CHAPTER 5
RESOURCE MATERIALS

Understanding Families —Part 2

CONTENTS

CASA
Court Appointed Special Advocates

Methamphetamine: What Child Welfare Workers Should Know

To protect and support families, child welfare workers need to know what methamphetamine is and how it affects users.

WHAT IS METH?

Meth is methamphetamine, a powerful central nervous system stimulant. A highly addictive drug, meth comes in different forms; most often it is a powder that dissolves easily in water, though it can also come in clear, chunky crystals called "ice." Meth can be swallowed, snorted, injected, or smoked. It is known by many names, including speed, meth, crystal, crank, biker's coffee, and chalk (ONDCP, 2003; Shaw, 2004).

Although known primarily as an illegal drug, methamphetamine does have legitimate medical uses. It is sometimes prescribed for the treatment of narcolepsy, attention deficit disorders, and obesity (NIDA, 2002). Medical methamphetamine is sold in the U.S. under the trade name Desoxyn (Narconon, 1998).

Yet the legal use of meth is almost entirely eclipsed by growing tide of illegal production and abuse. Nationally, four times as many people sought treatment for meth addiction in 1998 [as] in 1992 (NCPC, 2002). Meth is also showing up in the workplace. Between 1999 and 2003, the percentage of positive workplace drug tests containing amphetamines doubled, from 4.5% to 9.3% (CESAR, 2004). During 2000, 4% of the U.S. population reported trying meth at least once in their lifetime (NIDA, 2002).

Child welfare agencies may see a much higher incidence of meth use, just as they see more domestic violence and mental illness than are present in the general population. One western North Carolina county we spoke with said that the majority of CPS reports it has received so far in 2005 have involved meth.

EFFECTS ON USERS

Users are drawn to meth because when they first take the drug they get an intense rush of pleasure followed by a sense of euphoria, energy, and elevated self-esteem lasting up to 8 hours (Swetlow, 2003).

Asked by a child welfare worker what taking meth was like, a user responded: "Imagine the most pleasurable experience you have ever had. Now multiply that times ten."

Users also like meth because it helps with weight loss and acts as a sexual stimulant (Shaw, 2004). Another draw is meth's relative affordability. Whereas $100 will hardly buy enough crack cocaine to get a user through the night, for the same amount a meth user can stay high for days (Shaw, 2004).

Because of severe depression and other negative effects that begin when the drug starts to wear off, users try to avoid sobering up. They may binge to stay high—and awake—for many days at a time and then use other drugs, such as alcohol or depressants, to help them sleep. Meth users who binge commonly crash and sleep for days afterwards. When chronic users stop taking meth they experience depression, anxiety, fatigue, paranoia, aggression, and an intense craving for the drug (NIDA, 2002).

According to the US Drug Enforcement Agency (2005), "methamphetamine has a phenomenal rate of addiction, with some experts saying users can get hooked after just one use." Once a person becomes addicted, explains Agent Van Shaw of the North Carolina State Bureau of Investigations (SBI), "home maintenance, personal health and hygiene, and parenting all suffer" as the drug becomes the person's only focus (Shaw, 2004).

Using meth can have many immediate physical side effects. Signs of meth use include the following:

- Euphoria
- Grinding of teeth
- Light sensitivity due to pupil dilation
- Dry mouth
- Rapid heartbeat and breathing
- Sweating and increased temperature
- Hyperactivity
- Tremor
- Rapid/pressured speech
- Depression (when drug wears off)
- Irritability, paranoia, suspiciousness
- Hallucinations
- Presence of drug paraphernalia

(Mason, 2004; Crowell and Webber, 2001)

Long-term negative physical effects of chronic use include lung and nerve damage, heart attack, kidney failure, extreme weight loss, tooth loss and cavities, stroke, seizures, and death (Mason, 2004; McFadden, 2003). Because they may engage in risky behaviors, there is also a higher rate of hepatitis, HIV, and STDs among meth users (NIDA, 2002).

The psychological side effects of meth use include hostility, impulsivity, irritability, insomnia, paranoia, and behaviors such as skin picking, pacing, chattering, and repetitive movements. Long-term psychological effects of chronic meth abuse can include delusions, hallucinations, homicide, suicide, psychosis, and bizarre and violent behaviors (Mason, 2004).

In addition to the physical and psychological effects, meth users are at risk for negative outcomes such as unemployment and criminal activity. Meth use and meth labs are linked to increases in crime, especially car thefts, forgeries, identity theft (NCDOJ, 2004), and domestic violence (Shaw, 2004).

USER PROFILE

In North Carolina, most meth users are "young, white, small-town residents with limited education and a blue collar-career" (Lacour & Gregory, 2004). As with most drugs, the majority of users are men (McWhirter & Miller, 2004). Yet many women find the drug attractive. Today women account for 47% of all treatment admissions for meth—a much higher percentage than for most other drugs (Vaughn, 2003).

Anecdotal reports suggest that a significant percentage of the friends and family of parents arrested for cooking meth also use the drug. Though these reports do not have the weight of empirical evidence, they underscore the importance of thorough assessments before placing children.

CHILD MALTREATMENT

Compared to other children, children whose parents use drugs or alcohol are three times more likely to be abused and four times more likely to be neglected (Wells & Wright, 2004). This increased risk certainly seems to apply in the case of meth.

Pregnancy

Meth use during pregnancy can result in prenatal complications, low birth weight, birth defects, increased rates of premature delivery, and abnormal infant behavior (NIDA, 2002; Wells & Wright, 2004). Children born to meth-addicted mothers go through painful withdrawal for weeks or months (Lacour & Gregory, 2004). Long-term, most children prenatally exposed to meth function normally as they get older, though some may have "subtle impairments" that negatively affect regulation of emotions and ability to concentrate, which could put them at risk for behavioral and learning difficulties (Matthias, 2001).

Neglect

When parents use or make meth, their children often do not have necessities such as food, water, and shelter, and they frequently lack adequate supervision and medical care, including proper immunizations and dental care (NDIC, 2002). In addition, the cycle of meth abuse has a built-in phase when parents usually "crash" and are unable to look after their children (Wells & Wright, 2004). Children in meth-using families may also face hazards such as used hypodermic needles and razor blades (Swetlow, 2003).

Abuse

Exposure to parents intoxicated by meth may compromise child safety: when high, users often exhibit poor judgment, confusion, irritability, paranoia, and increased violence. Given the effects it has on libido, children of meth-using parents may be at greater risk for sexual abuse (Swetlow, 2003; Riverside DEC, 2005), either by parents themselves

or by other adults coming in and out of the home (NCDOJ, 2004).

Brain changes brought on by chronic meth use can impair cognitive function long after a person stops using the drug. Experiments indicate that for up to six months after they stop using, addicts recovering from sustained, heavy meth use may have trouble processing information and may experience anhedonia (inability to experience even the simplest pleasures), depression, and anxiety.

On the bright side, research finds that meth users' brains show signs of recovery after 12 to 14 months of abstinence (Wells & Wright, 2004).

TREATMENT FOR METH

Although many people are pessimistic about the future of those addicted to meth, experts say that treatment for meth is just as effective as for other drugs, with 50% to 60% of patients recovering (Worth, 2005).

Predictions of low recovery rates, experts say, often arise in communities with little or no experience with crack, cocaine, or heroin abuse, where substance abuse professionals are unprepared for the challenges of meth addiction (Sommerfield, 2004). Thus, the problem is not that treatment doesn't work with meth, but that the most effective treatment models can be hard to find (Szalavitz, 2005).

One approach that has been proven to work with meth is the Matrix model, which combines elements from relapse prevention, motivational interviewing, and other programs (Larimer County, 2004). One key difference between this model and others is its duration: whereas many programs last 30 or fewer days, Matrix lasts up to six months. This fits better with what we know about how long it takes the brain to shake off the effects of meth.

CHILD WELFARE POLICY

In North Carolina, child welfare policy dictates that allegations of children exposed to meth labs must be investigated by DSS in cooperation with law enforcement. In Multiple Response System (MRS) counties, if the allegation concerns meth use (but no lab), the individual county DSS may respond to the report using either the family assessment or the investigative assessment approach.

WORKING SAFELY WITH METH USERS

Possible Danger Signs

- Signs of methamphetamine use (see above)
- Client is extremely irritable or argumentative, or there is an escalation of irritability
- Regular client does not appear to know who you are
- Evidence of paranoid thinking, delusions
- Client verbalizes implicit or explicit threat against you
- Presence of knife, firearm, or other weapon in the immediate vicinity

Safety Tips

- Inform supervisor/co-workers you will be visiting a client with a history of making or using methamphetamine
- Follow agency safety protocols
- Ask permission if you want to go to another area of the client's dwelling or look in cabinets (e.g., to ensure food is in the house)
- Watch for:
    - Symptoms of stimulant use
    - Paraphernalia for using meth such as glass smoking pipes, syringes, straws and razor blades on mirrors or other surfaces
    - Signs that client is becoming upset, angry, or suspicious
    - Scratch marks or scabs, particularly on hands and arms, could be evidence of tactile hallucinations and indicate a prior episode of stimulant psychosis
    - Evidence of hallucinations
    - Strong chemical odor (may indicate manufacturing of meth)

    (Adapted from Crowell and Webber, 2001)

References in this article can be found at www.practicenotes.org/vol10_n2/ref_v10n2.htm.
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The Treatment Perspective in Permanency Decisions for Substance Abusing Parents

By Vostina DiNovo

How do you make fair permanency decisions for families in the child welfare system when parental substance abuse is involved? This is arguably one of the most controversial subjects the legal system faces, and often engenders contention among all parties involved.

Making these decisions demands a practical understanding of the recovery process, and the multiple obstacles this population often faces. This understanding is vital to ensure parents have a fair opportunity to preserve their families, and protect the interests of their children. As a clinician working with mothers who are substance abusers, I have witnessed firsthand the miracles that can and do happen when people fully commit themselves to recovery. I have had the pleasure of observing the metamorphosis of women who overcame turbulent histories and lifelong dysfunction to become nurturing parents, and self-sufficient, self-respecting adults.

On the other hand, I am a firm advocate for children; on a daily basis, my work reinforces my awareness of the devastating impact of addiction upon families. Many of the mothers I treat were themselves children of alcoholics and addicts; children who experienced chaos as a normal way of life; children who were passed from one caretaker to another while they waited for their parents to come back; children who grew up to become their parents. It is a sad and chilling recapitulation of pathology. Given a stable home earlier in their childhoods, these women could likely have been spared the neglect and abuse that destroyed their self-esteem, and impaired them as adults.

These issues have plagued families as long as alcohol and other mood altering drugs have existed. With passage in 1997 of the Adoption and Safe Families Act (ASFA), however, the crucible now comes to a boil with unprecedented quickness. This federal law mandates permanency hearings in child protection cases at one year. The strict timelines imposed by ASFA have exacerbated preexisting conflicts of interest among the child welfare, treatment, and legal systems. Lucid and compelling arguments for and against termination emerge from all fronts, and must be fully considered in rendering a fair decision.

So how do you decide? When have parents had sufficient opportunity to demonstrate improvement, and by their conduct merit preservation of their parental rights? Conversely, when is termination of those rights warranted? To answer this question, and to effectively address other issues in permanency decisions, it is essential that you clearly understand the critical factors that determine success or failure of a parent in recovery. Although personal investment in recovery and reunification is key, the parent's motivation is an issue to consider. Individual accountability must be measured within the context of systems, and a conversance with these systems is as fundamental to working with this population as a basic grasp of addiction and the recovery process.

To make effective decisions in these cases, lawyers, judges, social workers, and other child welfare advocates must have a well-informed and realistic sense of how treatment works, and more broadly the myriad forces beyond the individual that significantly influence success or failure in recovery. When it comes to the weighty decision of preserving or dissolving a family, the endeavor to serve the best interests of the children demands a comprehensive and balanced perspective.

This article will:

- illuminate the forces and factors involved in recovery for parents, particularly for women;
- provide a framework for better understanding and evaluating the recovering individual in the context of systems; and
- propose guidelines for effectively dealing with these cases.

Examining these complex issues will enhance your ability to work effectively with these perplexing, infuriating, and occasionally inspiring people.

THE WIDE-ANGLE LENS: THE INDIVIDUAL WITHIN THE SYSTEM

Although substance-abusing parents are responsible for their behavior and decisions, they have little to no control over the operation of the systems involved in their lives, and the interplay between these systems. The efficiency and comprehensiveness of the child welfare, treatment, and legal systems varies considerably from state to state and jurisdiction to jurisdiction. How these agencies and the individuals within them perform directly and profoundly impacts the parent's success or failure in recovery. When the machine is well oiled, the parent's accountability becomes much clearer. Sound infrastructure within systems, and effective collaboration between them, can significantly enhance parents' likelihood of success in reunifying with their families. On the other hand, for a population notorious for externalizing responsibility for their lives, efficient functioning within and between systems ensures that parents are afforded sufficient opportunity to remedy their issues, and limits parents from shifting the blame for failure. Reasonable efforts to support reunification can be thwarted by conflicts of interests between agents involved in these cases, and by service gaps resulting in treatment failures.

From the time parents are first identified as having substance abuse issues that jeopardize the stability of their families, thorough and accurate assessment helps to establish appropriate intervention strategies. Child welfare caseworkers must know about treatment resources, and effectively address issues other than substance abuse, such as domestic violence and homelessness. It is a tall order, as these cases are often already unwieldy by the time the workers become involved. Moreover, some parents may be very invested in their children, but unprepared to address their substance abuse issues. Recovery involves stages of acceptance and moving towards change, and substance abuse treatment may not be the most effective initial approach for parents who remain ambivalent about their addiction. The more appropriate goal in these cases may be to utilize the parents' investment in their children to motivate readiness to change their substance-abusing behaviors. For example, a parenting psycho-educational intervention targeting substance abusers may achieve the dual purpose of improving parenting skills, while helping the parent recognize the destructive impact of her substance abuse on the family.

Within the treatment arena, availability of services is critical, particularly for women. The timeliness and appropriateness of placement depend upon the efficiency of the assessment and referral process, as well as the comprehensiveness and accessibility of treatment options. Waiting lists are frequently unavoidable. While parents in need of services are awaiting placement, caseworkers, lawyers, judges and others involved can reinforce the parents' accountability for their recovery by requiring attendance at local 12-step programs such as Alcoholics Anonymous and Narcotics Anonymous. Parents' compliance with this expectation can provide an early indicator of their motivation level. One way to gauge compliance is to require the parent to obtain and produce a "Where and When" booklet that lists times and locations of meetings. However, recall that investment in family is related to but not dependent upon investment in sobriety, and some parents who are motivated to keep their children may not be ready initially to embrace twelve-step programs.

COLLABORATION

A good working relationship between the treatment provider and other agents involved in the case depends upon regular communication about the parent's progress in treatment. This can be achieved by monthly progress reports submitted by the treatment provider to other parties involved, such as caseworkers, probation officers, lawyers, and judges in cases where the parent is court-ordered into treatment. These monthly reports serve several key purposes: they provide ongoing documentation of the parent's progress in treatment; they reinforce the parent's awareness of the direct potential consequences for noncompliance; and they facilitate timely intervention, such as case conferences attended by outside agents, when a parent falters in treatment.

Treatment efficacy is significantly enhanced when other parties are directly involved; a unified front that is supportive, yet unflinching in holding the parent accountable, increases the leverage of the treatment provider when working with the parent. Addiction impairs the parents' capacity to make connections between actions and consequences, so any measures taken to elucidate the role of cause and effect for the parent can positively impact the recovery process. Denial is a powerful thing, and frequent reality checks help parents accept that their addiction is the root of the unmanageability in their lives.

WORKING TOWARDS REUNIFICATION

Since the initial permanency goal in these cases is generally family reunification, effective collaboration between the treatment provider and the child welfare caseworker in matters involving the children is critical. This becomes especially important in cases where children from one family are in different placements, or in multiple jurisdictions. In such cases, basic logistics like transportation for visitation can become obstacles to progress. A strong alliance between the treatment provider and the caseworker can circumvent these obstacles, and bolster parents' confidence that their service providers support them in the goal of reunification.

Forging this alliance begins by establishing a clear agreement between the service providers about goals and expectations for parents at the outset of treatment. Differing agendas between the service providers can undermine parents' ability to achieve reunification, and create loopholes for parents to attribute blame for noncompliance. The best outcomes in treatment are attained when parents have opportunities to regularly visit with and gradually increase reinvolvement in their children's lives. Parents' level of investment in reunifying with their families can be evaluated by their consistency in following through responsibly with visitation, and other matters involving their children such as court appearances, school-based services for their children, and participation in concurrent permanency planning. However, these parents require emotional support, practical guidance, and often assistance with planning and transportation to fulfill these obligations.

THE STARTING POINT

In reviewing a case, consider when the first point of intervention actually took place. How long has the parent had to come to terms with the addiction, and to follow through with appropriate measures to keep the family intact? For most substance abusing parents, the first point of child welfare intervention occurs well before removal takes place, meaning these parents have had some opportunity before the permanency timeline begins to struggle through denial, and realize the need to invest in recovery. However, in cases where the removal of custody is the first point of systems intervention, the parent experiences a much more tumultuous entry into facing their addiction. For these parents, the clock starts ticking much sooner; this rapid-fire chain of events may jump-start motivation, but also calls for more intensive intervention and support services. For example, if a pregnant woman with no treatment history delivers an infant who tests positive for drugs, in one fell swoop she has provided irrefutable evidence of her addiction that may result in removal of custody. The more catastrophic nature of this entry into the system demands intensive support.

Mothers in these circumstances are more likely to encounter the powerful stigma attributed to addicts. They are often perceived and treated as deplorable, an experience that makes it hard for them to trust their service providers. For these mothers, this is an overwhelming combination of stressors: sudden family disintegration; entanglement with the child welfare system; strident confrontation of the addiction; punitive measures such as criminal charges, and demoralizing value judgments. In cases in which the mother loses custody at birth, first-time mothers and mothers with little to no previous exposure to treatment may reasonably require more time to stabilize after removal than those who have had longer histories of involvement in services.

Most parents are more gradually introduced to the child welfare system. Many parents enter service because their children's behavior signals dysfunction in the family. Children of substance-abusing parents begin to display warning signs that are recognized by their teachers, such as absenteeism; indicators of neglect such as poor health and hygiene; and evidence of emotional, physical, or sexual abuse, and behavior problems in school. Evaluating parents' motivation for reunification includes noting their response to these initial interventions, which generally begin well before removal of custody. At the first point of intervention, it is essential for the parent to be made fully aware of the potential consequences of noncompliance, and to have clear goals and expectations.

FOR WOMEN ONLY

Since these cases most commonly involve the mother as the primary caregiver, it is extremely important to know about issues that uniquely affect women who are substance abusers and parents. For women, alcoholism generally follows a more insidious progression, as women are more likely to be solitary drinkers who drink at home, and go to great lengths to conceal their alcoholism. They tend to progress

further in their alcoholism before they begin to exhibit overt manifestations of their impairment, such as driving violations, which more commonly result in earlier interventions for men. For this reason, women are often initially identified with alcohol-related problems at later stages of their alcoholism then men, and may require more intensive interventions.

Involvement in abusive and dysfunctional relationships with men who are also substance abusers is a core issue for women, further complicated by the fact that these men are often the fathers of their children. The course of treatment and recovery heavily centers upon the development of healthier boundaries in relationships. For women in early recovery, difficulty disengaging from partners who do not support their recovery poses a serious risk factor for relapse. When these men are also the fathers of their children, the relationship becomes a tie that binds. Even if the mother reaches the point of making a healthy decision to end the relationship as a couple, she faces the difficult task of maintaining a functional relationship as parents only, without simultaneously jeopardizing her recovery. This area represents a tremendous pitfall for substance-abusing mothers.

Women commonly have serious clinical issues other than substance abuse that more fully emerge after they achieve sobriety, such as histories of sexual abuse, dual diagnosis with mental illnesses such as depression, and extremely low self-esteem. Additionally, the responsibility of being a single parent is daunting even for women who are not impaired, and overwhelming for women in early recovery who are in the beginning stages of establishing self-sufficiency. Economic hardships and the shortage of affordable housing further hinder these women in their journey towards stability as working single parents; for those with limited educations and poor employment histories, the challenge of supporting a family on a minimum wage job is burdensome.

Child care is a prominent issue for most parents, and even more so for substance-abusing moms whose families of origin are dysfunctional, and therefore inappropriate as care providers. Their cases are compounded by the fact that their children generally have significant needs such as health, behavioral, and emotional problems, further taxing their already limited resources as parents. The realization that the problems experienced by their children frequently result from their addiction deepens the shame and guilt experienced by these women. These potent stress factors culminate in rendering these women more vulnerable to relapse.

For a new mother, postpartum depression is a real and potentially devastating condition that further compromises the woman's ability to manage the stress of struggling through early recovery. Additionally, pregnant women who are dually diagnosed with mental illness have fewer options for psychoactive medications due to the risks of birth defects, and may decompensate as a result of necessary changes in their psychiatric medication regimen. These women require more intensive support in attaining emotional stability.

In residential treatment, women tend to have poorer outcomes than men in coed settings. Women often require a more nurturing approach than is usually provided in traditional programs designed for men. Additionally, there are few residential treatment programs that admit mothers with a child, or retain a pregnant woman after she delivers her infant. This becomes a serious obstacle to treatment for women who lack appropriate kinship care options for their children while they participate in residential treatment, and refuse to consider placing their children in foster care for fear of losing custody. The "fear factor" also inhibits some women from seeking services in the first place due to the viable concern that disclosing their substance abuse will result in losing their children. These women may be aware of their need for services, but persist in attempting to manage on their own until they are in crisis, or become so conspicuously impaired that they demand intervention.

Mothers in early recovery face multiple issues that can hinder their progress and undermine their recovery. They require a comprehensive assessment of their needs, and a well-integrated approach that adequately addresses these issues. To be effective for these women, treatment interventions must incorporate stress management, relapse prevention, parenting education, and intensive work on developing healthy relationships, as these elements are fundamental for success.

MANAGING RELAPSE AND NONCOMPLIANCE

The dilemma for professionals working with these cases is that they are rarely clear-cut. Cases in which the parent shows little to no motivation or

possesses no redeeming qualities spark relatively little controversy in deciding whether to terminate parental rights, and are also relatively uncommon. Most cases are not black and white, and almost always involve shades of gray. Despite efforts to intervene effectively and appropriately, few cases are free from regression and relapse. The natural progression of recovery is two steps forward, and inevitably one step back. This population is maddeningly inconsistent, characterized by sporadic compliance and emotionality, and fraught with complicating factors. It is vitally important to recognize, however, that alcoholics and addicts are often capable of overcoming relapse and successfully achieving sobriety. Maintaining long-term sobriety depends upon the parent's ability to recognize relapse warning signs, and develop effective strategies for protecting their recovery. Regressions and episodes of relapse that occur in treatment should not necessarily be viewed as a total disaster; to the contrary, encountering these setbacks in a supportive environment can be an invaluable learning experience for the parent.

The progression towards relapse is usually behaviorally apparent to the treatment provider before the actual physical relapse, and requires swift and decisive intervention. Blunt restatement of the potential consequences for noncompliance, particularly when provided directly by the agents responsible for enforcing them, such as caseworkers and probation officers, may restore the parent's investment in their recovery. When all else fails, and resistant parents relapse repeatedly, the most appropriate treatment goal may become helping them come to terms with the reality that adoption may, indeed, be in the best interest of their children.

CONCLUSION

The challenge of making permanency decisions when the parent is a substance abuser can be surmounted by attaining a balanced and well-informed perspective of the multiple factors that determine success. A comprehensive and objective understanding of the individual, in the context of systems, can maximize the likelihood of rendering a fair and impartial decision.

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