

# Responding to the Needs of Mothers and Children Affected by Methamphetamine Abuse in Central California



*The effects of methamphetamine abuse extend beyond the boundaries of any individual. They are felt at virtually every level of society, including community, family and the child.*



May 2008



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To Whom It May Concern:

In 2006, Central California Area Social Services Consortium (CCASSC) identified the need to increase outpatient and residential methamphetamine abuse treatment facilities as a top-priority issue. The lack of effective, accessible treatment was cited as a primary factor negatively affecting the arenas of child welfare and employment, and placing children of parents who abuse methamphetamine and other substances at even higher risk for foster care placement. Based on the history of methamphetamine abuse in Central California and publicly available data, the CCASSC concluded that more study was needed in order to further identify the treatment needs of parents who abused methamphetamine and were involved with child welfare agencies.

Responding to the Needs of Mothers and Children Affected by Methamphetamine Abuse in Central California represents this effort. This policy brief examines what is known about the current prevalence of methamphetamine abuse in Central California and the extent of its effects on children, families and communities in the region. It features various national and state data sources, and summarizes current knowledge about methamphetamine abuse and its effects on achieving safety, well-being, permanency and best practices for women in treatment for methamphetamine abuse. Characteristics of model programs that address the intersection of child welfare and substance abuse systems of care are featured. Implications and recommendations for responding to the treatment needs of parents of children in foster care or at risk for foster care placement due to methamphetamine abuse are also offered.

The CCASSC operates as an agency-university partnership with California State University campuses in Bakersfield, Fresno and Stanislaus and is supported by a membership that promotes and provides training to public human services administrators. Data driven activities, action-oriented research, policy analysis and policy/program development activities are emphasized. This policy brief is one of several products developed through this partnership with the larger goal of developing a policy and planning road map toward improving the quality of life for Central California residents.

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# Responding to the Needs of Mothers and Children Affected by Methamphetamine Abuse in Central California

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May 2008



## **Central California Social Welfare Evaluation, Research and Training Center**

The Central California Social Welfare Evaluation, Research and Training Center (SWERT) supports knowledge and learning about the human condition, social issues, and service delivery systems in the Central California region. The SWERT seeks to advance inquiry, theory, education, policy and practice that promote social welfare and social justice. The Central California region is defined by the San Joaquin Valley, but may include other proximate regions as well (i.e. Central Coast). The SWERT serves as a university resource for human service organizations, providers, and stakeholders in the identification and study of social welfare issues and policies impacting the region. Through acquisition of external resources and support, SWERT engages in research, training, and evaluation activities consistent with the university's mission of scholarship and community engagement.

Additional information about the SWERT, its projects and activities, including this report and other academic and community resources, may be found at <http://www.csufresno.edu/swert/index.shtml>.

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### **Suggested Citation**

Rondero Hernandez, V., & Noriega, L. (2008). Responding to the needs of children and families affected by methamphetamine abuse in Central California. Fresno: Central California Social Welfare Evaluation, Research and Training Center, California State University, Fresno.

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### **Acknowledgements**

Juanita Fiorello  
Jason Good  
Maria Mendez  
Anamika Barman-Adhikari

This report was funded by the Central California Area Social Services Consortium.

# Executive Summary

The Central Valley region has historically been heavily impacted by the production, sale, distribution and abuse of methamphetamine. The abuse of this substance can have profound physical and psychological effects on the individuals who consume it. However, the effects of methamphetamine abuse extend beyond the individuals involved with this drug. The effects of methamphetamine also pervade into the lives of the families, and more specifically, the lives of children whose parents abuse this highly addictive drug.

The science of estimating the extent of methamphetamine abuse currently is imprecise, at best. Available data is largely limited to self-report data collected from publicly-funded treatment service providers. These data, however, are informative and verify that methamphetamine is the most frequently used drug for which treatment services are sought in the Central Valley. During the 2006-07 year, the Office of Applied Research Analysis, California Department of Alcohol and Drug Programs (OARA-ADP) estimated that 13,811 persons residing in the Central Valley received publicly-funded treatment services for methamphetamine abuse (2007a). Almost two-thirds of them were parents of minor children (2007e).

In 2006, the Central California Area Social Services Consortium identified the need for additional study of the effects of methamphetamine in the lives of children who must enter foster care as a result of their parents' substance abuse problems (Fiorello, 2006). This policy brief represents this effort and examines what is known about the current prevalence of methamphetamine abuse in the region and the extent of its effects for children, families and communities in the Central Valley, including the counties of Fresno, Kern, Kings, Madera, Merced, San Luis Obispo, San Joaquin, Santa Barbara, Stanislaus, and Tulare.

This brief features national, state and region-specific data sources, and summarizes current knowledge about methamphetamine abuse and its effects on achieving safety, permanency

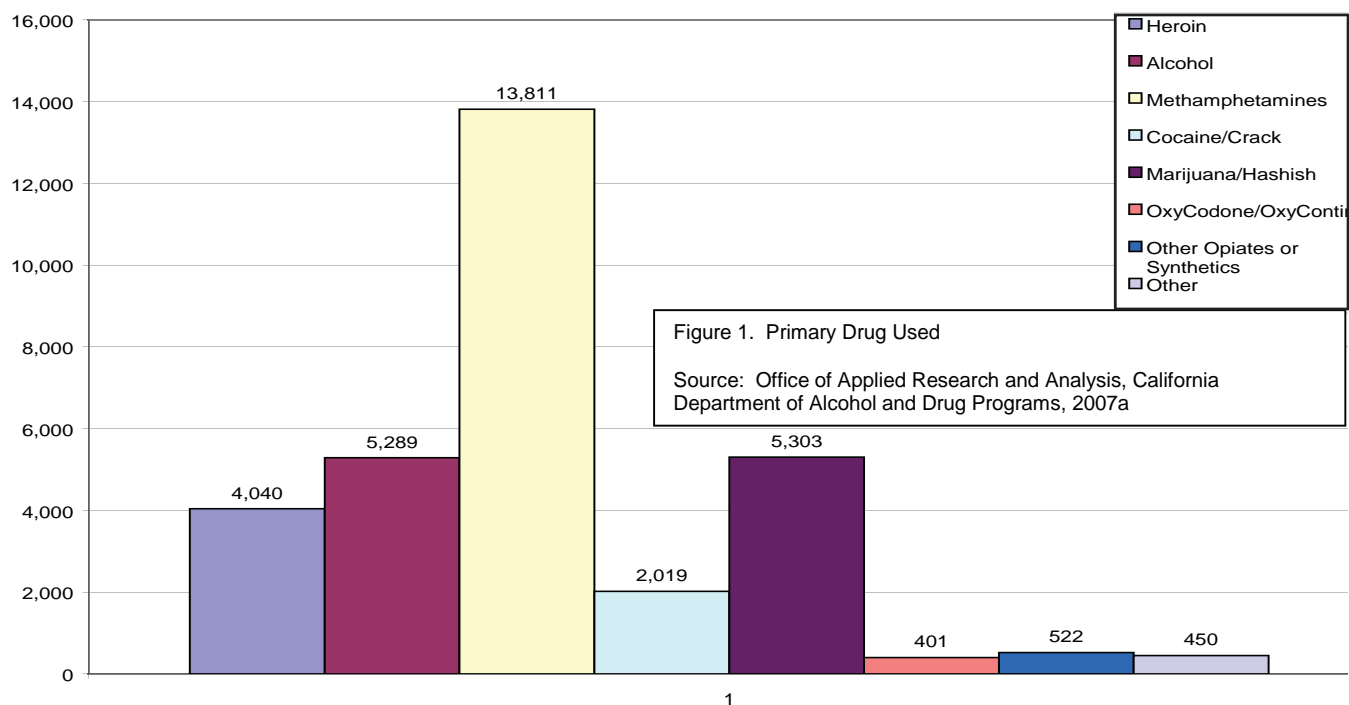
and well-being of children in foster care. Discussion of key legislation and policies that affect the delivery of substance abuse services is also included. Finally, barriers to treatment, collaborative approaches for responding to barriers, and national and state models that specifically address the intersection of child welfare and substance abuse systems of care are described. Implications and recommendations for responding to the treatment needs of parents of children in foster care or at risk for foster care placement due to methamphetamine abuse are offered.

## Background

The number of methamphetamine labs seized in the state of California has decreased over the last few years. However, the rural areas in the Central Valley remain the source of much of the methamphetamine produced in California and seized elsewhere in the U.S. Subsequently, local distribution and usage rates remain high (National Drug Intelligence Center, 2007; Office of National Drug Control Policy, 2006; U.S. Drug Enforcement Administration [DEA], 2007a).

At a national level, at least 1.4 million persons ages 12 and older reported using methamphetamine during 2004-2005 (Substance Abuse and Mental Health Services Administration [SAMSHA], 2006) and 9 percent of all persons admitted for treatment reported methamphetamine as their primary drug problem (SAMSHA, 2007). Historically, more men than women have reported using drugs; however, national data on treatment admissions reflect that more women are using drugs and the proportion of women seeking treatment is increasing (Brady & Ashley, 2005; Amatetti & Young, 2006).

In California, methamphetamine ranks as the most commonly reported abused drug, surpassing alcohol and heroin. State data reflect that the number of clients admitted to publicly-funded treatment for methamphetamine abuse increased from 46,198 (26.2 percent) in FY 2001-02 to 58,039 clients (31 percent) in FY 2004-05 (OARA-ADP, 2006). This increase is evident in the number of women admitted for methamphetamine abuse during the first half of the decade. In 2001-02



27,400 women were admitted into treatment for methamphetamine abuse throughout the state; in 2005-06, this figure rose to 35,900 (OARA-ADP, 2007c). Other sources report the ratio of women estimated to seek treatment for methamphetamine abuse now equals that of men (Brecht, 2006; UCLA Integrated Substance Abuse Programs, 2006).

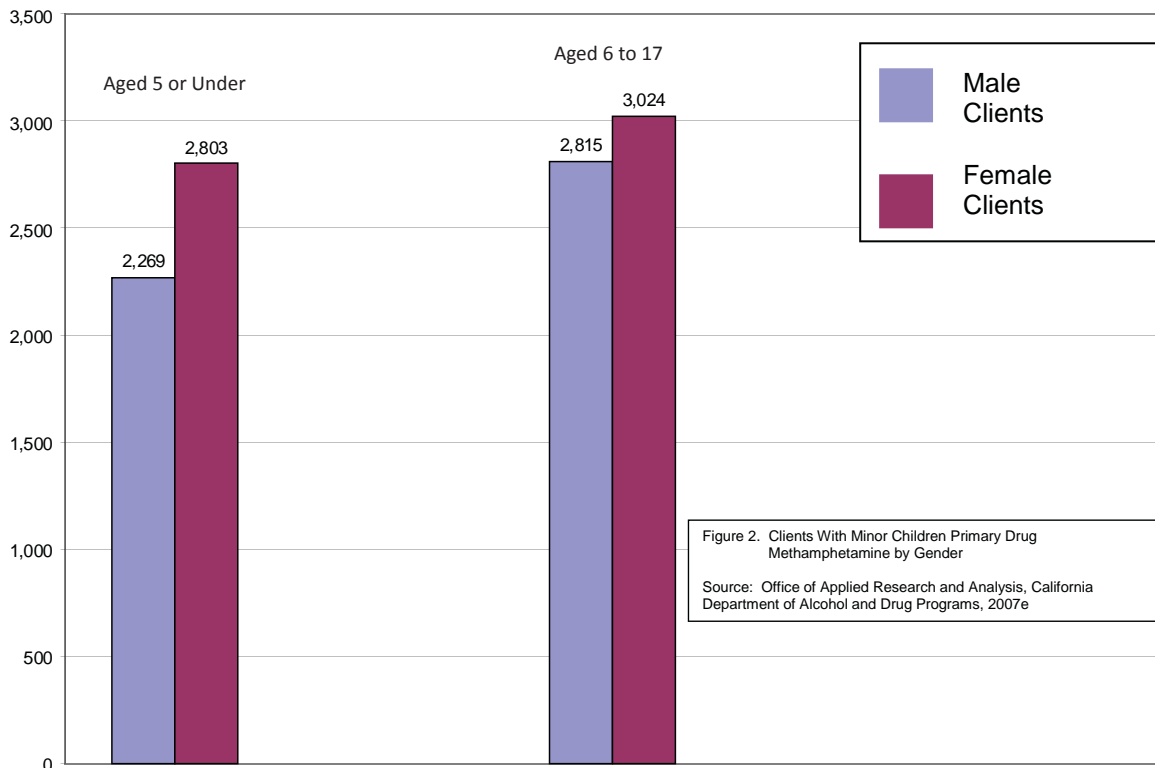
Recent data for the Central California region reflect that 13,811 persons were admitted for publicly-funded treatment for methamphetamine abuse; these admissions comprised 43.4 percent of total admissions for treatment during 2006-2007 (OARA-ADP, 2007a). (See Figure 1.) At least 8,318 clients were parents of minor children (2007e). A total of 15,542 minors had parents who were in treatment primarily for methamphetamine abuse and at least 3,266 of these children were living with someone other than a parent due to a child protection court order (2007e). Although fewer women (42.9 percent) received publicly funded treatment for methamphetamine abuse than men (57.1 percent) during FY 2006-07 (OARA-ADP, 2007d), women reported more minor

children than did men (OARA-ADP, 2007d and 2007e).

## Women in Treatment and Involved with Child Welfare

During 2000-02, 47 percent of women admitted to treatment for methamphetamine abuse in the state of California were involved with child welfare agencies (Grella, Hser, & Huang, 2006). At the regional level, women who were treated for methamphetamine abuse during 2006-07 reported more minor children than did men, indicating that more female than male parents were likely to be involved with Central Valley county child welfare agencies (OARA-ADP, 2007e). (See Figure 2.)

An important subset of women in treatment and involved with child welfare is women who abuse methamphetamine during pregnancy. National data reflect that the number of pregnant women admitted for treatment for methamphetamine abuse across the nation more than



doubled from 8 percent in 1994 to 21 percent in 2004 (Amatetti & Young, 2006).

The percentages of pregnant women admitted to treatment for methamphetamine at State and regional levels during 2006-07 were on the lower end of the range of national figures. A total of 2,442 or 7.9 percent of all women admitted to treatment in the state during this time period were pregnant. This compares to 8.7 percent or 516 pregnant women from the Central Valley who were admitted for treatment for methamphetamine abuse during the same time period (OARA-ADP, 2007b; OARA-ADP 2007d). These low figures do not diminish the fact that prenatal exposure to methamphetamine may result in detrimental outcomes for children that may not be evident at birth.

Specific data about the numbers of child welfare cases involving parental methamphetamine abuse in the Central California counties are extremely limited and largely anecdotal. A recent request by the Central California Training Academy to county analysts responsible for agency data management yielded responses from only three Central California child welfare agencies. Estimates of cases involving methamphetamine ranged from 33.5% to 49.3% and indications were

that large numbers of cases are not coded for primary drug used by parents. Administrators and practitioners interviewed across the region estimate that anecdotally, anywhere from 60-75 percent of child welfare cases involve neglect related to parental substance abuse, primarily methamphetamine abuse.

Although no formal mechanisms are currently in place to support a systematic approach for measuring the prevalence of parental methamphetamine abuse in child welfare cases in the Central Valley, Mancuso (2007) identified child welfare case review strategies that could assist in efforts to do this.

## Current Treatment Approaches

Treatment is effective when it is available, and an increasing number of persons are seeking recovery. However, treatment capacity is increasing at a slower rate than incidences of new and repeat methamphetamine use and addiction (Hser, Evans, & Huang, 2005). The lack of effective, accessible treatment for methamphetamine abuse has a negative effect on every domain of

life, especially for persons involved with public child welfare agencies and work force development programs. These effects may be especially profound for single female householders who live below the poverty line.

Currently, substance abuse treatment in any form is primarily delivered on an outpatient basis. In 2005, 81 percent of all substance abuse treatment in the U. S. was provided in outpatient settings (SAMHSA, 2006), and 71 percent of substance abuse treatment services in the state of California were provided similarly (SAMSHA, 2005).

Treatment is based on several models:

1) a medical model, which assumes addiction is a disease that must be treated in order to achieve and maintain sobriety; 2) a social model, which assumes abstinence and sobriety can be achieved through self-help and support gained through peer recovery groups; or 3) a behavioral model, which assumes substance abuse is supported by problems or conditions which interfere with achieving sobriety and recovery, but are considered manageable using forms of therapeutic interventions (SAMSHA, 1999).

Recent clinical research and women's treatment studies cite several reasons women start abusing methamphetamine, including to: 1) demonstrate commitment to a boyfriend; 2) suppress appetite; 3) self-medicate for depression and/or anxiety; 4) boost energy levels and productivity; and 5) escape painful feelings, memories, and situations (Brecht, 2006; UCLA Integrated Substance Abuse Programs, 2006). These factors are also cited in other studies demonstrating that the treatment needs of women who abuse substances, including methamphetamine, differ from those of men. Factors such as increased psychological symptoms, lower levels of self-esteem and higher rates of childhood abuse are more prevalent among women (Hser et al., 2005). In addition, women, especially women with children, experience more poverty, more unemployment, lower levels of education and increased reliance on others for economic support (Grella et al., 2006). These findings imply that a gender-specific approach is needed to support recovery and prevent relapse among women in treatment.

The effectiveness of treatment services is challenged by a number of personal and environ-

mental factors cited in the literature, including the severity of the addiction, psychiatric conditions, involvement with the criminal justice system, economic instability, relapse experiences, and involvement with child welfare systems (Grella et al.).

The effects of methamphetamine abuse extend beyond the boundaries of any individual. They are felt at virtually every level of society. Responding to these effects requires a broad vision and approach to controlling for the competing interests of reducing the harm caused by methamphetamine abuse in communities, while supporting treatment that leads to recovery and the reunification of families.

## The Intersection of Methamphetamine Abuse and Child Welfare

Methamphetamine abuse takes on special significance in the arena of child welfare because of its numerous implications for policy and practice. Families with parents who abuse substances are often affected by complex and difficult problems such as unemployment, poverty, poor housing or homelessness, domestic violence, involvement with the criminal justice system and mental health problems (Connell-Carrick, 2007; Green, Rockhill, & Furrer, 2006). In addition, federal legislation designed to address the urgency of children lingering in foster care has resulted in policies that do not fully consider the challenges of recovery.

For example, the Adoptions and Safe Families Act (AFSA) prescribes a 12-month timeframe in which a plan for permanency must be achieved and parental rights may be terminated if a child remains in foster care for 15 of the prior 22 months (National Association of Social Workers, 1997). This legislation created a "Catch-22" for parents in treatment as the time period in which permanency must be achieved may not match the amount of time necessary to acquire treatment services for methamphetamine abuse or achieve adequate economic, emotional, social stability to support reunification (Green et al.). In addition, the pace of recovery from addiction does not always follow a smooth trajectory. Relapse is common, especially in the early stages of recovery



and there may be a long-term need for social support and concrete assistance in order to cope with the multiple personal and environmental stressors associated with recovery, relapse, and ultimately, reunification of parents with their children (Connell-Carrick; Green et al.; Mancuso, 2007; Miller, Fisher, Fetrow, & Jordan, 2006; SAMHSA, 1999; Williams, Griffin, Davis, & Bennett, 2006).

## Recovery, Relapse and Reunification

Early studies on reunification focused on understanding what promotes and what deters reunification outcomes and processes. Successful and unsuccessful reunification have been associated with demographic and family characteristics (e.g. ethnicity, age of child, family size, income, poverty), environmental characteristics (e.g. housing, neighborhood), utilization of services (e.g. medical services, dental services, substance abuse services) and placement issues (stability of placement, length of time in placement, and child's last placement) ( Miller et al., 2006; Ryan, 2006; Wells & Guo, 1999). Many of these same characteristics are reflected in literature that discusses reunification for families where substance abuse is involved; however, the processes and outcomes of reunification for these families are far more complex because of the barriers associated with substance abuse treatment, recovery and relapse.

In general, women in treatment for substance abuse are more economically dependent on others and have less formal education, and achieving self-sufficiency becomes more difficult if more than one child must be cared for (Fuller, 2005; Maluccio & Ainsworth, 2003; SAMHSA, 2005). In addition to the economic burden of caring for children, securing substance abuse services may become difficult if outpatient treatment sites do not offer child care or inpatient treatment services are not licensed for children to accompany their mothers to treatment (SAMHSA, 2005). The severity of one's addiction, psychiatric issues, involvement with law enforcement or having a criminal history can complicate matters further (Grella et al., 2006; Maluccio & Ainsworth).

The demand to recover often competes

with the interests of child welfare agencies, who are charged with ensuring safety, well-being and permanency for children (Williams et al., 2006). Relapse can place a woman in jeopardy of having her parental rights terminated should she not be able to achieve the goals of self-sufficiency, recovery, and reunification in the specified timeframe.

Unfortunately, relapse is common among parents with substance abuse problems, as they confront the simultaneous challenges and stresses of recovery and parenting (Fuller; Marsh & Cao, 2005). Even if a woman manages to achieve these goals, the parental stressors associated with reunification can jeopardize the process and provoke relapse (Maluccio & Ainsworth; Mancuso, 2007). The age of a child, the number of children cared for, instability in the post-reunification environment, and the mental health status of a parent are key variables associated with reunification failure (Fuller; Ryan, 2006).

## Key Legislation and Policies

The following federal and state legislation and policies define interventions for parents with children who abuse methamphetamine and other substances. Some pertain primarily to achieving safety, permanency, and well-being for children of parents involved child welfare agencies; others have been developed to address the treatment and recovery needs of adults, many of whom are parents. The degree to which they are used to guide the development of interventions varies, depending on the practice setting and the particular treatment population.

### Federal Level

#### *Adoptions and Safe Families Act (ASFA)*

On November 19, 1997, the ASFA was signed into law with the intent to improve the safety of children, to promote adoption and other permanent homes for children who need them, and to support families. This law made fundamental changes and clarifications in a wide range of policies established under P.L. 96-272, the Adoption Assistance and Child Welfare Act, the major federal law enacted in 1980 to assist the states in

protecting and caring for abused and neglected children. Major features of the bill include:

- 1) continued and expanded family preservation and support service programs;
- 2) time line and conditions for filing termination of parental rights;
- 3) a new time frame for permanency hearings;
- 4) modification of a reasonable efforts provision in P.L. 96-272;
- 5) requirements that check prospective foster and adoptive parents for criminal backgrounds;
- 6) mandated assessment of state performance in protecting children; and
- 7) required study on the coordination of substance abuse and child protection (Child Welfare League of America (CWLA), 2007a; NASW, 1997).

#### *Child Abuse Prevention and Treatment Act (CAPTA)*

CAPTA originated in 1974 and is one of the key pieces of legislation that guides child protection. Although CAPTA was most recently reauthorized in 2003, it went through five previous reauthorizations. With each reauthorization of CAPTA, amendments followed that expanded and refined the scope of the law. Three programs are funded as part of the CAPTA statute. State grants are available to all 50 states to help fund child protective services systems, and discretionary grants are available to support program development, research, training, technical assistance, and data collection. These funds are awarded through an application process on a competitive basis. The third funding stream is for the Community-Based Child Abuse Prevention (CBCAP) program. To encourage and enhance local prevention efforts, CBCAP provides funds to the states for community-based initiatives (CWLA, 2007b).

#### *Promoting Safe and Stable Families (PSSF)*

PSSF is a capped entitlement and was first passed into law as a part of the Omnibus Reconciliation Act of 1993. It has been amended several times since then, most recently in 2006. In 2001, the program was changed to allow Congress to appropriate an amount up to \$200 million in discretionary funds, in addition to the base total of \$305 million in mandatory funds, meaning Congress does not have to approve the funding as part of the annual appropriations process. PSSF funding can be used for four types of services: family preservation, adoption services, family reunification, and family support. As a general rule, at

least 20% of the money must be spent in each of four categories of programs. In 2006, additional separate funding was allocated to address the courts, substance abuse, and the child welfare workforce. To receive funds from PSSF, the state must include a description of how these funds are to be expended and include that information in the state's five-year Child Welfare Services Plan. A 25% non-federal match is required. PSSF funding is set aside for federally-recognized Indian tribes or organizations (CWLA, 2007c).

#### *Drug Endangered Children Program (DEC)*

DEC programs were implemented at the beginning of the Bush Administration by the U.S. Department of Justice (DOJ), Drug Enforcement Agency (2007). To date, 25 states or regions have undergone national DEC training and have formally implemented local DEC programs (DEA, 2007b). DEC programs combine the collaborative efforts of local law enforcement agencies, the district attorney's offices, public health and child welfare agencies to protect children found at methamphetamine manufacturing sites and in danger of exposure to the drug itself, and toxic, combustible chemicals. DEC programs are currently authorized and funded under Section 755 of the USA PATRIOT Improvement and Reauthorization Act of 2005 (42 U.S.C. 3797cc-2(c)). U.S. Congressman Dennis Cardoza of the 18th District has introduced H.R. 1199 the Drug Endangered Children Act of 2007, which seeks to extend the DEC Grant Program until 2009 (Library of Congress THOMAS, 2007).

#### **State Level**

##### *CalWORKs*

The California Work Opportunity and Responsibility to Kids (CalWORKs) program is California's implementation of the federal Temporary Assistance to Needy Families program (TANF), which was created under the Personal Responsibility and Work Opportunity Act of 1996. The CalWORKs program provides time-limited (60 months maximum) temporary cash assistance to families with children. CalWORKs recipients are automatically eligible for Medi-Cal and may be eligible for Food Stamp benefits. Benefits are based on family size and income sources, including property of the applicant. Most able-bodied parents

are also required to participate in the CalWORKs' GAIN employment services program. Under the CalWORKs program, participants are eligible for several forms of supportive services, including services for domestic violence, mental health, family preservation and substance abuse. The types of services offered through the Substance Abuse Program include: detoxification programs; residential treatment; individual, group and family counseling; day treatment; perinatal care and counseling; HIV counseling; and health care information and referrals. Participants can access these services through referrals made by their CalWORKs eligibility worker or GAIN services worker (California Department of Social Services, 2004).

*Office of Women's and Perinatal Services,  
California State (OWPS)*

Under the direction of recently-appointed California State Alcohol and Drug Programs (ADP) director, Renee Zito, the title and services of the state's Office of Perinatal Substance Abuse (OPSA) have been expanded to enhance and improve alcohol and other drug services for women of all ages, their children, and their families. The OPSA was created in 1990 to address the pervasive issue of perinatal substance abuse. Since then, ADP has established more than 300 programs that have resulted in improved outcomes for pregnant and parenting women, all of which are required to provide comprehensive, gender-responsive services. The OWPS' vision is that every woman in need of AOD services in California will have access to the services she needs. Comprehensive treatment services for women are to be participant/client-centered, strengths-based, age-appropriate, trauma-informed, recovery-oriented, and address the relapse risks unique to women (ADP, 2007).

*Proposition 36*

The Substance Abuse and Crime Prevention Act of 2000, also known as Proposition 36, was passed by ballot initiative in 2000. This vote permanently changed state law to allow first- and second-time nonviolent, simple drug possession offenders the opportunity to receive substance abuse treatment instead of incarceration. In effect since July 2001, \$120 million for treatment services has been allocated annually over the last five years and over 150,000 people have ben-

efited from Proposition 36; however, an estimated \$228.6 million is actually needed to fund treatment needs in the state. The 2007-08 budget recently signed by the governor threatens to reduce county-level funding of treatment services. Of the \$120 million allocated, \$100 million is earmarked for the Proposition 36 trust fund and \$20 million for a separate fund for the Substance Abuse Offender Treatment Program (OTP). The first fund is distributed to all 58 counties, depending on need (as determined by the ADP). But the second fund requires that counties match funds at a ratio of 1:9. Counties unable, or unwilling, to match funds cannot access OTP funding. It is anticipated that waiting lists will continue to grow and that current funding levels will affect the quality of treatment services provided. (Drug Policy Alliance, 2007; Office of Criminal Justice Collaboration [OCJC], 2007c).

*Substance Abuse Offender  
Treatment Program (OTP)*

The OTP was established in FY 2006-07 to serve and enhance outcomes and accountability of Proposition 36 for eligible offenders. Program funds are used to enhance Proposition 36 by providing treatment services for offenders assessed to be in need of residential treatment and narcotic treatment therapy; to increase the proportion of sentenced offenders who enter, remain in, and complete treatment; reduce delays in the availability of appropriate treatment services; and promote use of the drug court model, including strong collaboration by the courts, probation, and treatment personnel. As noted above, counties are required to use matching funds from a source other than state provided funds. (OCJC, 2007c).

*Drug Court Programs*

California's first adult drug court began in 1991 and was developed as an alternative to incarceration for non-violent drug offenders. The goals of drug court programs are to reduce drug usage and recidivism, provide court-supervised treatment, integrate drug treatment with other rehabilitation services to promote recovery and reduce social costs, reduce the number of children in the child welfare system and access federal and state support for local drug courts. Drug courts are diverse and serve varied populations of

adults, parents whose children are in the dependency drug court system, juveniles, repeat drug offenders, multiple offenders, and drug-offending probation violators. As of March 2007, there were 76 adult drug courts in California counties, 16 juvenile drug courts in 12 counties (including Tulare County) , and 29 dependency drug courts in 20 counties (including Merced, San Joaquin, and San Luis Obispo Counties). Drug courts generally fall into one of four models, including pre-plea models, post-plea models, post-adjudication models, and civil models. The Drug Court Partnership (DCP) Act of 1998 provides counties with State General Fund (SGF) monies to support adult courts. The Comprehensive Drug Court Implementation (CDCI) Act of 1999 provides counties with SGF monies to operate drug courts for adult, juvenile, dependency, and family drug courts. Currently, DCP funds adult drug courts in 32 counties (including Fresno, Kern, Merced, San Joaquin, San Luis Obispo, Santa Barbara and Stanislaus Counties). The CDCI funds adult, juvenile, dependency and family drug courts in all ten Central California counties (OCJC, 2007a).

#### *Parolee Services Network (PSN)*

The PSN provides community alcohol and drug treatment and recovery services to parolees in Fresno and Kern Counties. Programs provide up to 180 days of treatment and recovery services, placing parolees in appropriate community-based alcohol and drug programs immediately upon release from prison. The intent is to improve parolee outcomes resulting in fewer drug-related revocations and related criminal violations and supporting parolee reintegration into society (OCJC, 2007b).

## Barriers to Recovery and Reunification

Although family reunification can be a strong motivation for parental recovery, there are many barriers that limit the success of recovery and the achieving reunification. These barriers include economic considerations; psychological problems, including trauma; family and partner influences; abuse and neglect of children; social stigma and discrimination; and disproportionate,

abbreviated deadlines among child welfare, substance abuse, and court systems (Brady & Ashley, 2005; Maluccio & Ainsworth, 2003).

#### *Economic Considerations*

Many women in treatment, both pregnant women and women with children, rely on CalWORKs to sustain their families. CalWORKs helps families where a parent is temporarily unable to support his or her family due to incapacitating illness or injury, including drug addiction. It may provide cash aid, food stamps, and non-health benefits, such as job training and other services, to eliminate barriers to employment. However, because women are often the primary caregivers, mothers have difficulties securing employment and meeting the required 40 hours per week of work preparedness activities required by CalWORKs.

Although participating in treatment is considered a work-related activity and participants can meet the requirement by attending treatment, it is no guarantee that a parent will find a job that leads to independence and self-sufficiency. Since parents in need of treatment often do not follow up on referrals, accessing treatment becomes that much more difficult and increases their vulnerability. This, in turn, limits success in recovery and obtaining self-sufficiency, which can delay reunification with children (Austin & Osterling, 2006; Brady & Ashley, 2005).

The federal law enacted in 1996 that implements CalWORKs further impedes independence after treatment by prohibiting cash aid, food stamps, and non-health care benefits to people convicted of felony possession, use, or distribution of controlled substances. The children in families where a parent has controlled substance convictions remain eligible for assistance; however, the parent is no longer eligible. Parents with felony convictions who are in substance abuse treatment programs are ineligible for employment assistance after graduating substance abuse treatment.

#### *Psychological Problems*

Women substance abusers face increased risk of psychological problems and are more likely to have psychological antecedents associated with their substance abuse (Brady & Ashley, 2005).

These psychological issues are often associated with past history of trauma and various forms of abuse, experiences that are more prevalent among women who abuse substances, compared to men (Austin & Osterling, 2006; Brown, Melchior, Waite-O'Brien, & Huba, 2002; Brady & Ashley). Women who abuse substances are also more likely to need emotional help at younger ages and have attempted suicide more often than their male counterparts. A dual diagnosis of psychological disorder and substance abuse requires specialty training to manage these simultaneously existing conditions. Specialty training is also necessary for treatment approaches which require confronting past abuse with individuals who may not want to revisit traumatic experiences. Limited or inaccurate assessment of such issues severely impacts the effectiveness of services and recovery and reunification (Brady & Ashley).

#### *Family and Partner Influences*

Pressures exerted by family members and significant others and limited experience in managing the stresses of interpersonal relationships can create a large barrier for women seeking treatment. In addition, women who abuse substances tend to experience an increased amount of domestic stressors including dysfunctional relationships with one's family of origin, lack of adequate parental role models, and poor interaction with children (Brady & Ashley, 2005).

Women engaged in substance abuse also tend to be involved in dependent relationships with dominant partners. Partners may discourage women from entering treatment by threatening violence or termination of the relationship (Brady & Ashley). Not being able to resist and manage these pressures can pose an additional barrier to recovery and reunification.

#### *Abuse and Neglect of Children*

Women who abuse substances often possess limited parenting skills, insufficient knowledge of child development, poor behavior management skills, and lack of natural supports from friends, family, and the community (Austin & Osterling, 2006; SAMHSA, 1999; Maluccio & Ainsworth, 2003). In addition, a significant number of the children of women who abuse substances exhibit adjustment problems, behavior, conduct,

and attention deficit disorders and difficulties managing social tasks and emotional challenges. If a mother is ill-equipped or has limited support in managing the demands and needs of her children, she may resort to abusive or neglectful behaviors in an attempt to deal with child-related stressors (Austin & Osterling; Maluccio & Ainsworth). Abuse or neglect is the basis for child welfare intervention and a primary content area that must be addressed in treatment if reunification is to occur.

#### *Stigma and Discrimination*

Social stigma and discrimination are significant factors that influence a woman's decision to seek and stay in treatment (Brady & Ashley, 2005). Social ostracism, labeling, and the guilt associated with substance abuse and involvement in the child welfare system is more heavily felt by women compared to men, as society views women as primary caregivers to children (Brady & Ashley; Maluccio & Ainsworth, 2003). Stigma and guilt may force women to avoid or deny issues that can affect the quality of treatment. A high proportion of women in treatment belong to a racial or ethnic minority group, which can generate distrust of the provider community, especially if services do not respect or address cultural and linguistic needs. Stigma, discrimination and feeling disrespected can negatively affect the therapeutic relationship and create barriers to effective recovery and successful reunification.

#### *Service System Conflicts*

A significant barrier to recovery and reunification are the competing interests and objectives of substance abuse, child welfare and court systems. Amatetti & Young (2006) have identified the following "key barriers" between these systems. They are related to: 1) differing beliefs and values; 2) competing priorities; 3) gaps in treatment; 4) information system limitations; 5) staff knowledge and skills, 6) lack of communication among these systems; and 7) differing mandates.

Chief among these barriers are the disproportionate and abbreviated deadlines of child welfare, substance abuse treatment, and court systems. Child welfare mandates put into place by ASFA accelerate the timelines for developing permanency plans and/or terminating parental

rights. Child welfare agencies are being asked to identify parental substance abuse and determine its effects on the child, the likelihood that parents can recover, and family stability. Similarly, dependency courts are being challenged to keep current and informed about parents participating in treatment and the status of their recovery. However, a 12 or 15 month period may be only a portion of the time needed in the recovery process and can serve to delay, if not abort, reunification efforts.

The key barriers identified earlier and how to resolve them have generated a national discussion on how to manage the challenge of shortened timelines for all parties involved. This discussion has also resulted in new knowledge about screening instruments and collaborative practice principles that can assist child welfare, substance abuse treatment and court personnel in making informed and evidence-based decisions about safety, well-being, and permanency for children of parents who abuse substances, including methamphetamine (Young, Nakashian, Yeh, & Amatetti, 2007).

National discussion about building collaboration, within and across systems is expanding. Best practices and advanced models of system collaboration have been identified in several cities in California, most notably in Sacramento, where reunification rates have doubled as a result of comprehensive cross-system joint training, the implementation of a substance abuse system of care, inclusion of early intervention specialists and recovery management specialists, and the implementation of a dependency drug court. The results include increased and accelerated reunification rates, decreased time spent in foster care, and \$2.9 million in cost savings for out-of-home care (Amatetti, Young, & Wurscher, 2006).

## Best Practices for Women and Families Affected by Methamphetamine Abuse

Best practices for women in treatment for methamphetamine addiction include actively addressing abuse and trauma, polysubstance abuse,

mental health issues, relationship issues, pregnancy and parenting difficulties (including contact with child welfare systems) and medical issues (UCLA Integrated Substance Abuse Programs, 2006). Specific treatment strategies include: 1) an empowerment approach to help women restore their self-esteem and sense of self; 2) "trauma-informed" techniques that assist women in identifying traumatic events or situations that trigger the need to self-medicate; 3) encouraging women to develop sound nutrition, exercise habits and healthy body images; 4) gender-specific treatment sessions that create a safe environment for women to discuss issues specific to women; and 5) learning about common reasons for relapse, including returning to methamphetamine-addicted partners or environments that encourage or support drug use (California Department of Alcohol and Drug Programs & UCLA Integrated Substance Abuse Programs [ADP & UCLA-ISAP], 2007; Brecht, 2006).

One way in which the treatment community is responding to the growing need for collaboration among service delivery systems is to provide more gender-specific and family-centered services to the females who abuse substances (ADP, 2007; Brown et al., 2002). Brady and Ashley (2005) found that for substance-abusing females, treatment programs that included ancillary and/or wraparound services (i.e., child care services, prenatal care services, women-only treatment, mental health services, and supplemental services and workshops addressing women-focused topics) are linked to positive treatment outcomes. Family-centered services are also associated with longer stays in treatment, where this retention allowed for higher rates of treatment completion and better treatment outcomes (ADP & UCLA-ISAP, 2007; Bissell & Miller, 2007; Brown et al.).

Effective substance abuse treatment programs for women recognize that recovery, relapse and reunification are intimately connected. Model programs share similar characteristics and all feature gender-specific treatment that addresses: 1) child care services, whether in outpatient or residential treatment settings; 2) prenatal care services, health and dental services; and 3) women-only treatment that affords women in treatment opportunities for social support and social modeling. These models of care also recognize

that recovery runs along a continuum and that aftercare is an essential element in assisting women who often return to environments and locales where they initiated their addiction to drugs.

Table 1 and Appendix A identify several treatment programs that reflect the characteristics of service delivery models. This is not an exhaustive list; however, it reflects common elements of effective practice noted in the literature for mothers who abuse methamphetamine. These elements include:

- Treatment that is individualized, least restrictive, and provides a continuum of care with regular performance evaluations conducted to assess the need for increased or decreased levels of care;
- Comprehensive and multi-dimensional treatment that addresses the physical, emotional, and mental health needs of individuals and their families and/or other support systems;
- Family-centered treatment, addressing the needs of all family members while promoting the family's participation and support in the recovery process;
- Supports that maximize the success of treatment outcomes in outpatient settings, as well as residential settings;
- Treatment that is cognitive-behaviorally based, gender-specific and long-term in duration with intensity of treatment decreasing over time;
- Treatment-on-demand so as to take advantage of "windows of opportunity", when individuals actively seek out treatment;
- Multi-disciplinary teams with members including therapists, referring agencies, mental health service providers, and providers of medical, family, legal, financial, housing, transportation, educational, and vocational services;
- Case management, preventive services, counseling, crisis intervention and safety planning, substance testing, and linkages and referrals to resources including housing and other ancillary services; and
- Outcome and quality assurance measures to evaluate program effectiveness.

## Discussion

Methamphetamine is the primary drug used by persons admitted to treatment in the State and Central California and is associated with a high number of referrals and open cases with child welfare agencies on the West Coast (Hser et al., 2005; Green et al., 2006) and the Central California region. Women with minor children comprise the majority of persons in treatment in the State, and as a result may experience economic, psychological, and social barriers to achieving treatment goals and recovery. Treatment is effective when it is available, and an increasing number of persons are seeking recovery. However, treatment capacity is increasing at a slower rate than incidences of new and repeat methamphetamine use (Hser et al.).

Even if treatment is available, the shortened timelines for family reunification mandated by federal law are not always adequate enough to surpass barriers to treatment and recovery. This places the children of women who abuse methamphetamine at particularly high risk for re-entry into the child welfare system if a mother relapses. Best practices with women in treatment include interventions that are gender-specific, family-centered, offer social support, and provide basic medical, child care and social services. Treatment models represent a continuum of care that ranges from residential treatment to transitional living services and reintegration into community to outpatient treatment that offers social support and child care.

## Implications

Current national and state legislation and policies affect the delivery of services to parents who abuse methamphetamine in Central California. Broadening concern about cross-system conflict (e.g., competing timelines and agendas) among child welfare, treatment and court systems underscores the need for increased collaboration. This strategy would be helpful in implementing and disseminating best practices and effective interventions across the Central California region. In order to disseminate and implement best practices and model programs locally, specific ef-

fort is needed to identify the numbers of families involved with child welfare, treatment and court systems and to prepare and support personnel from these representative systems for collaborative practice (Young et al., 2007).

## Recommendations

The challenges of addressing the prevalence of methamphetamine abuse in Central California and its impact on child welfare systems are likely to continue in the near future. Altering this situation will require additional study, advocacy and policy change to address the competing values and interests of child welfare, substance abuse treatment and court systems and move toward more collaborative models of practice. In light of these facts, the following recommendations are offered for the Central California region:

### **Identify the Extent and Use of Effective Interventions for Parental Methamphetamine Abuse**

- Inventory the types of services for parents, particularly women, provided by treatment programs in the region.
- Assess the extent to which treatment providers in the region engage in best practices associated with model programs in other areas of the state.
- Develop assessment protocols that index the extent to which parents, particularly women, experience barriers to treatment.
- Develop assessment protocols that index the number of barriers.

### **Invest in Efforts to Measure the Prevalence of Parental Methamphetamine Abuse**

- Conduct local case review efforts to identify the physical needs, treatment needs and support needs of parents who abuse methamphetamine and are involved with county child welfare, substance abuse treatment and court systems.
- Support a regional effort to utilize currently existing fields in the CWS-CMS system that could be used to annotate types of parental substance abuse.
- Advocate for specific fields for parental substance abuse in future generations of the CWS-CMS system.

### **Support the Development of Collaborative Practice Models**

- Assess the extent to which child welfare, substance abuse treatment and court systems engage in collaborative practice in child welfare cases where parental substance abuse is involved.
- Commit to the philosophy of cross-system collaboration and the principles of standardized approaches to screening and assessing each case involving the abuse of methamphetamine and other substances by parents.
- Promote agency interventions that are family-centered and support family engagement in the recovery and reunification processes.

## Conclusion

National survey data and state treatment data indicate there was a slight decrease in methamphetamine use compared to previous years (SAMSHA, 2007; OARA-ADP, 2007a and 2007b). However, the proportion at which methamphetamine is abused in California still almost triples that of any other primary substance reported. Its prevalent use, especially in Central California, indicates that child welfare agencies in the region will continue to be faced with the challenges of meeting federal mandates for the safety, well-being and permanency for the children they protect and the reality of time it takes for a parent to recover from methamphetamine abuse. Women are more affected by barriers to treatment and the challenges of maintaining sobriety and recovery, requiring interventions that address these particular challenges. It is incumbent upon community and agency leaders and service providers to adopt policies, effective interventions and model approaches that address the conflicting values and agendas of the systems that serve this population. Such measures are necessary if family reunification is to be achieved, recovery is to be supported, and foster care re-entry is to be avoided.



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Program Features									
	Individualized Case Planning	Counseling Services	Multi-dimensional/ Comprehensive	Family-centered	Community-based/ Least restrictive	Continuum of Care	Gender specific	Long-term	Readily Available
Family Reclaim (Oakland, CA)	X	X	X	X	X				
Friendship House (Oakland, CA)		X	X	X	X	X	X		
SHIELDS (Los Angeles, CA)	X	X	X	X	X	X	X		
Walden House (SF, CA)	X	X	X	X	X	X	X		
Women in New Recovery (Mesa, AZ)	X	X	X	X	X	X	X		

Program Features										
		Multi-discipline/ Team approach	Case management	Preventative services	Substance testing	Assistance in locating safe, affordable housing	Assistance in meeting basic needs (food, clothing, etc.)	Crisis intervention/ Safety planning	Linkages with resources/ Referring	Outcome and quality assurance (Evaluation Mechanisms)
Family Reclaim (Oakland, CA)			X		X	X	X	X	X	
Friendship House (Oakland, CA)			X		X				X	X
SHIELDS (Los Angeles, CA)		X	X		X	X	X	X	X	X
Walden House (SF, CA)		X	X		X	X	X	X		
Women in New Recovery (Mesa, AZ)					X				X	

# Appendix A.

## **Family Reclaim**

Family Reclaim offers intensive community- and home-based services to families referred by CPS whose children have been abused or neglected, or are at risk of abuse and neglect, in Oakland, California. The program specifically targets families experiencing multiple issues including substance abuse and child maltreatment. Culturally-sensitive services are designed to preserve the family unit and prevent out-of-home placement. Social workers and advocates provide parenting training, household and money management, nutritional guidance, crisis intervention and counseling, respite care, transportation services, and help families access resources to meet housing and other basic needs. Family strengths and community resources are emphasized in this program. For more information please see <http://www.fssba-oak.org/programs/familypres.htm>.

## **Friendship House**

Friendship House is a residential drug and alcohol treatment program that offers both residential and aftercare services to individuals with substance abuse issues. This program utilizes a holistic model linking culturally-relevant substance abuse treatment, rehabilitation, and prevention. Friendship House offers individual and group counseling for substance abuse and mental health issues, family counseling, case management, substance abuse education, relapse prevention, positive parenting classes, nutritional and wellness education, life skills training, education and job training, housing referrals, traditional American-Indian spiritual and cultural values, clean and sober community events, and aftercare counseling to support re-entry into the community. Further information about Friendship House can be located at <http://www.friendshiphousesf.org/INFO.html>.

## **SHIELDS for Families, Inc.**

SHIELDS is a non-profit agency serving the Compton and Watts communities in South Central Los Angeles. Serving approximately 3,000 families annually, SHIELDS provides comprehensive, community-based programs at multiple sites. Services include outreach, intake, and assessment; indi-

vidual, group, and family counseling for mental health and substance abuse issues; medical care, family support, family preservation, parenting and child development, adoption support, youth services, vocational services, life skills training, educational classes, academic assistance, case management, aftercare, housing, and transportation services. For more information please see [www.shieldsforfamilies.org](http://www.shieldsforfamilies.org).

## **Walden House**

Centered in the San Francisco Bay Area, Walden House provides behavioral health and substance abuse services to its surrounding community as well as throughout California. Based on the therapeutic community model of treatment, this program emphasizes self-help and peer support in a highly structured and humanistic environment. Programs are offered in residential, day-treatment, intensive outpatient, and outpatient settings. Services are delivered by multi-disciplinary teams with counselors, medical staff, and case managers. Services include screening and assessments, individual and group counseling that addresses mental health and substance abuse issues, 12-step programs, housing, case management, financial management, skills training, medication services, health services, family services, parenting skill development, child care, adolescent services, crisis intervention, relapse prevention, and linkages to services that strengthen community supports. Further information about Walden House can be located at [www.waldenhouse.org](http://www.waldenhouse.org).

## **Women in New Recovery**

Women in New Recovery (WINR) is a 7-month program that provides residential alcohol and substance abuse treatment in Mesa, Arizona. WINR is a 12 step-based program and orderly living environment that promotes sober, socially-acceptable attitudes and skills in order to provide women with tools to face life with resiliency and self-sufficiency. Services include group and individual sessions to address social, emotional, physical, family, and legal issues; life skills training, money management, vocational training, transitional living services, relapse prevention, and support services for mothers reuniting with dependent children. For more information see [www.winr.org](http://www.winr.org).