) 776-0110 • www.fightcrime.org

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to submit this written testimony. My name is David Kass, and I am the Executive Director of FIGHT CRIME: INVEST IN KIDS, an anti-crime organization of more than 2,500 police chiefs, sheriffs, prosecutors, and victims of violence from across the country who have come together to take a hard-nosed look at what the research says works to keep kids from becoming criminals.

Law enforcement leaders know from their firsthand experience and the research that child abuse and neglect is too often only the first chapter in a tragic story of violence. Although most abused and neglected children go on to live productive lives, they are at greater risk of engaging in later violence. Leaving children in dangerous homes where they may be subject to continuing abuse or neglect makes them even more likely to grow up to become criminals. As the methampethamine epidemic grows, the impacts on the child welfare system and the safety of our communities is likely to be substantial.

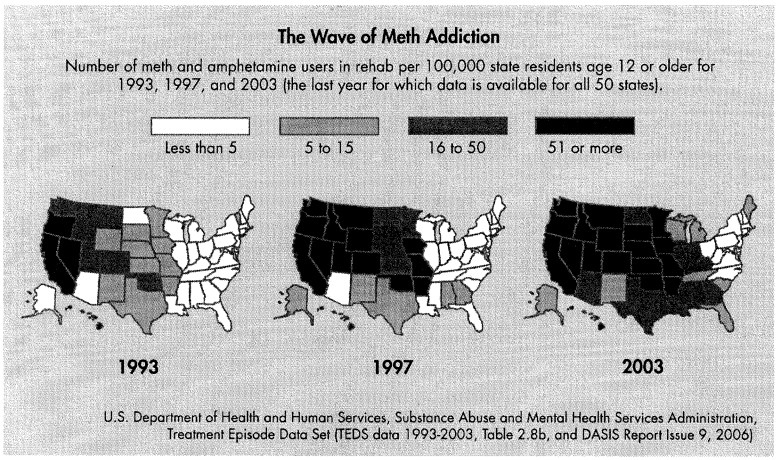
We commend the Senate Finance Committee for drawing attention to the link between the methamphetamine epidemic and the child welfare system. **As you consider the impact of methamphetamine abuse on the child welfare system, we encourage you to adopt the following recommendations:**

- Strengthen the Promoting Safe and Stable Families program during this year's reauthorization by preserving the core program's focus on prevention, together with increased authorization levels for both discretionary and mandatory funding in order to enable states and communities to better address child abuse and neglect resulting from meth and other substance abuse;
- Maintain Title IV-E foster care maintenance "room and board" funding as an uncapped entitlement; and
- Allow states to reinvest funding saved by reducing foster care expenditures into prevention and services, without capping foster care funding.

Meth on the Move

Methamphetamine addiction in many parts of the country has risen dramatically in the last five years. According to data from the National Survey on Drug Use and Health conducted by the U.S. Department of Health and Human Services (HHS), the number of methamphetamine users addicted to stimulants has more than doubled. The HHS survey found, "past month methamphetamine users meeting criteria for stimulant abuse or dependence increased from 63,000 in 2002 to 130,000 in 2004."[i]

U.S. Attorney General Alberto Gonzales testified before Congress on January 23rd, 2006, that, "according to our most recent national data, 583,000 people are 'current' users of meth – having used the drug sometime within the 30 days before being surveyed. Over the previous year, 1.4 million people had used meth."[ii] From its origins among West Coast biker gangs, use of meth has spread rapidly across the United States.



More law enforcement and emergency room personnel are confronting methamphetamine addiction:

- In 2002, a nationally representative survey showed that 32 percent of law enforcement agencies listed methamphetamine as their number one drug problem. By 2004, 40 percent cited it as their number one problem, more than for any other abused substance. In 2004, one-third of all law enforcement agencies also identified methamphetamine as the drug that most contributes to both property and violent crimes in their jurisdictions.[iii]

- In late 2005, the National Association of Counties (NACo) contacted county public hospital or regional hospital emergency rooms in 48 states. Two hundred responses were received from hospital emergency room officials in 39 states. The survey found that 47 percent of the responding hospitals reported methamphetamine as the top illicit drug involved in emergency room visits. Marijuana abuse came in second at 16 percent. Sixty-eight percent of hospitals reported increases in the last three years for emergency room visits involving methamphetamine.[iv]

Meth and Child Abuse and Neglect

Meth has a profound impact not only on those who manufacture and use the drug, but also on the children who are exposed to this growing epidemic. Methamphetamine has been fueling abuse and neglect throughout the country. In a January 27, 2005 article titled "Methamphetamine scourge sweeps rural America," the Reuters news agency reported, "In thousands of cases, people have been caught cooking the highly toxic chemicals in homes where children were present, breathing the poisonous fumes."[v] National Public Radio reported that when children are removed from these homes they "are scrubbed down and changed into clean clothes. They take nothing with them, no books, no stuffed animals, because everything is contaminated."[vi]

Much of the recent attention to the issue of children and methamphetamine has been focused on children exposed to the toxic chemicals in home-based meth labs. But a continuing problem - especially now that many small labs are being shut down because of meth precursor (pseudo ephedrine) restrictions - is the child abuse or neglect that is so often a byproduct of parents' addiction to methamphetamine.

The meth-induced burden on the foster care system has been significant. More and more children of meth addicts are beginning to show up in the foster care systems in some states. A July 2005 National Association of Counties (NACO) survey found that 40 percent of child welfare officials across the nation reported increased out-of-home placements because of meth in the last year.

- Oregon's demand for foster care homes shot up 11 percent from 2003 to 2004, with more than half of all children coming from meth-involved households.[vii]

- Montana's number of children in foster care went up 17 percent in the year and a half before August 2005.[viii]

- A careful study of ongoing child welfare cases in southwest Iowa where lab seizures were down found that "of 1,469 child abuse cases examined in 2003, 720 involved parental meth use. In 2005, 781 of 1,605 cases involved parental meth use. Both account for about half of the cases handled in that area."[ix]

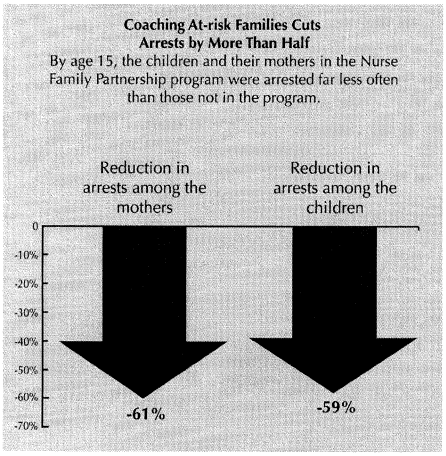
Child abuse and neglect, most often resulting from parental abuse of meth or other drugs, is widespread. Each year, 900,000 cases of child abuse and neglect are investigated and verified by state child protection systems. The Third National Incidence Study of Child Abuse and Neglect, a Congressionally mandated study, concluded that the actual number of children abused or neglected each year is three times the officially recognized number, meaning that an estimated 2.7 million children in America are abused or neglected every year. It is estimated that more than 2,000 children die from abuse or neglect each year, including 1,400 deaths that are officially reported to be the result of abuse or neglect.

Sadly, such child abuse and neglect is often only the first chapter in a multi-generational story of violence. Severe abuse and neglect, particularly when they occur during the earliest months and years of life, can permanently injure children in ways that make them much more susceptible to engaging in violence. The best available research indicates that, based on confirmed cases of abuse and neglect in just one year, an additional 35,000 violent criminals and more than 250 murderers will emerge as adults who would never have become violent criminals if not for the abuse or neglect they endured as kids.

Child Abuse and Neglect Prevention

By the time law enforcement gets involved, it is too late to undo the damage that results from child abuse and neglect. After all, over half of the children who die from abuse or neglect were previously unknown to Child Protective Services, and children who survive abuse or neglect are dramatically more likely to engage in later crime and violence.

Fortunately, there are effective, evidence-based prevention programs that are proven to reduce child abuse and neglect and later delinquency, helping to reduce the need for foster care placements. For example, the Nurse Family Partnership (NFP) randomly assigned at-risk pregnant women to receive in-home visits by nurses starting before the birth of the first child and continuing until the child was age two. The nurses coached the expectant mothers in parenting and other skills and helped the mothers address their own problems. Rigorous research, originally published in the *Journal of the American Medical Association*, shows that children of mothers in the program had half as many substantiated reports of abuse or neglect. Children of mothers who received the coaching also had 59% fewer arrests by age 15 than the children of mothers who were not coached. Additionally, the RAND Corporation found that NFP averages more than $18,000 in savings for every family in the program. A Washington State cost-benefit analysis produced similar results and found that reduced crime costs accounted for almost two-thirds of the savings.



Unfortunately, too many families do not have access to such high-quality prevention programs. In fact, the Nurse Family Partnership serves only 12,000 of the 500,000 eligible women nationwide. This inadequacy has led to numerous preventable foster care placements, and an unnecessarily large number of kids growing up to become violent criminals.

Strengthen and Increase Promoting Safe and Stable Families

Preventing child abuse and neglect before they happen is the best way to ensure children get off to a good start in life. The Promoting Safe and Stable Families (PSSF) program, which is scheduled to be reauthorized this year, funds community-based services like in-home parent coaching that prevent child abuse and neglect.

PSSF should be strengthened through upcoming reauthorization by preserving the program's focus on prevention, with increased authorization levels for both discretionary and mandatory funding to enable states and communities to better address child abuse and neglect resulting from meth and other substance abuse. A September 2003 Government Accountability Office report demonstrated that over 70% of funding from the flexible Title IV-B Child Welfare Services program is spent on child welfare system uses to help kids who have already been abused or neglected and only 10% is spent on family support/prevention and family preservation, In contrast, over 60% of funds from PSSF supports prevention and family preservation services and only 8% is spent on child welfare system uses. Without funding specifically designated for

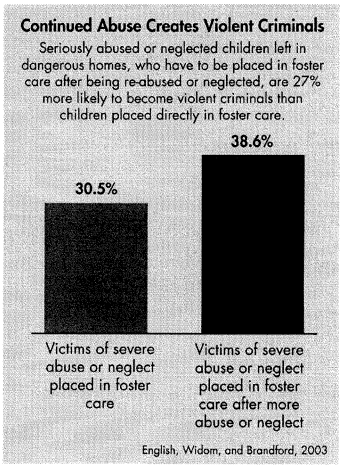
upfront prevention services, as is now the case with PSSF, states are likely to decrease their investments in prevention.

Increasing funding for PSSF would enable states to implement programs proven to prevent child abuse and neglect and thereby reduce foster care placements. The discretionary component of PSSF is currently authorized at $200 million per year. Despite the fact that the President had requested this amount, PSSF has never received more than $101 million per year in discretionary funding. The Fiscal Year 2006 budget reconciliation bill increased mandatory funding for PSSF, by $40 million. To reduce foster care caseloads and keep children safely at home, Congress should ensure continued – and increased - investments specifically designated for prevention, such as in-home parent coaching. Responding to the youngest victims of the growing epidemic of meth and other drugs requires strengthening the Promoting Safe and Stable Families program through increased discretionary and mandatory funding.

Maintain Uncapped Foster Care "Room and Board" Funding

For over 25 years, the federal government has maintained a commitment of assistance for each eligible abused or neglected child who needs a safe foster home. When the number of children needing a foster home increases, the federal government matches the states' help for each eligible child. The Administration's Fiscal Year 2007 budget proposal includes a provision that would abandon that national commitment, substituting federal payments to states that would have rigid limits. This is similar to legislation introduced in the last Congress by House Ways and Means Subcommittee on Human Resources Chairman Wally Herger. The proposed cap in almost all cases would not budge even when child abuse caseloads surge due to the meth epidemic or other reasons.[x]

More than three-quarters of the states had an increase in demand for foster care in at least one of the four years from 1999 to 2003 for which federal data is available. Six states, including New Jersey and Texas, had at least a third more children in foster care at the end of the four years.[xi] As previously noted, more recent state data show that Oregon's need for foster care homes is up 11 percent from 2003 to 2004, [xii] and Montana's need for foster care recently went up 17 percent in just a year and a half. [xiii]



For children who are victims of severe abuse or neglect, safe foster care homes are essential to protect the children from further harm. Research shows that almost four out of 10 of the children who are re-abused or neglected rather than put in safe foster homes will become violent criminals.[xiv]

To ensure that children are not left in dangerous homes where they are subject to continuing abuse or neglect, it is critical that Congress maintain Title IV-E foster care maintenance "room and board" funding as an open-ended entitlement. Between 1999 and 2003, over 3/4 of the states

had increases in the number of children needing a safe foster home during at least one year. In 2003, ten percent of the states had foster care caseloads that were at least 35% higher than their 1999 caseloads.

There are many reasons why a state's foster care caseload may grow, some of which are beyond the control of a child welfare agency. The meth epidemic is a prime example. Judges and child protection workers in Colorado have labeled methamphetamine the "walk away" drug because many parents who are addicted to methamphetamine abandon their children, resulting in the need for more safe foster homes.

Foster care caseloads may also rise as states improve their ability to fully and more accurately investigate reported cases of abuse or neglect. As stated above, the actual number of children abused or neglected nationally is estimated to be three times the officially recognized number. Increased abuse and neglect education and awareness outreach efforts to doctors, nurses, law enforcement officers, teachers, child care providers, and the general public may also result in the identification of more children who have been abused or neglected and increased need for foster homes.

We are extremely concerned that, in the event of capped foster care "room and board" funding, a cash-strapped state with a rising foster care caseload and set funding would have to make a difficult decision: risk leaving children in dangerous homes where they may be subject to continued abuse or cut other services for kids, such as prevention, to pay for foster care. Either option would result in more child abuse and neglect and more crime. Therefore, we agree with the Pew Commission on Foster Care's recommendation to maintain the foster care "room and board" payments as an uncapped entitlement.

Allow States to Reinvest Saved Foster Care Funding

Capping foster care "room and board" funding is *not* the only way to allow states to shift funding from foster care to prevention and services if they reduce their foster care expenditures. We support the Pew Commission's recommendation to amend Title IV-E to allow states to reinvest foster care savings, while maintaining Title IV-E foster care "room and board" payments as an uncapped entitlement. Under such a proposal, if a state reduced its foster care "room and board" expenditures below the state's projected foster care expenditures by reducing the number of children in foster care or the length of stay in foster care, the state could reinvest the federal savings in prevention and child protection. This proposal would promote flexibility and would help ensure that states that can safely reduce their foster care expenditures have funding to pay for prevention and services to keep kids at home.

Recommendations

By strengthening the Promoting Safe and Stable Families program, maintaining Title IV-E foster care maintenance "room and board" funding as an uncapped entitlement and allowing states to reinvest funding saved by reducing foster care expenditures into prevention and services, Congress would protect the safety of kids who have already been abused and neglected in the wake of the epidemic of meth and other drugs, while preventing more kids from suffering abuse or neglect. These strategies will help to break the cycle of violence caused by the abuse of meth

and other substances, related child abuse and neglect and resulting increases in later crime as innocent child victims become the adult victimizers.

Thank you for this opportunity to present our views on how the Senate Finance Committee can take steps to help reduce child abuse and neglect and later crime.

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[viii] Data provided by Dave Thorsen, (August 4, 2005), Chief of the Fiscal Bureau of the Montana Department of Health and Human Services' Child and Family Services Division.

[ix] Lorentzen, A. (December 18, 2005). Study measures child abuse cases linked to meth. Des Moines, IA, *Associated Press.*

[x] Foster care cap legislation in recent years was introduced by Congressman Wally Herger of Calif. (H.R. 4856, 108th Congress). It allowed states to be reimbursed beyond capped allocations only in very limited -- and unlikely -- circumstances: either a state's caseload would have to grow by at least 20% in one year, or a state's caseload would have to grow by at least 15% in a year in which nationwide caseloads were up at least 10%. This bill is available through: http://thomas.loc.gov.

[xi] U.S. Department of Heath and Human Services. Administration on Children, Youth, and Families. Children's Bureau. (2004, August). *Foster Care FY1999 - FY2003 entries, exits, and numbers of children in care on the last day of each federal fiscal year.* Retrieved from http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit2002.htm

[xii] Rose, J. (2005, August 28). Oregon's meth epidemic creates thousands of "orphans," abused and neglected children who fall into the state's care after their parents are arrested. *The Oregonian.* Retrieved August 2005 from http://www.oregonlive.com/search/index.ssf?/base/front_page/112514027658120.xml?oregonian?fpfp&coll=7

[xiii] Data provided by Dave Thorsen, (August 4, 2005), Chief of the Fiscal Bureau of the Montana Department of Health and Human Services' Child and Family Services Division.

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NICWA

National Indian Child Welfare Association

Protecting our children • Preserving our culture

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STATEMENT OF THE

NATIONAL INDIAN CHILD WELFARE ASSOCIATION

PROVIDED TO THE SENATE FINANCE COMMITTTEE

REGARDING

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

April 25, 2006

Terry L. Cross
Executive Director

The National Indian Child Welfare Association submits this testimony on methamphetamine and its impact upon tribal children and families in the child welfare system. The focus of our testimony will be a national look at what we know about methamphetamine as a criminal and health epidemic affecting American Indian/Alaskan Native (AI/AN) people, the issues contributing to the impact in Indian Country, strategies for addressing the challenges affecting AI/AN children, and the recommendations. A brief description of the National Indian Child Welfare Association is provided below.

National Indian Child Welfare Association – The National Indian Child Welfare Association (NICWA) is a national, private non-profit organization dedicated to the well-being of American Indian children and families. We are the most comprehensive source of information on American Indian child welfare and work on behalf of Indian children and families. NICWA services include: (1) professional training for tribal and urban Indian child welfare and mental health professionals; (2) consultation on child welfare and mental health program development; (3) facilitation of child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) development and dissemination of contemporary research specific to Native populations; and (6) assisting state, federal, and private agencies to improve the effectiveness of their services to Indian children and families.

In order to provide the best services possible to Indian children and families, NICWA has established mutually beneficial partnerships with agencies that promote effective child welfare and mental health services for children (e.g., Substance Abuse and Mental Health Services Administration, Indian Health Services, Administration for Children, Youth and Families, National Congress of American Indians, Federation of Families for Children's Mental Health, and the Child Welfare League of America).

Introduction

The National Indian Child Welfare Association's mission is being dedicated to the well-being of American Indian and Alaskan Native (AI/AN) children and families. This focus requires us to address issues, such as methamphetamine, that threaten the safety and well-being of tribal children and their families. In addressing these issues we understand that the ability of tribal governments to effectively respond is a critical element in helping these children and families heal and rehabilitate. In this testimony we will be specifically examining the role methamphetamine has in bringing tribal children into the child welfare system, how this impacts tribal children, families, and communities and key issues for tribal governments as they seek to respond. While we do not consider ourselves to be experts in methamphetamine in particular, we do posses considerable knowledge and experience regarding the interface between alcohol and substance abuse and involvement of AI/AN children and their families in the child welfare system.

Dealing effectively with methamphetamine and child abuse and neglect in tribal communities requires a commitment to involve all areas of government and community in planning and implementation. This includes supporting communities as they define the scope of the problem, create a sense of ownership, and develop community-based solutions. This involves many tribal agencies such as social services, law enforcement, health, and judicial, and reflects the cultural protocols and processes that tribes have defined for themselves as they address community issues such as these. Unfortunately, while tribal governments are in the best position to define the problem and solutions, the limited resources of most tribes do not allow them to implement this knowledge and their related authority. Historically, much of the resources, authority, and responsibility for addressing child abuse and neglect in tribal communities was given to states or the Bureau of Indian Affairs, rather than tribes, which disrupted tribal capacity building and institutionalized responses that were not community derived. As examples, Public Law 280 of 1953 gave some states jurisdiction over child welfare matters on tribal lands involving AI/AN children. Federal funding sources that were used to support core child welfare services, such as Title IV-E Foster Care and Adoption Assistance, did not allow tribes to directly apply for the funds. Over time, the lack of recognition of tribal authority and the provision of resources being provided to non-tribal entities for services to AI/AN children has created a sense of hopelessness and dependency in many tribal communities that interfered with tribal efforts to nurture the responsibility that they do feel for the well-being of their children and families.

Nonetheless, since the 1970's after the passage of the Indian Self Determination and Education Assistance Act and the Indian Child Welfare Act there has been a rapidly increasing trend for tribal governments to develop and operate their own services. These federal laws recognized tribal rights to self-governance, the need to proactively fund tribal services, and the important role tribal governments play in developing and implementing effective solutions to the issues their community members face. Methamphetamine and its relationship to child abuse and neglect are prime examples of issues that require tribal involvement in all phases of intervention.

Our testimony will discuss:
- Effects of Methamphetamine in Indian Country
- Contributing factors
- The need for more information
- What some communities are doing about it
- What more is needed
- Recommendations

Effects of Methamphetamine on American Indian/Alaskan Native Children

Methamphetamine use in Indian Country is on the increase according to most tribes and Indian organizations and is above that of most other racial or ethnic groups according to the Substance Abuse and Mental Health Services Administration data as reported by Robert McSwain, Deputy Director for the Indian Health Service, who testified at a hearing before the Senate Committee on Indian Affairs on April 5, 2006. He described the situation as a crisis for Indian Country. While the rates of methamphetamine use in Indian Country vary, there is widespread recognition that it is fast becoming an epidemic for many tribes, especially those in rural areas where services and law enforcement are already stretched.

The data concerning methamphetamine use in Indian Country is not comprehensive and detailed enough to develop a full picture of the trends and scope. The Indian Health Service and tribal contracted health clinics operating on tribal lands do not collect data that specifically detail major indicators of methamphetamine use, as do some other non-tribal agencies and governments. States that report relevant data on AI/AN use are reporting data for this population that use state and federally supported agencies. Given that approximately one-third of AI/AN people live on or near tribal lands where tribal services may be available, data from states should not be considered to be conclusive. However, the limited data available do provide some indication of the level of increase of use in some areas and description of the issues that tribal governments are facing. As a beginning place, we are providing some key data below that help describe this drug's use and its impact on the AI/AN population.

State Agency Derived Data (Substance Abuse and Mental Health Services Administration Treatment Episode Data Set Analysis Performed March, 2006 by Children and Families Futures, Inc.)

- In 2003, methamphetamine/amphetamine admissions made up approximately 8% of all treatment admissions – for AI/AN, this figure was 10%.
- The number of methamphetamine/amphetamine treatment admissions for AI/AN has increased from 625 in 1993 to 2,829 in 2003.
- From 1993 to 2003, the percentage of AI/AN females admitted for methamphetamine/amphetamine abuse has increased from 4% to 15%; for men, it has increased from 1% to 7%.
- Among pregnant AI/AN women, methamphetamine/amphetamine admissions have also increased – from 6% in 1993 to 20% in 2003.
- Approximately half of all AI/AN admitted for methamphetamine/amphetamines in 2003 report being in treatment before.
- Nearly one-fourth (22%) of AI/AN women and 16% of American Indian men admitted to treatment for methamphetamine/amphetamines in 2003 had a co-occurring psychiatric problem at admission.
- Methamphetamine/amphetamine as a primary substance identified during treatment admissions among pregnant AI/AN women has increased from the fourth most reported substance in 1993 to the second most reported in 2003.

Indian Health Services (IHS) Data

- Beginning in 2000, the IHS observed marked increases in the number of patients reporting for services with methamphetamine related problems and the trend continues today. The number of contacts related to methamphetamine abuse increased from 3,000 in 2000 to 7,004 in 2005.
- The age group range with the highest use is from 15-44 years of age with 25-34 being the age group with the highest usage.

Methamphetamine use results in violent crime, domestic violence, and abuse (all categories, including sexual) and neglect of children. It is a health crisis for abusing parents and for children, including children addicted before birth. Suicides are also closely associated with methamphetamine use. These very serious social problems were linked to methamphetamine abuse by Chairwoman Kathleen W. Kitcheyan of the San Carlos Apache Tribe in her testimony submitted to the Senate Committee on Indian Affairs. Many other tribal leaders and agency administrators have reported similar experiences. Methamphetamine is dangerous to all, including children, who are living in or are around methamphetamine labs. This includes exposure to toxic chemicals as well as the dangers of explosion and fire. While data on the scope of this problem in Indian Country, especially data that can provide a reliable national picture and is tribal specific, are essentially non-existent, more reliable and tribal-specific data are needed. However, the limited data that are available tell a disturbing story that links methamphetamine use with high risk for child abuse and neglect and subsequent placement of children in foster care.

The National Indian Child Welfare Association (NICWA) estimates that approximately 85% of AI/AN children in the child welfare system have parents with alcohol or substance abuse histories, with the most indicated form of child maltreatment being neglect. Foster care placement rates of AI/AN children are already disproportionately high with tribal children being placed at a rate nationally that is 2-3 times higher than their population numbers should indicate. Other factors that increase risk for child abuse and neglect, such as poverty and unemployment, are already very high in most tribal communities. The increased presence of methamphetamine use in the tribal communities will likely push these placement figures higher and strain tribal governments already lean budgets.

Many of these children who get caught up in the child welfare system because of methamphetamine use by their parents, will be removed from their families and placed into foster care. Because treatment and recovery from methamphetamine addiction is significantly more difficult and takes longer than with alcohol and other substances, large numbers of these children will likely never return home again to their parents. Furthermore, many of these children will enter the child welfare system testing positive for methamphetamine as infants.

Factors Contributing to Methamphetamine use in Tribal Communities

A number of historical and current factors make tribal communities particularly vulnerable to the methamphetamine epidemic:

Several federal and state policies have served to weaken, rather than strengthen, AI/AN families and communities. The removal of AI/AN people from their lands, involuntarily placing their children in boarding schools or adopting them out in large numbers far from their families and communities, and other attempts to assimilate AI/AN people have taken their toll in the form of weakening family structures and repressing traditionally healthy ways of ensuring well-being. These policies resulted in generations of AI/AN people who were disconnected from their culture and the supports that helped maintain their well-being. Consequently, the supports that tribal culture offered were not available to many of these families raising the risk for serious social problems such as child abuse and neglect. Most AI/AN people suffer from unresolved inter-generational grief and trauma, and there are few supports or resources to help them with this. Consequently, it is not surprising that AI/AN children are removed from their homes and placed into foster care at a rate that is 2-3 times that of other children nationally and in some states, AI/AN children represent as much as 50 to 60% of the foster care population.

The geographic isolation of many tribal communities is a significant factor in both the manufacture and distribution of methamphetamine, and it is no secret that reservations have been targeted by distributors for both this reason and that the residents are demoralized and vulnerable to methamphetamine use. In addition, it is well documented that those vulnerable to the abuse of alcohol are easy targets for methamphetamine addiction.

Others have provided the committee with documentation of the law enforcement resources available on reservations compared to other governments including counties and states. Very few tribes have the resources to effectively combat the epidemic, either in terms of law enforcement or intervention and treatment of users.

All of these factors make many tribal communities particularly vulnerable to the methamphetamine epidemic, and the least well equipped or prepared to respond on their own.

While all tribal communities continue to struggle with these risks, however, many have become mobilized to create healthy communities capable of effectively dealing with these issues on reservation, as well as, joining forces with other outside agencies and jurisdictions.

What is Working in Tribal Communities

Tribal leaders who have presented testimony to the committee have given very encouraging examples of Tribal communities taking action either on their own or in concert with other governments. Community organization efforts are among the most promising of these. In addition, we offer comment on the following practices, which are proving fruitful where they are being implemented.

Agreements

In law enforcement, numerous tribes, in both Public Law 280 and non-Public Law 280 states have developed agreements to cross-deputize with local county law enforcement, and clarify roles through agreements or Memorandum of Understanding with tribal, Bureau of Indian Affairs, and state agencies. These collaboration efforts pay big dividends for Indian children and the tribes, as professionals involved in child protection find new and innovative ways to address problems, receive support from other professionals, conduct and receive joint training, and participate in larger community efforts to prevent child abuse and neglect.

When tribes have been in leadership positions with respect to investigations, whether they perform all the functions or not, better methods for investigation have been developed and utilized. Other benefits from tribes being in leadership positions include: greater community acceptance of investigative services; clearer expectations and definitions of what constitutes child abuse and neglect; and use of natural helping systems and other cultural practices that are more effective in protecting Indian children.

Agreements have also been helpful in the sharing of funding and other resources. While direct funding of tribal governments is always preferred, states that have been willing to join in partnership with tribal governments and share funding that is not accessible to tribes has helped improve tribal capacity. However, these agreements are not mandatory, often difficult to negotiate, and vulnerable to shifting political agendas and budget priorities.

Training and Technical Assistance

The development of culturally relevant trainings and technical assistance has helped many tribes initiate improvements in investigative services. NICWA has been instrumental in developing curriculum and training on child protection services that is tailored to the needs of tribal agencies. Our partnership with four of the 10 National Resource Centers in Child Welfare has enabled us to provide technical assistance to tribes on topics such as child protection team development, interviewing skills, child abuse and neglect assessment, intergovernmental agreement, and investigation protocol development.

However, even with NICWA's partnership, these resource centers are many times not able to respond to tribal requests for assistance and depend heavily on the National Indian Child Welfare Association to not only perform much of the work, but also subsidize a portion of it.

Court Oversight

Strong tribal court systems have also had an important impact. Where they have been supported, tribal courts have been effective in prosecuting and deterring child abuse in tribal communities. Some courts have adopted more traditional methods of addressing child abuse that utilize elders and leaders from the community to influence positive changes in abusive behavior that are difficult to get in state courts. Tribal courts also support investigation by providing some oversight into the process and failures that may occur. In some states, tribal justice systems and state juvenile court systems are collaborating (e.g., New Mexico and Oregon) to increase awareness of issues of mutual concern and collaborate on new models of cooperation in child welfare. These new collaborations are promising, but other states and tribes need further incentives and support to replicate these. The Deficit Reduction Act of 2005 contained a provision that will require state courts to consult with tribal governments in the development and implementation of state court improvement projects in child welfare, and we think there are other opportunities for Congress to build on these successes.

Prevention

Prevention of child abuse and neglect in Indian Country is one of the least supported child welfare activities, but has one of the highest potential benefits for Indian children, families, and tribal communities. Indian communities have characteristics that help protect children from abuse or neglect. Historically, tribes have had customs and traditions for regulating civil matter such as child custody. Tribal elders acted as judges; traditional chiefs governed as the protectors of child well-being. Clans, bands, societies, and kinship systems functioned as social service providers. The teachings of the past and natural prevention support systems continue to facilitate prevention today. When new families are intact, new parents can receive a lot of support. In tribal communities almost everyone knows everyone else. These networks of people can often help identify and support child abuse victims. When communities are intact and aware, neighbors, friends, and family can provide checks and balances against unacceptable behavior.

The key to prevention is making sure that services are community-based, culturally appropriate, and adequately funded. Promoting awareness of child abuse and neglect is the starting place and then facilitating ownership of the problem by the community follows. Everyone in the community who wants to support prevention efforts should have an opportunity to do so. Community involvement can take many forms from participating in larger community prevention planning, to helping out with child care for members of your own family that are experiencing stressful events. In Indian Country the primary approaches to prevention include, public awareness, parent support, child resistance education (safe touch and stranger danger, etc.), intervention to reduce problem behavior, social risk reduction (restoring cultural norms, substance abuse prevention, wellness projects, etc.), and promoting cultural strengths.

Traditional Healing Based Services

Issues related to utilization and effectiveness of services by Indian families is a critical factor in the ability of AI/AN children and families receiving treatment and becoming well again. It is well known that many tribal communities and families rely on natural helping systems or traditional healers in their pursuit of healing, which have been reported to be some of the most effective treatment. However, treatment services such as these are often not supported by state treatment providers, and providers such as the Indian Health Service or the Bureau of Indian Affairs have very limited funding for these services. Consequently, besides services availability being limited in many communities, services may not be culturally matched to the tribal community and their values, beliefs, customs, and traditions. This has a tendency to limit the effectiveness of treatment for Indian children and families, and provides a

disincentive for families to seek mental health services from providers that only offer services in a mainstream model.

What has begun to surface is more advocacy for the establishment of treatment services that incorporate traditional healing. In 1999, the Substance Abuse and Mental Health Services Administration and the Indian Health Services entered into a partnership to promote the development of more culturally appropriate children's mental health services in Indian Country designed around the System of Care principles that encourage community-based and family involved service delivery. These agencies have funded over 15 tribes in their efforts to plan for children's mental health services, and the majority of these tribal grantees have gone on to implement their service designs by leveraging federal, state, county, tribal, and private funding. The services that they have designed and are now offering in several communities have had widespread community support and have reached children and families in ways that were not evident with other mental health treatment.

What is Needed Now

Coordination and partnership are significant requirements that tribes face in pursuing effective interventions, because of overlapping jurisdictions and the lack of tribal resources to intervene without the involvement of other governmental entities.

As described above, interventions in Indian Country can involve a variety of agencies, some of which are from different governmental entities (tribal, state, or federal). Each has a different experience, role, and authority. If efforts are not carefully coordinated, the opportunity for things to go wrong can happen very quickly with children becoming victims once again. Federal action is needed to support the development and implementation of comprehensive government-to-government partnerships involving states, counties, and tribes.

More flexible and secure funding is the most prominent item necessary for tribal communities to be able to design and deliver necessary services. Tribes receive small amounts of federal funding for child protection and other child welfare services. Others have already documented the significant disparities between funding for states and funding for tribes, in many areas of service. A more comprehensive and secure source of funding is needed to address current and future needs in tribal child welfare. The Pew Commission on Children in Foster Care examined the current federal child welfare funding system, and developed several recommendations on how to reform this financing system and provide more effective oversight by courts. A number of the recommendations specifically identified tribal governments and the need to direct fund them from all the sources that states are eligible for including Title IV-E and IV-B.

Research and Data

While some tribal leaders are developing more reliable data on methamphetamine use in their local communities, we still lack comprehensive information about what is going on in tribal communities across the country. Tribes should be supported in developing their data systems, and there should be support for developing a national database to collect and track both the extent of the problem and progress in addressing it. NICWA has been actively involved in helping several tribal governments develop and pilot data collection systems regarding child abuse and neglect reporting, but much more is needed.

In addition, there should be a national resource center specifically to support tribes around promising or evidence-based practices in child abuse and methamphetamine intervention in Indian Country. Successful strategies employed by tribal communities should be identified and promoted, and further work done on improving outcomes for Indian families and communities.

Training and technical assistance for tribal child welfare personnel is another area requiring action. The proper investigation of child abuse and neglect is very sensitive and requires critical skills in interviewing, observation/interpretation, and evidence collection. These issues are only magnified in Indian Country where years of inappropriate investigation by non-Indian public and private agencies

have created a strong skepticism of child protection services in general. For example, law enforcement personnel are often chosen as the first responders to complaints of child abuse and neglect; there primary training is in law enforcement techniques, which may not include how to carefully interview an Indian child that has been the victim of child abuse. Inappropriate techniques can lead to further trauma for the child and their family and possibly taint the evidence needed to prosecute offenders. Tribes also need help in developing or enhancing their capacity to investigate, including protocol and cross-agency agreement development. When methamphetamine is overlaid in the law enforcement or child protection agency response, the capacity and protocols are even more critical. Safety issues for investigating personnel are also a strong concern.

Treatment programs and services for child abuse victims are in very short supply. Evidence for this conclusion can be found by examining the Indian Health Service (IHS) budget regarding behavioral health services. IHS is the primary provider and funder of mental health services in Indian Country.

The IHS budget for fiscal year (FY) 2006 has $59.3 million for mental health services, which comprises approximately 28% of their total behavioral health budget. Indian Health Service reports that they have about 500 tribal contracted and federal IHS mental health providers who's primary role is to respond to chronically mentally ill adults. There is no data available on how many providers are child trained. When asked how much of the mental health budget goes to services for children, IHS is not able to provide a figure. This information was not available because there is no separate budget for children's mental health and information on the expense side is not collected. However, IHS service utilization data for 2005 indicates that 29.6% of mental health visits are for children and youth under 18, with 70.4% over 18. Applying this data to the budget figures, one can determine that roughly 8% of the IHS behavioral health budget is spent on children's mental health needs. Nationally, 40% of the American Indian population is under 18, indicating that Indian children are underserved. This leads many to believe that the IHS system is generally designed for adults with chronic mental illness, and does not have a specific program or focus designed to respond to children's mental health.

In addition, the Surgeon General in a report on mental health wrote that the need for mental health services is still great; availability of services is severely limited and a higher number of AI/AN people do not have health insurance than the average for Whites (U.S. Department of Health and Human Services, 2001). Where mental health, substance abuse and treatment programs do exist at the tribal level, they often are overwhelmed with trying to meet crisis proportion needs for both adults and children.

Recommendations

- Provide authorization for funding to allow all tribal governments necessary and equivalent resources to operate child protection services, and treatment responses on the same basis as states. Without this, it is difficult for tribes to participate as full partners in responding to methamphetamine and child abuse. Currently, tribes, unlike states, do not have access to federal funding source(s) that can support comprehensive child protection services. The funding should allow tribes to enhance existing child protection services or work to develop capacity to offer services in the future (planning, infrastructure development).

- The Pew Commission on Children in Foster Care has developed a set of recommendations that support necessary changes in child welfare financing and court oversight. Within these recommendations are several recommendations specific to tribal governments that are supported by the National Indian Child Welfare Association and the National Congress of American Indians. While these recommendations do not address all of the systems that are impacted by methamphetamine use, they do provide a blueprint for a financing system that can be more responsive to crises such as this and support the types of solutions that have proven successful in Indian Country, such as subsidized guardianship placements, direct funding of tribal governments, and greater incentives for collaboration between state and tribal governments. We urge the committee to look carefully at these recommendations and consider their potential to address these and future crises in child welfare that may impact tribal communities.

- Provide authorization for funding to build on and refine tribal child abuse and neglect data demonstration work that has already taken place over the last three years with an emphasis on collection of data, reporting and interface with the National Child Abuse and Neglect Data System (NCANDS). This will need to include specific information regarding methamphetamine as it relates to child protection.

- Provide for the establishment of a national technical assistance and training center designed to support tribal programs, including leadership, tribal law enforcement, and child welfare services in all areas of child protection, including comprehensive training for tribes regarding methamphetamine and effective prevention and response strategies.

Conclusion

Child protection has to be one, if not the most, important government responsibility. We know that rates of child abuse and neglect of Indian children are higher than that for many other ethnic and racial groups, and the system for protection of Indian children is fragmented and needing attention. We also know that resources to address this issue from prevention to prosecution are not nearly enough to get the job done, and we know that methamphetamine use is increasing in Indian Country and involved in perhaps the majority of child abuse and neglect cases we are seeing now in tribal communities. This is the reality for thousands of Indian children, their families, and communities. Tribal governments have the authority, responsibility, and knowledge to set things right, but resources to exercise that authority are not available.

Decisive action by Congress is required to provide the funding, coordination, and supports necessary for tribes to build strong communities capable of preventing child abuse and neglect and the risk factors contributing to them, including methamphetamine abuse. We look forward to action by the Senate Finance Committee, and to the possibility of our collectively dealing with the current crisis and improving outcomes for our families.

We thank the Committee for inviting us to provide testimony and look forward to continuing the good work of ensuring protection and well-being for Indian children, families, and communities.

For more information regarding this testimony, please contact David Simmons, Director of Government Affairs at the National Indian Child Welfare Association at 503-222-4044, ext. 119 or desimmons@nicwa.org

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Testimony for

The United States Senate Committee on Finance

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

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Prevent Child Abuse America thanks Chairman Grassley and the other distinguished members of the U.S. Senate Committee on Finance for this opportunity to provide the organization's perspective on the impacts of methamphetamine abuse on the child welfare system. We hope that this testimony will be of assistance to the Committee as it begins to consider the reauthorization of Promoting Safe and Stable Families (title IV-B, Subpart 2 of the Social Security Act), a program that, among other things, provides funding to services that seek to ameliorate risk factors associated with child maltreatment.

Extensive research clearly indicates a strong correlation between parental alcohol and/or drug abuse and child maltreatment. According to the U.S. Department of Health and Human Services (HHS), substance abuse is a factor in between one-third and two-thirds of cases of substantiated abuse or neglect, and is a factor in the decision for removal in two-thirds of the cases of children in foster care.[1] Abused and neglected children from substance abusing families are more likely to be placed in foster care and are more likely to remain there longer than those from non-substance abusing families.[2]

Alcohol and/or drug abuse have been recognized as risk factors for child maltreatment for some time. In recent years, methamphetamine (meth) abuse has presented unique issues related to child safety. Individuals easily can manufacture meth using simple, though toxic, household products. During the cooking process, toxic fumes are circulated throughout the home. These fumes can leave a harmful residue on furniture, clothes, and other belongings in the home. If mixed incorrectly, these chemicals can cause explosions.

For Prevent Child Abuse America and many others, there is particular concern for how children who live in close proximity to the labs are affected. Children are especially vulnerable since their nervous and respiratory systems are still developing, and permanently can be damaged by the toxic fumes created in the cooking process. Additionally, young children face an increased likelihood of poisoning from the residue settled throughout the home. The U.S. Drug Enforcement Administration reports that approximately 2,900 children were affected by the labs seized in 2003.[3] This number is likely an underestimate because it only captures the number of children present in the home at the time of reported lab seizures.

Earlier this year, Congress took important steps to curb the availability of materials used to manufacture meth and to protect children living in clandestine labs by passing the *Combat Meth Act of 2005* as part of the USA Patriot Act reauthorization. Among its many provisions, the Combat Meth Act authorizes $20 million in FY 2006 and FY 2007 to support state Drug Endangered Children (DEC) programs. These collaborative efforts combine resources from law enforcement, public health, and social services in an attempt to meet the needs of children who are affected by meth processing.

Prevent Child Abuse America is pleased that Congress is taking an active role in addressing meth abuse, and is encouraged to see this Committee make the important link between meth abuse and the child welfare system. The Committee's interest in this issue presents an opportunity to provide a more complete context for the issue of child abuse and neglect, and the need for the range of prevention services funded by the Promoting Safe and Stable Families program.

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[1] U.S. Department of Health and Human Services. *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection.* Washington, D.C.: U.S. Government Printing Office, 1999.
[2] Ibid.
[3] U.S. Department of Justice, El Paso Intelligence Center. "Children Involved Summary". National Clandestine Laboratory Seizure System. Report generated on November 30, 2004.

In part due to the growth of the methamphetamine trade, many child welfare systems have been stretched beyond capacity to handle the full scope of child maltreatment. According to the most recent data from HHS, there were an estimated 872,000 substantiated cases of abuse and neglect in 2004.[4] To address the consequences of abuse and neglect, billions of dollars are spent each year in out-of-home care, health and mental health care, special education, juvenile justice, and adult crime. In contrast, very little money is dedicated to preventing harm before it occurs.

Prevent Child Abuse Iowa reports that a record *15,060* children in Iowa suffered from abuse and neglect in 2005.[5] Most of the rise in child abuse between 2001 and 2005 resulted from increases in two categories of abuse: *neglect* and *the presence of an illegal drug in a child's body*.[6] The confirmed cases of neglect rose by 8.9 percent in that time period, while the confirmed instances where authorities found the presence of illegal drugs in the child's body almost doubled from 678 cases in 2001 to 1,354 cases in 2005.[7] On an encouraging note, the number of meth manufacturing cases dropped more than 60 percent from 2004 to 2005, likely due in part to state legislation passed in 2005 restricting access to pseudoephedrine.[8] This does not mean that meth use doesn't continue to have a negative impact on the child welfare system in Iowa. According to Prevent Child Abuse Iowa, parental meth use can lead to neglect, chaotic home lives, violence associated with drug sales, and inconsistent parenting.[9] PCA Iowa attributes the following possible explanations for the persistence of child neglect in Iowa:[10]

- Parental methamphetamine use remains high, putting substantial stress on many Iowa families.
- Past reductions in state resources for protecting children and preventing abuse have made it harder for officials and private agencies to support families and adequately protect children from the risk of neglect.
- Iowa has not developed and implemented strategies that comprehensively and effectively address the challenges of preventing neglect and its insidious and lasting effects.
- Many Iowa families have not recovered from Iowa's earlier economic downturn, due in part to ongoing unemployment.

Promoting Safe and Stable Families (PSSF) provides the largest federal funding source dedicated to prevention and family support services in child welfare, and if adequately funded, could help states address many factors that lead to child abuse and neglect. The program's flexibility allows states and localities to determine the best use of the dollars to meet the unique needs of their communities.

In 1993, Congress created a program – then known as the *Family Preservation and Family Support Program* –in response to rising foster care caseloads that were partially attributed to the growth in crack cocaine use during the 1980s. Congress intended to slow the growth in caseloads by providing families with services that would prevent the need to place children in foster care. Congress created the program as a capped entitlement to states, and authorized the funding level to increase from $60 million in FY 1994 to $255 million in FY 1998.

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[4] U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004* (Washington, DC: U.S. Government Printing Office, 2006).
[5] Prevent Child Abuse Iowa. *The Number of Abused Children Reaches Record High in 2005.* March 1, 2006.
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Prevent Child Abuse Iowa. *Drug-Related Child Abuse in Iowa.* Together For Prevention. Summer/Fall 2005.
[10] Prevent Child Abuse Iowa. *The Number of Abused Children Reaches Record High in 2005.* March 1, 2006.

Originally, federal funding was available, as the name suggests, solely for family preservation and family support services. When reauthorized in 1997, Congress added two additional purposes: time-limited family reunification and adoption promotion and support. HHS specified that states must spend 20 percent of their allotments on each of the four categories, or provide a "strong rationale" for doing otherwise. The name of the program was changed to *Promoting Safe and Stable Families (PSSF),* and the mandatory funding level was increased incrementally to $305 million in FY 2001.

While all four categories of the program provide vital support to children and families, two of the categories focus on prevention, and are of particular importance to Prevent Child Abuse America: family preservation services and family support services. ***Family preservation services*** are designed to keep families together and avoid the need to place children in foster care. These services are generally targeted towards families already known to the child welfare system and can include: intensive family preservation services; respite care to provide temporary relief for parents and other caregivers; services to improve parenting skills; and infant safe haven programs. ***Family support services*** are geared more towards families that are not yet in crisis as a way to prevent child abuse and neglect before it occurs, and may include: home visiting programs; state and regional support centers for young mothers; and early developmental screening for children.

Home visiting is just one example of a family support service with proven positive outcomes for children and families. Healthy Families America is a national home visiting program model designed to help expectant and new parents get their children off to a healthy start. A recent randomized control evaluation of Healthy Families New York found positive outcomes, including a reduced incidence of child abuse or neglect for the at-risk mothers and infants who participated in the program. The study found that Healthy Families New York mothers experienced better childbirth outcomes than control mothers and were less likely than control mothers to report neglecting their children and reported committing fewer acts of severe physical abuse, minor physical aggression, and psychological aggression against their children.[11]

In 2001, during the most recent reauthorization of PSSF, Congress set the capped entitlement funding level at $305 million through FY 2006 and added a $200 million discretionary grant subject to annual appropriations, placing the total authorized funding for PSSF at $505 million. Unfortunately, PSSF has not been fully funded since the discretionary grant was authorized. The combined mandatory and discretionary funding level for FY 2005 totaled just $403 million. As of this testimony, funding for FY 2006 is unclear. In FY 2006, Congress appropriated $89 million in discretionary funding, a $9 million decrease from the previous year. The *Deficit Reduction Act of 2005* (DRA) included a $40 million increase to the mandatory funding, but that funding has not been allocated to date.

As the Committee considers ways to strengthen PSSF through reauthorization, Prevent Child America strongly recommends that the Committee ensure family preservation and family support efforts remain program priorities and are adequately funded. This can be accomplished by providing all of the authorized PSSF funding as a $505 million capped entitlement, and by continuing to require that states spend at least 20 percent of their PSSF allocation on each of those purposes. Investing in positive outcomes for children and families through evidence-

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[11] New York State Office of Children and Family Services, Bureau of Evaluation and Research, Albany, N.Y.: Center for Human Services Research, University at Albany. *Evaluation of Healthy Families New York (HFNY): First Year Program Impacts.* February 2005.

based family support and family strengthening programs can lead to fewer incidences of child abuse and neglect. If fully funded, PSSF would promote expansion of family support services in communities across the nation and provide more intensive help for families in crisis.

We look forward to working with the Committee as you examine other potential areas for improving PSSF, such as through enhanced reporting requirements and an increased focus on ensuring positive outcomes for children.

About Prevent Child Abuse America
Since 1972, Prevent Child Abuse America has been building awareness, providing public education and encouraging hope in the effort to prevent the abuse and neglect of our nation's children. Working with our 41 statewide chapters and 450 Healthy Families America sites nationwide, we provide leadership to promote and implement prevention efforts at both the national and local levels.

Our vision imagines a culture (and a cultural attitude) wherein the well-being of children is universally understood and valued and where raising children in surroundings which ensure healthy, safe and nurturing experiences is supported by the actions of every individual and every community.

This is a generational vision in which it becomes the norm for all parents and caregivers to seek and accept qualified support regarding the knowledge and skills required for effective parenting and child development; and for the general public to become educated and engaged in supporting the well-being of children.