Families Affected by Methamphetamine and other Substances:

How Collaboration Can Lead to Better Outcomes

Cathleen Otero, MSW, MPA
National Center on Substance Abuse and Child Welfare
A Program of the
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
and the
Administration on Children, Youth and Families
Children’s Bureau
Office on Child Abuse and Neglect
To improve outcomes for families by promoting effective practice, and organizational and system changes at the local, state, and national levels.

- Developing and implementing a comprehensive program of information gathering and dissemination
- Providing technical assistance
Overview
Spectrum of Addiction

A Problem for Child Welfare and Court Officers: The most frequently used marker of substance abuse problems in child welfare and family court does not tell you anything about the individual’s place on the spectrum.
Children Living with One or More Substance-Abusing Parent

1,000,000 CA Children Living With Parent
About 83,000 are in Out-of-Home Care for Child Abuse/Neglect

- Used Illicit Drug in Past Year: 10.6
- Used Illicit Drug in Past Month: 8.4
- Dependent on Alcohol and/or Needs Treatment for Illicit Drugs: 8.3
- Dependent on AOD: 7.5
- Dependent on Alcohol: 6.2
- Dependent on Illicit Drugs: 2.8
- Need Treatment for Illicit Drug Abuse: 4.5

Numbers indicate millions
The Five Clocks

1. Adoption and Safe Families Act (ASFA)
   - 12 Months Permanent Plan
   - 15 Months out of 22 in Out of Home Care
   Must Petition for TPR

2. Recovery
   - One Day at a Time for the Rest of Your Life

3. Child Development
   - Clock doesn’t stop
   - Moves at Fastest Rate from Prenatal to Age 5
The Five Clocks

Temporary Assistance for Needy Families (TANF)

- 24 Months Work Participation
- 60 Month Lifetime
- Reauthorization in December 2005
- Stricter work requirements for FY 2007
  - 50% of single parent families must meet work requirements
  - 90% of two parent families must meet work requirements
- New treatment provision

The Fifth Clock: How quickly will we put the pieces together?
Use Patterns
Scope of the Problem

• Meth use increased
  – In recent years, new users have decreased and treatment admissions have increased

• Accounts for a small percentage of the total number of people affected by drug and alcohol problems

• The impact of meth use on child welfare varies widely among States and among Counties
Ways to Look at the Data

• New users
  – Those that initiate substance use in a given year; monitor to estimate future problems

• Persons who meet criteria for substance abuse or dependence
  – Began to experience consequences and problems and need treatment

• Persons who were admitted to treatment
  – Those that met abuse/dependence criteria and were admitted to publicly funded treatment programs
Trends in Past Year Initiation of Methamphetamine Use

Among Persons Aged 12 or Older, by Gender: 2002-2005

Source: SAMHSA, OAS (2007)
Trends in Past Year Meth Use Among Persons Aged 12 or older, by Gender: Percentages, 2002-2005

Source: SAMHSA, OAS (2007)
The percentage of current methamphetamine users who met criteria for substance abuse or dependence doubled between 2002 (27.5%) and 2004 (59.3%), but then declined slightly (50.2%) in 2005.
## Treatment Admissions by Selected Primary Substance: 2002 – 2005

<table>
<thead>
<tr>
<th>Primary Substance</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>42.8%</td>
<td>41.5%</td>
<td>40.2%</td>
<td>39.2%</td>
</tr>
<tr>
<td>Heroin/Opiates</td>
<td>17.5%</td>
<td>17.6%</td>
<td>17.6%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>15.2%</td>
<td>15.5%</td>
<td>15.9%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12.9%</td>
<td>13.6%</td>
<td>13.7%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Stimulants*</td>
<td>6.7%</td>
<td>7.4%</td>
<td>8.1%</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

* Includes methamphetamine, amphetamine and other stimulants

Meth/Amphetamine Treatment Admission Rate
Per 100,000 Population Aged 12 or Older - 1994-2004

Meth/Amphetamine Admissions

By Gender - 2004

Source: Online analysis using Treatment Episode Data Set (TEDS) 1992-2004 Public Use File
Trends in Primary Substance Use
Treatment Admissions for **Pregnant Females** by Primary Substance 1994-2004

Percent of Pregnant Women’s Admissions for **Meth/Amphetamine** and **Marijuana** More than Doubled over 10 Years

Source: Analysis of Treatment Episode Data Set (TEDS) Computer File
Risks to Children When Parents Use Methamphetamine
Different Situations for Children

- Parent uses or abuses methamphetamine
- Parent is dependent on methamphetamine
- Parent “cooks” small quantities of meth
- Parent involved in trafficking
- Parent involved in super lab
- Mother uses meth while pregnant

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Different Situations for Children

- Each situation poses different risks and requires different responses
- Child welfare workers need to know the different responses required
- Relatively few parents “cook” the drug
- The greatest number of children are exposed through a parent who uses or is dependent on the drug

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Parent Uses or Abuses Meth

Risks to safety and well-being of children:

- Parental behavior under the influence: poor judgment, confusion, irritability, paranoia, violence
- Inadequate supervision
- Inconsistent parenting
- Chaotic home life
- Exposure to second-hand smoke
- Accidental ingestion of drug
- Possibility of abuse
- HIV exposure from needle use by parent

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Parent Is Dependent on Meth

Risks to safety and well-being of children:

- All the risks of parents who use or abuse, but the child may be exposed more often and for longer periods
- Chronic neglect is more likely
- Household may lack food, water, utilities
- Chaotic home life
- Children may lack medical care, dental care, immunizations
- Greater risk of abuse
- Greater risk of sexual abuse if parent has multiple partners

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Parent “Cooks”
Small Quantities of Meth

- All the risks of parents who use or are dependent on meth, with added risks of manufacturing the drug:
  - Chemical exposure
  - Toxic fumes
  - Risk of fire and explosion

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Environmental Methamphetamine Exposure and Risks

- Toxic effects of manufacturing
- Children more at risk:
  - Higher metabolic rates
  - Developing bone and nervous systems
  - Thinner skin than adults which absorbs chemicals faster
  - Children tend to put things in their mouth and use touch to explore

Source: Mason (2004)
Parent Involved in Trafficking

- Presence of weapons
- Possibility of violence
- Possibility of physical or sexual abuse by persons visiting the household

Parent Involved in Super Lab

- Lower likelihood of children on the site

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Multidisciplinary DEC TEAMS

- Medical and Mental Health Services
- Child Protective Services
- Law Enforcement
- Public Safety
- Prosecution
Medical Interventions for Children

- Field medical assessment
- Immediate care protocol
- Baseline assessment protocol
- Initial follow-up care protocol
- Long-term follow-up care protocol

Source: Colorado DEC
Mother Uses While Pregnant

- Scope of the problem:
  - An estimated 10% to 11% of all newborns are prenatally exposed to drugs or alcohol; this amounts to 400,000 to 480,000 newborns per year nationally
  - Only about 5% of prenatally exposed newborns are placed in out-of-home care; the rest go home without assessment and services

Sources: Vega; SAMHSA, OAS, National Survey of Alcohol and Drug Use During Pregnancy, 2002 and 2003
Mother Uses Meth While Pregnant

- Risk to child depends on frequency and intensity of use, and the stage of pregnancy
- Risks include birth defects, growth retardation, premature birth, low birth weight, brain lesions
- Problems at birth may include difficulty sucking and swallowing, hypersensitivity to touch, excessive muscle tension (hypertonia)
- Long term risks may include developmental disorders, cognitive deficits, learning disabilities, poor social adjustment, language deficits

Sources: Anglin et al. (2000); Oro & Dixon, (1987); Rawson & Anglin (1999); Dixon & Bejar (1989); Smith et al. (2003); Shah (2002)
Substance Abuse Pattern of Pregnant Methamphetamine Users

- Women who use meth/cocaine in the first trimester are more likely to use during the third trimester
- Nicotine use is universal among drug-using pregnant women
- Marijuana and alcohol are secondary drugs, used in 60% of the group

Source: Dr. Rizwan Shah, presented at NASADAD Annual Meeting, June 2005
Mother Uses Meth While Pregnant

- Observed effects may be due to other substances, or combination of substances, used by the mother
  - For example, if the mother also smokes, growth retardation may be significant
- Observed effects may be complicated by other conditions, such as the health, environmental, or nutritional status of the mother

Source: Nancy Young, Ph.D., Testimony before the U.S. House of Representatives Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, July 26, 2005
Mother Uses While Pregnant

• Home environment is the critical factor in the child’s outcome

• Consequences can be mediated
Treatment for Methamphetamine
Food:

- NAc shell
- % of Basal DA Output
- Time (min)
- Source: Di Chiara et al.

Sex:

- DA Concentration (% Baseline)
- Copulation Frequency
- Sample Number
- Source: Fiorino and Phillips

Natural Rewards Elevate Dopamine Levels
Effects of Drugs on Dopamine Levels

**MORPHINE**

Dose (mg/kg):
- 0.5
- 1.0
- 2.5
- 10

**NICOTINE**

Dose (mg/kg):
- Accumbens
- Caudate

**COCOAINE**

Diseases:
- DA
- DOPAC
- HVA

**AMPHETAMINE**

Diseases:
- DA
- DOPAC
- HVA

Source: Di Chiara and Imperato
Average Age First Use of Substance

- 13 yrs old: Alcohol, Tobacco, Marijuana
- 15 yrs old: Downers, Hallucinogens, Inhalants
- 17 yrs old: PCP, Cocaine, Methamphetamine
- 19 yrs old: Ecstasy, Opiates, Tranquilizers
- 21 yrs old: Crack

97-100% have used
Over 50% have used
Less than 50% have used

Source: M.L. Brecht, Ph.D., presented at NASADAD Annual Meeting, June 2005
Histories of Violence among Clients Treated for Methamphetamine

- Persons in treatment for methamphetamine reported high rates of violence
  - 85% women vs. 69% men
- The most common source of violence:
  - For women, was a partner (80%)
  - For men, was strangers (43%)
- History of sexual abuse and violence:
  - 57% women vs. 16% men

Prevalence of Co-Occurring Problems, and Violence and Trauma

- Women in treatment 2 times more likely to have history of sexual and physical abuse than general population
- Women who are dependent on meth usually have more severe problems than their male counterparts in many areas of their life
- Speaks to the need for comprehensive, and trauma-related services

Source: CSAT TIP 36
Self-Reported Reasons for Starting Methamphetamine Use by Gender

*p<.001

To lose weight

Male
Female

To relieve depression
Behavior Symptom Inventory (BSI) Scores at Baseline by Gender

- Scores were statistically significant at p < .001 for all categories.
- The categories include: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism.

Richard Rawson, Ph.D., Presentation to SAMHSA, August 2005
Abuse During Lifetime from a Women’s Treatment Population

**Emotional Abuse**
- % Women: 84
- % Men: 62

**Physical Abuse***
- % Women: 64
- % Men: 36

**Sexual Abuse***
- % Women: 29
- % Men: 7

*** significant difference between women and men p < .001

Judith Cohen, Ph.D. Presentation to NASADAD June 2005
## Age That Physical Violence Began

<table>
<thead>
<tr>
<th>Ages</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total reports of violence</td>
<td>365</td>
<td>324</td>
</tr>
<tr>
<td>Percent of total N</td>
<td>70%</td>
<td>80%</td>
</tr>
<tr>
<td>Began between 1 and 10 years of age</td>
<td>158</td>
<td>135</td>
</tr>
<tr>
<td>Began between 11 and 18 years of age</td>
<td>207</td>
<td>189</td>
</tr>
</tbody>
</table>
## Age That Sexual Abuse Began

<table>
<thead>
<tr>
<th>Ages</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total reports of sexual abuse</td>
<td>307</td>
<td>58</td>
</tr>
<tr>
<td>Percent of total N</td>
<td>56%</td>
<td>14%</td>
</tr>
<tr>
<td>Began between 1 and 10 years of age</td>
<td>134</td>
<td>34</td>
</tr>
<tr>
<td>Began between 11 and 18 years of age</td>
<td>173</td>
<td>24</td>
</tr>
</tbody>
</table>

Judith Cohen, Ph.D. Presentation to NASADAD June 2005
Gender Differences and Implications for Treatment

- Co-occurring mental health issues complicate treatment and require longer duration for treatment.
- Violence linked to meth use is related to trauma and safety needs which must be addressed in treatment.
- Body image and nutrition need to be addressed.
Gender Differences and Implications for Treatment

- Threats of violence and reduced cognitive capacity to manage activities of daily living suggest that a period of residential treatment or referral to safe houses or supervised housing may be indicated.

- Intensive outpatient treatment should be coupled with additional supports such as transportation, meals, child care.

- Gender specific treatment is indicated given women’s histories of trauma and violence.
CSAT’s Methamphetamine Treatment Project

- Largest randomized clinical trial of treatment for meth dependence
- Compared the MATRIX manualized treatment model developed at UCLA to treatment as usual
- 8 study sites; site in HI was all women
Matrix Model

- Intensive outpatient setting
- Three to five visits per week of comprehensive counseling for at least the first three months
- Cognitive behavioral approach
- Contingency management
Similar Outcomes

- Treatment outcomes do not differ from other drugs of abuse
- Treatment outcomes have more to do with the quantity and quality of treatment than type of drug abused
Cognitive Effects

- Rate of recovery is associated with severity of abuse and days of abstinence.
- Study documented significant recovery with Meth abusers who were able to stay drug free for at least 9 months.
- After 4 years of abstinence, no deficits in:
  - Memory
  - Learning
  - Attention
  - Executive function
  - Motor function

Sources: Lundahl et al. (2004); Volkow et al. (2001)
Use, Addiction and Recovery can be Seen in the Brain
What Predicts Longer Abstinence?

Longer abstinence following treatment for women with:

- Longer time in treatment (e.g. those with 4 or more mo. of treatment have more than double the rate of 24-48 mo. abstinence)
- More sessions per month of individual counseling
- Treatment, intervention and case planning need to account for short-term effects, especially cognitive deficits and verbal communication
- Drug Court involvement
- Family involvement

M.L. Brecht, Ph.D., et al. (2005)
Compliance with Medical Treatment

**Insulin Dependent Diabetics**
- Compliant with medication: < 50%
- Compliant with diet and foot care: < 30%
- Retreated in 12 months: 30 - 50%

**Hypertensives**
- Compliant with medication: < 30%
- Compliant with diet: < 30%
- Retreated in 12 months: 50 - 60%
Compliance with Medical Treatment

> 50% of "re-occurrence" was due to lack of compliance

> 50% of medical patients lie about compliance
Reasons for Disease Re-Occurrence

#1 - Lack of Compliance
#2 - Socioeconomic Factors
#3 - Family Support
#4 - Psychiatric Co-morbidity

AOD Treatment - Predictors of Outcome
Employment
Family Support
Psychiatric Status
Continuum of Care

Prevention

Intervention

Assessment

Treatment

Maintenance
Treatment Levels of Care

Outpatient
- Organized non-residential services

Intensive Outpatient
- A structured day or evening program

Residential/Inpatient
- Residential settings designed to achieve stability and foster recovery skills

Medically Managed Intensive Inpatient
- 24-hour care in a medically managed setting
Treatment Effectiveness

- Research has shown that drug abuse treatment is both effective and cost effective in reducing not only drug consumption but also the associated health and social consequences...

- Treatment gains are typically found in reduced intravenous and other drug use, reduced criminality, and enhanced health and productivity (IOM 1996).
Components of Comprehensive Drug Addiction Treatment

- Family Services
- Child Care Services
- Vocational Services
- Intake Processing/Accessment
- Behavioral Therapy and Counseling
- Treatment Plan
- Substance Use Monitoring
- Clinical and Case Management
- Pharmacotherapy
- Self-Help/Peer Support Groups
- Continuing Care
- Financial Services
- Medical Services
- Legal Services
- Educational Services
- AIDS/HIV Services
Principles of Effective Drug Treatment

- No single treatment appropriate for all
- Is readily accessible
- Attends to multiple needs of the individual
- Modifies treatment regimen as needed
- Ensures adequate time in treatment
- Includes both counseling and other behavioral therapies
- Includes medications as important elements
- Treats coexisting mental disorders in an integrated way
Principles of Effective Drug Treatment

- Views medical detoxification as only a first stage of treatment that does little to change long-term drug use.
- Does not need to be voluntary to be effective.
- Continuously monitors drug use during treatment.
- Provides assessment for infectious diseases.
- Recognizes recovery can be a long-term process that frequently requires multiple episodes of treatment.
Models and Evaluations from Across the Country
Mid to late 1990s – Practice Models

- Many communities began program models
  - Paired Counselor and Child Welfare Worker
  - Counselor Out-stationed at Child Welfare Office
  - Multidisciplinary Teams for Joint Case Planning
  - Persons in Recovery act as Advocates for Parents
  - Family Treatment Courts
  - Training and Curricula Development
Substance Abuse Title IV-E Waiver Project Evaluations

- Focused on early identification of parental substance use disorders and service referrals
  - Delaware – co-located staff
  - Maryland – Family Support Service Teams
  - New Hampshire – CD contracted staff on-site
- Emphasized the recovery of caregivers not yet in treatment but whose children had already been removed
  - Illinois – Recovery Coaches
Substance Abuse Title IV-E Waiver Project Evaluations

• Challenges
  • Referrals and enrollment
  • Inadequate worker training and education and staff turnover
    • Training, tools and appropriate interventions
  • Service coordination, strong managerial support, and consistent cross-system communication
  • Information tracking systems
Substance Abuse Title IV-E Waiver Project Evaluations

• Challenges
  – Permanency and reunification outcomes were more difficult to affect than treatment access, engagement and retention outcomes
  – Differences in system management styles and professional philosophies
  – Improved identification must be accompanied by access to adequate and appropriate substance abuse treatment resources
Successes

- Illinois had the highest success in connecting parents to treatment (73% vs. 50%)
- Delaware CPS units in which supervisors took an active role in reviewing cases and in directly referring cases to substance abuse counselors had the smoothest, most consistent referral process.
- Delaware and Illinois demonstrated positive effects on length of time in foster care placement
Models of Family Treatment Courts

**Integrated** (e.g., Santa Clara, Reno, Suffolk)
Both dependency matters and recovery management conducted in same court with the same judicial officer

**Dual Track** (e.g., San Diego)
Dependency matters and recovery management conducted in same court with same judicial officer *during initial phase*
If parent is noncompliant, case may be transferred to a specialized recovery management judicial officer

**Parallel** (e.g., Sacramento)
Dependency matters heard on regular family court docket
Specialized court services offered before noncompliance
Compliance reviews and recovery management heard by a specialized court officer
Common Ingredients of Family Treatment Courts

- System of identifying families
- Earlier access to assessment and treatment services
- Increased management of recovery services and compliance
- System of incentives and sanctions
- Increased judicial oversight
FTDC Evaluation – NPC

Implications

- **IF** time to FTDC entry and time to treatment entry meant increased likelihood of FTDC graduation, longer treatment stays and treatment completion

- **AND** FTDC graduation, longer stays in treatment, and treatment completion meant more likely to reunify and less likely to TPR

- **THEN** engagement and retention of parents in FTDC and treatment is critical
Sacramento County Dependency Drug Court Evaluation Findings
Sacramento County Initiatives

- Comprehensive cross-system joint training
- Improvements to county data system and cross-system information
- Priority for CPS parents for access to treatment
- Early Intervention Specialists
  - Immediate access to intervention and assessment at the court hearings
Sacramento County Initiatives

• STARS
  – Motivational enhancement
  – Immediate access to recovery management and treatment services
  – Compliance monitoring—Twice monthlies

• Dependency Drug Court
  – 30, 60 and 90-day compliance hearings
  – Structured incentives for compliance and sanctions for non-compliance
  – Voluntary participation in on-going services
Sacramento County Dependency Drug Court Model

Jurisdiction & Disposition Hearings

Level 1 DDC Hearings
- 30 Days
- 60 Days
- 90 Days

Level 2 Weekly or Bi-Weekly Hearings
- 180 Days

Level 3 Monthly Hearings
- 180 Days Graduation

Child in Custody → Detention Hearing → Jurisdiction & Disposition Hearings → Early Intervention Specialist (EIS) Assessment & Referral to STARS → Court Ordered to STARS & 90 Days of DDC → STARS Voluntary Participation → STARS Court Ordered Participation
Primary Drug Problem by Gender

![Bar chart showing the percentage of men and women with primary drug problems for different substances: Heroin (2.9% men, 2.5% women), Alcohol (22.6% men, 15.2% women), Methamphetamine (49.0% men, 51.6% women), Cocaine (6.4% men, 11.5% women), Marijuana (18.5% men, 16.8% women).](https://example.com/chart)

*p<.05; **p<.01
Baseline Characteristics with Significant Gender Difference

- Unemployed***: 72.0% (Men), 87.8% (Women)
- Less than a High School Education**: 40.4% (Men), 48.5% (Women)
- Disability Impairment***: 23.2% (Men), 33.6% (Women)
- Chronic Mental Illness***: 13.1% (Men), 35.8% (Women)
- Homeless***: 35.7% (Men), 46.9% (Women)

**p<.01; ***p<.001
Treatment Admission Rates***

<table>
<thead>
<tr>
<th></th>
<th>Comparison (n=111)</th>
<th>DDC (n=1738)</th>
</tr>
</thead>
<tbody>
<tr>
<td>53.2</td>
<td>84.8</td>
<td></td>
</tr>
</tbody>
</table>

***p<.001
Treatment Discharge Status by Primary Drug Problem

***p<.001
24-Month Child Placement Outcomes by Parent Primary Drug Problem

* p < .05
Total Time in Out of Home Care

- Comparison: 33.1 months
- Court Ordered: 21.6 months
Time in Out of Home Care by Parent’s Primary Drug Problem

- Heroin: 23.7 months
- Alcohol: 25.1 months
- Methamphetamine: 20.2 months
- Cocaine/Crack: 20.3 months
- Marijuana: 19.0 months
24-Month Cost Savings Due to Increased Reunification Rates

- Takes into account the reunification rates, time of out-of-home care, time to reunification, and cost per month

- 27.2% - Reunification rate for comparison group children
- 42.0% - Reunification rate for court-ordered DDC children
- 128 Additional DDC children reunified

- 33.1 – Average months in out-of-home care for comparison group children
- 9.4 - Average months to reunification for court-ordered DDC children
- 23.7 month differential

❖ $5,823,208 Estimated Savings in Out-of-Home care costs
For Further Information
Recent NCSACW Products

- **Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)**
  - Provides screening and assessment tools
  - Includes guidelines for communication and collaboration across the systems responsible for helping families

Order your free copy now
SAFERR is based on the premise that when parents misuse substances and maltreat their children, the best way to make sound decisions is to draw from the talents and resources of at least three systems: child welfare, alcohol and drugs, and the courts.
Principles

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

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

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

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

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

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

1. The team is the tool, and people, not tools, make decisions
2. The family is the focus of concern
3. Problems don’t come in discrete packages; they are jumbled together
4. Assessment is not a one-person responsibility
Premises

5. Information is limited, and there is no research-based answer

6. There is no time to lose

7. ICWA creates specific guidelines for working with American Indian populations

8. Developing and sustaining effective collaborations is hard work
Organization of SAFERR

I. Building Cross-System Collaboration
   Creating the structure to create and sustain change

II. Collaboration Within and Across Systems
   What each system needs to know about itself and its partners

III. Collaboration in Action: Working Together on the Front Line
   Presents activities that create cross-system practice changes
Organization of SAFERR

A. Facilitator’s Guide
   - Templates and exercises
B. Fact Sheets
   - To educate administrators, legislators and stakeholders about the initiative
C. Understanding the Needs of Children
D. Screening and Assessment Tools for Substance Use Disorders
Organization of SAFERR Appendices

E. Substance Use, Abuse, Dependence Continuum, and Principles of Effective Treatment
F. Safety and Risk Assessments for Use by Child Welfare Staff
G. Sharing Confidential Information
H. Glossary of Terms
I. Guide to Compliance with the Indian Child Welfare Act (ICWA)
Recent NCSACW Products

• On-Line Training – **Now Available**

• **Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers**
  – Includes a Methamphetamine Resource List