PERSPECTIVES ON HEALTH RISKS TO CHILDREN AND ADOLESCENTS IN METHAMPHETAMINE HOMES

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A Thesis

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by

Kathleen Marie Moran

Spring 2011

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LIST OF ACRONYMS

ACRONYMS

BCMSF	Butte County Methamphetamine Strike Force
CA DoJ	California Department of Justice
CADEC	California Alliance for Drug Endangered Children
CAN	University of California, Davis Child Abuse and Neglect Conference
CASA	The National Center on Addiction and Substance Abuse at Columbia University
CASA	Court Appointed Special Advocate
CDRT	Child Death Review Team
CPS	Children's Protective Services
CSD	Children's Services Division
CVPC	Crime and Violence Prevention Center
DEA	United States Drug Enforcement Administration
DEC	Drug Endangered Children
DoJ	United States Department of Justice
EOP	Executive Office of the President
LRM	Life Recovery Ministries
NACo	National Association of Counties
NCSL	National Conference of State Legislatures

ACRONYMS

NDIC	National Drug Intelligence Center (U.S. Department of Justice)
NIDA	National Institute on Drug Abuse
OCOPS	Office of Community Oriented Policing Services
ONDCP	Office of National Drug Control Policy
SAMHSA	Substance Abuse and Mental Health Services Administration
SCDRC	State Child Death Review Council

ABSTRACT

PERSPECTIVES ON HEALTH RISKS TO CHILDREN AND ADOLESCENTS IN METHAMPHETAMINE HOMES

by

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California's North State has been hit particularly hard by the meth epidemic. This thesis explores how methamphetamine (meth) production and use have evolved in the United States, and how that has impacted the health, wellbeing, and economic status of the population. It also details an emerging collaborative multidisciplinary approach involving aspects of treatment, prevention, and law enforcement programs targeting meth abuse. Special attention is paid to programs within the collaboration designed to mitigate the health risks to children and adolescents living in methamphetamine homes. Anthropology has a long history of studying drug use. However, in ten pages of a 2002 editorial reflection, covering 35 years in the drug field, Michael Agar does not mention methamphetamine at all. In fact, beyond needle sharing and HIV/AIDS and discussions about using an agent-based model to understand drug epidemics in general,

anthropology seems particularly quiet on meth addicts in the United States. They seem even quieter when it comes to the children of meth addicts. The focus is on risk reduction for addicts, not the children of addicts. While there is broad debate on the use of needle exchange programs and methadone use in treatment programs, there is no real debate in anthropology on how the children of meth addicts, raised in a sub-culture of violence and paranoia, will grow up and help shape the society we live in. This thesis was written to help fill the research gap involving children and adolescents in meth environments.

CHAPTER I

METH

Introduction

California's North State has been hit particularly hard by the meth epidemic. This thesis explores how methamphetamine (meth) production and use have evolved in the United States, and how that has impacted the health, wellbeing, and economic status of the population, particularly in California's North State. It also details an emerging collaborative multidisciplinary approach involving aspects of treatment, prevention, and law enforcement programs targeting meth abuse in the United States. Special attention is paid to programs within the collaboration designed to mitigate the health risks to children and adolescents living in methamphetamine homes.

The focus on children and adolescents found in meth homes is recent. The manufacture of meth was previously viewed as a victimless crime. Children were not treated for exposure to meth, and little effort was made to ensure their safety during and after lab raids. As this thesis shows, that attitude has changed (Swetlow 2003:1). Agencies, such as the United States Department of Justice, now instruct personnel involved in meth lab seizures to work with qualified professionals, to ensure children are safely taken into protective custody, and that they receive necessary medical care. Children are tested for drug exposure and they are interviewed as witnesses (Swetlow 2003:1-2).

Previously, the objective was to simply arrest drug addicts. The children of addicts were ignored. The real interest of the "war on drugs" focused on the drugs, the money, the weapons, and the chemicals. Either through the nature of the drug, or by timing, perhaps a little of both, the meth epidemic has changed some of the focus of the "war on drugs" from eradication, to intervention. As a society, we have moved through the drug policies of the late 1970s and the Reagan and Clinton eras, to policy shifts that consider different, and sometimes innovative, treatment options that might keep family units whole, and integrate users back into the general populace (as discussed by Agar 2002; Brown 2008; Taylor 2008; Webber-Brown and Hirsch 2008; and others).

An important feature of any culture is its collective values. Those values include, the distinction between right and wrong, what is important, or should be viewed collectively as important, customs, child-rearing practices; the sense of collective identity. Collectively, the meth sub-culture values silence, autonomy, violence as a solution to problems, hyper-sexual activity, money, and participation within the drug community (Brown 2008; Taylor 2008; Webber-Brown and Hirsch 2008; CA DoJ, Meth Trilogy, Video, 51 minutes, 2007).

The meth sub-culture revolves around the manufacture, distribution, and use of illicit methamphetamine. Members of the sub-culture have shared, learned values, traits and behavior. Chapter three includes information how adults in the meth sub-culture pass these on to their children. The meth sub-culture has defined forms of communication, and a unique language. The sub-culture is mutually constructed and changes over time. For instance, chapter two of this thesis details how meth "cooks" throughout the country change and adapt methods almost simultaneously, in response to

societal efforts to shut down labs. There is a sense of community in the context that those who are part of the drug trade have an established place within it.

The people within the sub-culture are influenced by, and adapt to, the cycle of supply and demand for meth. The sub-culture evolves as the members of the dominant culture, mainstream America, act to cut off the supply of the finished drug and the precursors used to manufacture meth (Frontline, The Meth Epidemic, DVD, February 14, 2006; Suo 2004b; Piccini 2010). The resulting battle over access to meth and the precursors has changed how a significant number of professionals perform their work duties. In this way, mainstream America and the meth sub-culture respond and adapt to one another.

Meth has altered the economy. It has changed how society views addicts and addiction. And it has changed how society views the children of addicts. Professionals have begun to ask how children brought up in meth homes develop, and how those children will impact society if they grow up within the meth sub-culture, and without effective intervention. This thesis explores how the values of this sub-culture affect the children raised with those values. It asks if those children, the ones who survive the extreme health risks inherent within the meth sub-culture, can grow up to become productive members of society through effective intervention.

A Brief History of Methamphetamine

Meth, an amphetamine derivative, is a highly addictive and destructive, man-made stimulant, that affects the central nervous system. The manufacture and abuse of meth have significantly altered the landscape of the country, creating a climate with

greater health risks, escalating violence, and significantly higher death rates (as discussed in NIDA 2006; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; CA DoJ, Meth Trilogy, Video, 51 minutes, 2007; and others). However, this climate was not created overnight. It evolved over the course of about a century.

In general, there is agreement on how the methamphetamine epidemic evolved (e.g. Grant 2008; Justine Hunt, American Meth, DVD, 75 minutes 2007; Maki 2006; and the Vermont Department of Health 2005) (http://healthvermont.gov/adap/meth/brief_history.aspx). The only disagreement appears to be regarding when meth was first developed, and by whom. Most experts and reference materials consulted for this thesis maintain that Lazar Edeleanu synthesized amphetamine in Germany in 1887, and that a Japanese chemist, Akira Ogata, then developed the derivative methamphetamine in 1919. Akihiko Sato (2008:718) maintains that Nagayoshi Nagai was an assistant to August Wilhelm von Hofmann at Humboldt University, Berlin. Nagai then discovered ephedrine in Japan, in 1885, a year after he left Germany. He then discovered methamphetamine in 1888. Whatever the origin of meth, it has been described as a drug in search of a disease, since, unlike most drugs, it was not developed in response to a particular medical need.

According to multiple experts (e.g. Sato 2008; Maki 2006; and the Vermont Department of Health 2005) use of amphetamine compounds were common in the United States by the end of the 1930s. In 1932 an amphetamine based nasal spray, Benzedrine, was used to treat asthma and rhinitis. In 1937 doctors began using amphetamine tablets to treat narcolepsy. In the 1940s bomber pilots and soldiers from the United States, Great Britain, Japan, and Germany used amphetamine and methamphetamine products to

maintain alertness. The first recorded methamphetamine epidemic was in post war Japan. From there the epidemic spread through Guam, the U.S. Marshall Islands, and then to the United States by way of Hawaii and the West Coast. By the end of the 1950s a large cross section of the U.S. population, including housewives, truckers, college students, and athletes were using "pep pills" or "bennies" (dextro-amphetamine hydrochlorine tablets, common trade name: Dexedrine) for non-medical purposes. An excerpt from an April 11, 1958 (201-202) United States Department of Justice, United States Attorney's Bulletin, details a case involving a physician who violated the provisions of the Food, Drug, and Cosmetic Act that prohibit the dispensing of dangerous drugs without a prescription. On January 3, 1958, Thomas Guy Brown was indicted in the District Court for the Northern District of Texas for unlawfully distributing large quantities of "pep pills".

Despite growing concern regarding meth and amphetamine abuse in Japan and amphetamine abuse in the United States, during the 1950s Benzedrine was still widely used throughout the United States to treat narcolepsy and sinus inflammation, and methamphetamine (e.g., Methedrine and Obedrin-LA tablets) was heavily marketed to American housewives as a way to stay happy, slim, and energized while taking care of the household (Maki 2006). "Diseases" had been found for methamphetamine to cure: housework, eating, and sleep. Methamphetamine is still legally prescribed in the United States for narcolepsy, attention deficit disorder, and for the short-term treatment of obesity (NIDA 2006:2).

In the 1960s the Hell's Angels began transporting meth across the country in their crank cases, hence the slang name of "crank" for methamphetamine. Meth use was

increasing, and injectable forms of the drug emerged (Frontline, DVD, 60 minutes, 2006; Grant 2008; Justine Hunt, American Meth, DVD, 2007; Maki 2006). In 1971 meth was listed as a schedule II controlled substance (Butte County Communities Mobilizing Against Methamphetamine Addiction, final report 2008:11), but in 1976 the Food and Drug Administration approved over the counter sales of pseudoephedrine (ONDCP 2010:1). The 1980s saw the emergence of supercharged speed, crystal meth. It was during this time that meth labs began to appear, and the connection between meth and pseudoephedrine would eventually become apparent (NIDA 2006:2; Frontline, The Meth Epidemic, February 14, 2006; Grant 2008; Justine Hunt, American Meth, DVD, 75 minutes, 2007).

A Brief Overview of Current Meth Abuse

The Drug and its Use

Meth has evolved from a water-soluble pill to a concoction that is up to 99 percent pure, and six times more powerful than its original form. Three grams of methamphetamine is enough to keep a person high for about three days (Justine Hunt, American Meth, DVD, 75 minutes, 2007). Names for meth include speed, go fast, ice, crystal, glass, tweak, chalk, and peanut butter (Grant 2008; NIDA 2006:2). Paraphernalia associated with meth use includes razor blades, mirrors, syringes, spoons, light bulbs, and surgical tubing (Smith 2008).

Methamphetamine can be smoked, orally ingested, snorted, or injected. Smoking and injection produce an intense pleasurable rush or “flash” that only lasts a few minutes. In addition to the immediate flash, smoking will produce a long lasting high.

Snorting and ingestion produce euphoria without the intense rush, within two to three minutes for snorting, and within 15 to 20 minutes with ingestion (Grant 2008; Smith 2008; NIDA 2006:3).

The Emergency Room and Treatment

Meth production and use represent a significant portion of emergency room and treatment admissions each year. Many emergency room admissions involve children from meth homes (SAMHSA 2004; Lowry 2008; Grant 2008; Smith 2008). According to the Office of the Washington Attorney General, in 2004, 495 children were present during lab seizures in Washington. 49 infants exposed to meth and 14 infants exposed to a combination of amphetamines and cocaine or opiates were admitted for treatment (http://www.atg.wa.gov/alliedagainstmeth/stats.aspx). Meth abuse is significantly higher in the Western United States than on the East Coast. Table 1 shows the states with the highest rates of methamphetamine and amphetamine admissions in 1992 per 100,000 for ages 12 and older, ranked from highest to lowest. Western states are on the left of the table. Eastern and southern states are on the right (SAMHSA 2004).

In an April 2007 report to the California Legislature it was reported that approximately 500,000 Californians were using meth, and that in fiscal year 2004/2005 meth accounted for more than 34 percent of drug treatment admissions in California. Populations singled out as being at particular risk are women of childbearing years, men who have sex with men, and youth ages 12 to 20 (Report to the Legislature 2007:ii).

Production, distribution, and use have evolved into a lucrative business, from small kitchen labs, to drug cartel super labs in California capable of producing 4.5 kilograms or more meth in a single production cycle, to mega-labs, mostly in Mexico,

Table 1. *1992 Methamphetamine and Amphetamine Admissions per 100,000*

Western State	# admissions per 100,000	Eastern/Southern State	# admissions per 100,000
Oregon	72.4	Oklahoma	15.5
California	48.6	Arkansas	7.2
Nevada	34.6	Texas	7.2
Montana	33.5	Vermont	4.7
Hawaii	32.8	Louisiana	3.9
Wyoming	15.2	New Jersey	2.6
Colorado	14.0	Pennsylvania	2.5
Washington	11.4	Delaware	2.1
Utah	10.0	Rhode Island	2.1

Source: Data for table compiled with information from Substance Abuse and Mental Health Services Administration, 2004, The Drug and Alcohol Services Information System Report. Office of Applied Studies, Substance Abuse and Mental Health Services Administration. Washington, D.C.: Department of Health and Human Services.

capable of producing 1,000 kilograms in a single cycle (United Nations Office on Drugs and Crime 2008). California has the highest number of meth lab seizures in the United States. There were 324 labs seized in 2006 (Report to the Legislature 2007:4). And the number of super labs is on the rise. In 2007, 10 super labs were raided in California, while 15 were raided in 2008, and 13 were raided in 2009 (ONDCP 2010:3). Production is organized, with cooks adapting almost in unison to measures taken to shut meth labs down, and cut off their supply of precursors (Frontline, The Meth Epidemic, February 14, 2006; Suo 2004b).

Literature Review

Meth, more than any previous perceived drug threat, has united groups and agencies that previously worked independently of one another, with much of the unified effort focused on saving children found in meth homes (as reported by numerous professionals interviewed for this thesis, and presenters at the 2008 University of California, Davis, Annual Child Abuse and Neglect [CAN] Conference). In part because there are so many entities involved, this epidemic presents a particularly complex problem, not just in terms of the eradication of the epidemic, but in how it is defined and explained. As Michael Agar (2004:411) once asked, "… how can illicit drug epidemics be explained? Traditional social research is simply not adequate to the task."

But, as Agar (2004:412) also indicates, American anthropology has always favored using a small group of people to illustrate and explain the culture of a larger group. To that end, in this thesis, a small group of professionals and addicts have been consulted to represent California in general, and the North State in particular.

Anthropology has a long history studying drug use. Ethnographic research on illicit drug use began in the 1960s. Most engaged in that research focused on heroin addiction, particularly among minority populations in urban areas. During that time the concept that street markets and physical dependence determined the style of addiction was developed, and a portrait of heroin addicts was formed. According to Agar (2002:251), prior to that, drug literature was based on top-down models. He insists that early ethnographic models revealed that heroin addicts were not accurately portrayed in the prevailing literature. Through ethnographic research addicts were viewed as competent enough to make comments on, and comparisons about, the advantages and

disadvantages of their lives, and their choices in drug use. He states however, that despite the new image of heroin addicts, no new paradigms were generated for drug policy or intervention (Agar 2002:251).

Agar (2002:251) contends that "Ethnography, a prisoner of its own ideology, focused primarily on a small group of interacting people and explored in detail their meanings and practices". This promoted the view that ethnographers were "preoccupied with the local and the exotic," making anthropologists great sources of "fascinating anecdotes and interesting excursions," but not the first people consulted regarding drug policy in a field dominated by medicine, political moral agendas, and law enforcement.

Agar (2002:252) contends that with the Reagan era, the 1980s saw social science come under attack as a matter of public policy, and the official stand on drug use was any use is "drug abuse", making the term useless in the scientific or clinical sense. From there, anthropology, and drug research in general, moved into HIV/AIDS and harm reduction research, such as needle exchange (e.g. Campbell and Shaw 2009; Fitzgerald 2008; and Koester et al. 2005).

When the drug field was developed, ethnographers drew on what they knew best, the model of bands, tribes, villages, distinct populations they could set apart from others and study (Agar 2002:254). However, instead of studying a remote and isolated culture that evolved with little influence from those beyond established boundaries, anthropologists developed "street ethnography" to study a tribe whose individuals were also tied to other places and people beyond the street market (Agar 2002:254).

George E. Marcus (1986:165) writes that while "ethnographies have always been written in the context of historic change: the formation of state systems and the

evolution of a world political economy", ethnographers have "not generally represented the ways in which closely observed cultural worlds are embedded in larger, more impersonal systems." Larger systems and events are seen as external forces impinging on and bounding the culture being studied, without being integral to that culture. Somewhat in contradiction to that view, this thesis proposes that those living within the meth sub-culture and those living within the dominant culture intersect and interact. They change and adapt their lives, as a result of those interactions. The response of those within the dominant culture to the meth sub-culture is integral to the evolution of the meth sub-culture.

Generally speaking, prior ethnographic research done in the drug field is not particularly relevant to this thesis. In ten pages of reflection, covering 35 years in the drug field, Agar (2002) does not mention methamphetamine at all. In fact, beyond needle sharing and HIV/AIDS (e.g. Campbell and Shaw 2008), and a discussion about using an agent-based model to understand drug epidemics in general (Agar 2004), anthropology seems particularly quiet on meth addicts and their everyday lives in the United States. They seem even quieter when it comes to the children of meth addicts. The focus is on risk reduction for addicts, not the children of addicts. While there is broad debate on the use of needle exchange programs and methadone use in treatment programs, there is no real debate in anthropology on how the children of meth addicts, raised in a sub-culture of violence and paranoia, will grow up and help shape the society we live in. In fact, with regard to research on the health effects on minors living in meth homes, Asanbe et al. (2008:229) note that little is known about the effects of growing up in a meth home because, according to their research, prior to their article, there were only three published

studies on the effects of a meth environment on children. One by Ostler et al. 2007 in the *Journal of the American Academy of Child and Adolescent Psychiatry*, and two by Haight et al. in the *Children and Youth Services Review* in 2005 and 2007.

Generally, only articles written in the last decade were reviewed for this thesis. Exceptions include the chapters written for the National Institute on Drug Abuse Research Monograph 168, published in 1997. Rural drug issues have only widely been addressed since perhaps the mid to late 1990s (Sloboda et al. 1997:5; Conger 1997:41). Much of the best data to evaluate rural drug sub-cultures, the long-term societal and health problems associated with methamphetamine use, efficacy of drug treatment programs, and emerging legislation, has only been published recently.

Methods

Data were obtained through twenty-two open-ended interviews conducted between July 2008 and May 2009. Personal and professional connections were used to obtain some interviews. Four interviews were obtained through "To Whom it May Concern" emails sent to various agencies. Those interviewed signed consent forms, and were given the option of confidentiality. However, many who were interviewed are recognized experts in their field, and their work is appropriately credited in this thesis. The interviews were taped, and verbal consent was given on tape at the beginning of each interview. The proposal for the research was reviewed and approved by the Human Subjects in Review Committee at California State University, Chico.

Also used were DVDs produced by both government and private entities. In 2007 the California Department of Justice produced a video meth trilogy, "Hidden

Dangers: Meth Labs", "Meth: The Great Deceiver", and "Meth: Where Meth Goes Violence and Destruction Follow". This trilogy gave access to the recorded comments of the experts the California Department of Justice (CA DoJ) relies on when they need information about methamphetamine. "American Meth" filmmaker, Justin Hunt, interviewed police officers, meth addicts, people involved in various recovery programs, the governor of Montana, and the mayor of Rock Springs Wyoming. He also took his camera into a home with active meth addicts and their small children. Another DVD used is the February 14, 2006 edition of the PBS show Frontline, "The Meth Epidemic". A main feature of this DVD is an interview with a reporter for The Oregonian, Steve Suo, who gathered records on possession arrests and emergency room admissions. He compared Oregon's programs treating methamphetamine with programs from other states. Suo's five part series, "Unnecessary Epidemic" can be accessed online at http://www.oregonlive.com/special/oregonian/meth/. Another interview on the Frontline DVD is Gene Haislip. While working for the United States Drug Enforcement Administration, Haislip tried to limit access to the ingredients used to manufacture methamphetamine before the addiction spread across the county.

Rosalie Sanz of Adult and Children's Services of Butte County processed and made available for this thesis unpublished data from their files. Data were also obtained online from the National Institutes of Health, the Department of Justice, the Drug Enforcement Administration, and other government agencies and websites at the county, state, and federal level.

Papers presented at the 2008 University of California, Davis, Annual Child Abuse and Neglect (CAN) Conference were a significant resource for this thesis. In order

to ensure accuracy of the information reported in this thesis, PowerPoint copies of almost all of the presentations used to write this thesis were obtained. Also referenced, were handouts that were made available at the conference.

As part of the 2007 National Healthy Minds Study (Eisenberg 2008), one thousand students were randomly selected from each of 13 universities across the United States. The data from that study were reviewed for this thesis to flesh out the larger picture of drug use in the North State and to determine to what extent college students who have moved into the area from other locations have impacted the available services in Butte County. Details of this study, and what the results suggest regarding access to services in Butte County, are explored briefly in chapter five of this thesis.

Materials were sorted by category (e.g. government documents, news articles, journal articles, interviews, and conference presentations), then analyzed in groups and compared. When writing this thesis, preference was given to comments made by those interviewed for this thesis, and those who spoke at the 2008 CAN conference.

Limitations and Boundaries

There are differences in regional drug use and populations. The western United States was hit first by the meth epidemic, while other states were still dealing with cocaine and heroin. Western states still have the highest incidences of meth abuse per 100,000 (Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Suo 2004b; SAMHSA 2004). Most of the meth "cooked" (manufactured) in the continental United States is cooked in California (Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Marshall 1998; Suo 2004b,c). Perhaps

there is a danger in using what could be referred to as a worst-case scenario as a comparison point for the rest of the country. However, since California has been dealing with the problem longer than most other states, California has had a longer period of time to develop and implement meth programs, and to determine the efficacy of those programs. As a counter balance, programs from other states, and one other country are also briefly examined.

The goals of each agency or entity that is involved in the conflict differ. Law enforcement seeks to arrest drug manufacturers and confiscate illegal drugs and arms (Brown 2008; Gerhardt 2008). Social services seek to remove and protect children (Smith 2008; Ely interview with author April 23, 2008). Medical doctors and health care professionals seek to counteract the effects of drug exposure, and break the cycle of drug abuse (Freier-Randall 2008). Above all of them, the state mandates reunification of families (Mosbarger interview with author April 13, 2009; Ely interview with author April 23, 2009; Nickelson interview with author April 28, 2009).

It is important to note, that it is law enforcement professionals who are probably leading the way in policy reform regarding children in meth homes. Based on comments made by peace officers and social workers, it appears that when law enforcement began seeing these children as victims, rather than future tweakers (a slang term for meth addicts, as well as a phase in the meth use cycle) that their own children would likely arrest in the future, policy began to change. It has been determined by a broad range of professionals that individual agencies working independently are unable to achieve significant results, a realization that meth abuse is a problem too large for a narrowly focused approach. This new war on drugs is not a war on addicts, but a war on

addiction, drug profiteering, and the collateral damage caused to the people and the environment (Butte County Methamphetamine Strike Force [BCMSF] 2007). This collaborative approach and the new view of addicts and their children form the foundation of this thesis.

Chapter II asks, what are the origins of the methamphetamine epidemic in the United States, and how does California fit into the meth epidemic? Chapter III asks, what types of health risks are inherent to the people living within a meth oriented drug sub-culture? What are the particular characteristics of meth as a drug, physiologically and psychologically that have shaped the meth sub-culture? How are children and adolescents uniquely affected by those inherent health risks? Chapter IV explores the collaborative approach taken by agencies that previously functioned independently of one another. Chapter V concludes with recommendations on further research and programs.

CHAPTER II

SOCIETAL RESPONSE

Booking Photos

Meth abuse contributes significantly to crime rates. According to Sheriff's Deputy Bret King, more than 50 percent of people booked into the Multnomah County (Oregon) jail where he works are meth addicts. King has collected booking photos that document the deteriorating effects on the physical appearance of meth addicts. For instance a series of booking photos of Teresa Baxter show that each time she was processed through the jail, her condition had visibly worsened. She began losing her teeth and eventually looked perhaps 20 years older than she was. According to King, some people have been through the jail over a hundred times, and over the course of 10, 15, 20 years the booking photos present clear documentation of their deterioration (Bret King, Frontline, The Meth Epidemic, 60 minutes, February 14, 2006) (To view King's booking photos, go to www.facesofmeth.com).

Portland, Oregon police officer, Travis Fields (Travis Fields, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006) stated that methamphetamine addicts commit 85 percent of property crimes in Oregon. Much of what is stolen ends up in meth garage sales (Travis Fields, Frontline, The Meth Epidemic, DVD, 60 minutes, 2006; Deputy Sergeant David Anderson, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). Meth dealers exchange meth for stolen items, which they

then sell to the general public. While addicts are high they steal things that they can take to dealer-run garage sales, so they can get more methamphetamine (David Anderson, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). In this way a meth and theft cycle is perpetuated.

Former Shasta County District Attorney, McGragor Scott (McGragor Scott, CA DoJ, Video, Meth: Where Meth Goes Violence and Destruction Follow, 17 minutes, 2007), stated that 90 percent of crimes committed in Shasta County are related to meth use, and 40 percent of murders in Shasta County are directly related to meth use. According to former Oroville Chief of Police, Mitch Brown (2008), almost all criminal activity in Butte County is tied to drugs somehow. Nationwide, in 2007, 47 percent of county sheriffs reported meth as their primary drug problem, and 55 percent reported that meth related crime increased in 2006. A workload increase due to meth was reported by 60 percent of sheriffs, and 43 percent of county sheriffs reported they were paying more overtime to combat meth crimes (National Association of Counties [NACo] 2007:2). Clearly, efforts to eradicate meth have had a significant impact on how law enforcement resources are allocated. The following sections briefly outline that escalation over the last quarter century.

Did We Miss a Chance to Stop the Meth Epidemic?

In 1985 Deputy Assistant Administrator Gene Haislip of the United States Drug Enforcement Administration (DEA), tried to limit access to the ingredients used to make methamphetamine. Haislip was convinced that if the availability of the precursors used to make meth were better controlled, authorities could stop the production of

methamphetamine. He based this assumption on his success in eradicating Quaaludes (Methquolone) in the early 1980s (Suo 2004b; Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Piccini 2010:49). Quaaludes were made from chemicals that drug dealers could not make themselves. Haislip traveled to the countries where factories that produced the necessary chemicals were located and worked with those governments to shut them down. By 1984 Quaaludes were no longer an issue in the United States (Suo 2004b; Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Haislip 2007; Piccini 2010). Haislip wanted to regulate and control the manufacture and sale of drugs, such as ephedrine, that can be used to manufacture meth, using the same method. Like Quaaludes, meth is susceptible to supply site intervention. The chemical composition of the precursor is sophisticated enough that it has to be produced in a factory, and only nine factories produce the bulk of the world's ephedrine. In 1986, with Haislip's urging, Senate Majority Leader, Robert Dole of Kansas (Republican) introduced a bill that included a requirement that distributors of ephedrine check the identities of their customers, and make their sales records available to the DEA (Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Piccini 2010:49; Suo 2004b). It was the first of many bills that have been introduced in an effort to stop the meth epidemic.

However, over the course of more than a decade, Allan Rexinger and other pharmaceutical lobbyists repeatedly delayed DEA efforts to control ephedrine and pseudoephedrine. In one instance, Haislip was summoned to a meeting with Reagan administration officials and industry lobbyists at the Old Executive Office Building next to the White House. During the meeting, pharmaceutical representatives made it clear

that they wanted the bill amended to exempt cold medicine, and representatives from the White House made it clear that Haislip was expected to work out a deal. The DEA was repeatedly pressured to agree to loopholes that allowed meth labs to continue production in the United States (Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Alex Rexinger, Frontline, The Meth Epidemic, DVD, 60 minutes, February, 14 2006; Piccini 2010:49; Suo 2004b).

The representatives of the pharmaceutical industry were against regulation, and most members of Congress were more concerned about cocaine. In the mid-1980s meth was still a West Coast issue, and dealing with the growing problem was not on the Congressional priority list. That view eventually changed as meth cooks dramatically increased production, and Mexican drug lords took control of the meth market, but billions of hits of meth were distributed throughout the United States before that happened (Suo 2004a,b,c,d; DEA 1998; Marshall 1998; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006).

The California Connection

By 1989 California's Central Valley was the meth production center for the United States. Meth production had become a huge industrial project, and shutting meth labs down became just as large a project, involving millions of dollars in resources (Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February14, 2006; Kahn 2007; Suo 2004b). The Fresno Meth Task Force, for instance, uses helicopters to scope out meth labs. When they find possible locations, they go in on the ground for a closer look at night using night vision goggles and infrared spotlights. Stealth is essential,

because lab cooks can slip into a location, cook a batch of meth in less than 48 hours and then vanish. If cooks suspect that they are being watched, they will use a different location for the next cook. In order to counter that sort of activity, the task force plants hidden cameras in locations they suspect may be used for meth production. Shutting super labs down is essential to meth control. A super lab can manufacture anywhere from 10 to 100 pounds in a cook cycle (Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). A 10 pound cook cycle will make more than 150 hits (Kahn 2007). A 100 pound cook cycle can bring in a profit of about four million dollars (Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006).

The drug kingpins who turned meth into big business were the Amezcua-Contreras brothers of Mexico. The brothers learned the drug trade by trafficking cocaine for Colombian organizations. They avoided violent clashes over territory by exploiting the under-developed meth trade in the United States (DEA 1998). And they bought ephedrine from the same factories as American pharmaceutical companies. (DEA 1998; Marshall 1998). During an 18 month period, the Amezcua-Contreras brothers legally purchased 170 tons of ephedrine, and turned that into two billion hits of methamphetamine. This made the methamphetamine on American streets cheap, plentiful, and remarkably pure (Frontline, The Meth Epidemic, DVD, 60 minutes, 2006). In 1991 the lowest price nationwide for a pound of meth was $6,000.00. By 1995 a pound of meth in California cost between $2,500.00 and $3,600.00 (DEA 2003:104).

Meth Production Adapts as Law Enforcement Goes After the Precursors

In March of 1994, a plane landed in Dallas, Texas. A customs officer went aboard to check the cargo. He found 120 cardboard boxes, chemical containers. The company of origin was painted over. He pulled a sample, and called the DEA. The cargo turned out to be 3.4 metric tons of ephedrine that would have been used to make meth. The DEA obtained copies of shipping documents. They were then able to go to the companies on those documents and ask them to stop selling to the Amezcua-Contreras brothers. Once cooperative efforts between the DEA and companies like Krebes in India cut off the brother's supply, the super labs in California's Central Valley ran out of raw materials to produce meth, and the purity of meth went down (Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, Februrary 14, 2006).

In 1995 Congress gave the DEA the power to regulate ephedrine in cold medicine, but not pseudoephedrine. In the production of meth, the two drugs are interchangeable, so cooks began using pseudoephedrine (Suo 2004b; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). The Fresno Meth Task Force started finding garbage bags in labs with empty bottles of pseudoephedrine pills that were razor cut at the bottom, so that the pills could be dumped out quickly. Cooks evaporated the binder, often cornstarch, which holds the pills together, using huge containers full of denatured alcohol. That is when the fires and explosions in meth labs began. During this period 60 percent of the labs found in California's Central Valley were the result of fires and explosions (Robert Pennal, Frontline, DVD, 60 minutes, February 14, 2006). A link

for a graphic from Suo's 2004 meth series in *The Orgonian* depicting how meth is manufactured can be accessed online at http://www.oregonlive.com/special/oregonian/meth/.

With super labs turning pseudoephedrine into methamphetamine around the clock, meth purity rose in 1997. And the number of states where methamphetamine use reached epidemic proportions increased. The relationship between the purity of meth and the spread of the meth epidemic is explored further on in this section and in chapter three of this thesis. The epidemic was spreading from west to east, but it still had not reached far enough across the Mississippi for most politicians to consider it a threat (Suo 2004b; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Kahn 2007).

The slow response of Congress made the control of pseudoephedrine, and the slowing of the meth epidemic, difficult. In 1996 when Haislip pushed through a regulation requiring a license to sell pseudoephedrine pills, Congress suspended it. The ruling was at the urging of the pharmaceutical industry. The decision was made in order to give legitimate businesses time to adjust to the new regulation, but it also gave drug traffickers time to adjust (Brian Baird, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Suo 2004b; Piccini 2010:49). The DEA was swamped with thousands of bogus companies applying for licenses. Because they were short on staff, they began issuing temporary permits while they processed the licenses. This policy led to companies licensed by the government that generated millions in profits by selling pseudoephedrine to meth cooks (Gene Haislip, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Suo 2004b). In 1997 and 1998 most meth labs seized in

California purchased their precursors from licensed wholesalers in the United States (Keefe 2001; Suo 2004b).

The Amezcua-Contreras brothers were arrested in Mexico in 1998. A DEA wiretap investigation known as Operation META provided information regarding the brothers' involvement in the United States meth trade. The results of the investigation included the following: 101 arrests, the seizure of 133 pounds of meth, the dismantling of three meth labs, and the seizure of 90 gallons of meth solution (converts to 270 to 540 pounds of meth). One of the labs was within 200 yards of a day care center (Marshell 1998). However, by the time the brothers were arrested, the meth trade had a secure foothold in the United States. According to maps from the Office of the California Attorney General (http://www.ag.ca.gov/publications/methlabs/) in 1999 6,760 clandestine labs were seized in the United States, 2,063 were in California, and 43 of those were in Butte County.

Licensed Clinical Psychologist Brian Baird, United States House of Representatives from Washington's third district 1999 to 2011, helped form the Congressional Caucus to Fight and Control Methamphetamine in 2001. By 2003, the caucus had grown from 21 members to 87, representing 27 states (Pasternack 2003). The caucus website (http://methcaucus.larsen.house.gov/members.shtml) lists 48 Republicans and 64 Democrats in its membership for the 110th Congress. Back in 2001 though, most politicians did not know what methamphetamine was, and they did not understand how pseudoephedrine is connected to methamphetamine (Brian Baird, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Pasternack 2003).

By 2000, the DEA managed to shut down all the bogus pharmaceutical companies. As they shut the bogus companies down, the purity of the methamphetamine in the United States dropped, from 56.9 percent in 1997 to 20.1 percent in 2000. Attributed to that reduction in purity is a brief fall in deaths and injuries related to methamphetamine (Keefe 2001; Suo 2004b; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). According to the National Institute on Drug Abuse (NIDA) (2006:2) data collected from hospital emergency departments in 21 metropolitan areas indicate that there was a significant decrease in methamphetamine related episodes between 1997 (17,200) and 1998 (11,500). However, between 1999 and 2000 there was a 30 percent increase in emergency room methamphetamine related episodes (NIDA 2006:2).

The strike force in Fresno began to find 60 milligram 1,000 count white bottles with no markings on them during raids of meth labs. There were no lot numbers or other identifying markings, but there was some writing in French on the bottom of the bottle (Suo 2004b; Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). It was two years before the DEA found the source of those bottles, in Québec, Canada. In 2003, the DEA and the Canadian government shut down the bogus Canadian drug companies that were shipping unregulated drugs to California (Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Suo 2004b).

That is when the “smurfing” began. The Fresno Meth Task Force received calls from local retail stores about people buying the maximum amount of cold medicine they could purchase at a time. Discarded blister packs were strewn across parking lots. Smurfers sat in their cars and punched the pills out of the blister pack, put them in freezer

bags, and then turned the pills over to chemical brokers (Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). Packs can be purchased from stores for seven to ten dollars, and they can be resold to meth lab cooks for $50 each (ONDCP 2010:2). These packs had long been the primary source for small kitchen labs, but by 2003 they were purchased and processed in bulk for the super labs. Because stores used handwritten records that were not shared, it was possible for smurfers to purchase more than allowed by law by moving from store to store (Rannazzisi 2007; Robert Pennal, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; ONDCP 2010:2-3).

A bulletin produced by the United States Department of Justice (Swetlow 2003:3) notes that although 85 percent of the nation's meth was produced in California, Mexico-based meth trafficking helped spread meth across the county. While on assignment for a meth series for The Oregonain, reporter Steve Suo went to a marketplace in Mexico City, to see how much pseudoephedrine he could buy. He maintains that three different pharmacies told him and a friend that they could sell them as many boxes as they wanted, in violation of Mexican laws restricting quantities (Steve Suo, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006). In 2004 Mexican pharmaceutical companies legally imported 226.5 metric tons of pseudoephedrine (National Drug Intelligence Center [NDIC] 2004:2-3). Much of the pseudoephedrine was cooked into meth, and smuggled across the border into the United States (NDIC 2004:2; Sou 2004b; Frontline, The Meth Epidemic, DVD, 60 minutes, February14, 2006). In 2005 Mexico began restricting pseudeophedrine imports. Meth production in Mexico began to decline. Meth seizures along the Southwest boarder decreased from 2,809 kilograms in 2006, to 1,745 kilograms in 2007, a 37.9 percent

decrease. Meth purity also decreased, by 28 percent between January 2007 and December 2007, from 56.92 percent to 40.98 percent. However there was an increase in Southwest boarder seizures in 2008 to 2,006 kilograms, despite a ban on all legal commercial imports of pseudeophedrine to Mexico (NDIC 2004:3-5)

Meth production in the United States increased significantly in 2008, following tighter restrictions on pseudoephedrine products in Mexico. There was an increase in United States lab seizers of 26 percent from 2007 (2, 876) to 2008 (3,616). Organized pseudoephedrine smurfing groups are again the primary suppliers for labs in the United States. Most labs are small-scale and use a simplified production method, which combines most of the ingredients into a single container. The method is known as "one-pot" or "shake and bake". The remaining large-scale labs in California are still controlled by Mexican drug trafficking organizations (NDIC 2004; NIDC 2010).

As meth cooks adapt to supply restrictions and changes in law enforcement procedures, and as the meth epidemic continues to spread across the United States, a broad range of services are affected. A significant cross section of professionals works differently today than they did just a generation ago. Agencies are less isolated, more integrated. More information is shared between agencies, and more agencies work together. More resources are allocated for problems originating within the meth sub-culture, and as a result of the conflict between the meth sub-culture and mainstream America. The next chapter details societal costs associated with meth and the increased allocation of resources to the meth epidemic. Although much of the data is incomplete, especially data dealing with children, the next chapter clearly illustrates the significant

financial burden the meth sub-culture places on American society. It also illustrates the health risks addicts and their children face.

CHAPTER III

EFFECTS

The Big Picture

The impact of methamphetamine abuse on society is huge. Since at least the late 1990s, there has been a focus on methamphetamine at the Office of the California Attorney General (Wendy Tully, Program Manager, Crime and Violence Prevention Center, California Attorney General's Office, interview with author July 29, 2008). Maps used by the Office of the California Attorney General to demonstrate the spread of meth in California (Tully interview with author July 29, 2008, personal communication July 29, 2008) indicate that in 2004 the national total of reported admissions for methamphetamine and amphetamine abuse was 144,899. 60,007 of those were in the state of California. The two states with the next highest number of admissions for methamphetamine and amphetamine abuse were Washington with 9,337 admissions and Oregon with 8,561 admissions (Treatment Episode Data Set [TEDS] for 2004 can be found at http://oas.samhsa.gov/dasis.htm). In State Fiscal Year 2000/2001, the primary drug of abuse noted at admission in California was methamphetamine for the following counties: Del Norte, Tehama, Butte, Yuba, Lake, Sutter, Napa, Solano, Sacramento, Santa Clara, Stanislaus, Merced, Kings, Kern, San Bernardino, Riverside, and San Diego. Heroin was the primary drug for San Francisco, Alameda, Madera, Fresno, Ventura, Los Angeles, Orange, and Imperial. Alcohol was the primary drug for all other counties. In

State Fiscal Year 2004/2005 the primary drug noted at admission was methamphetamine for all California counties, with the exception of Modoc, Plumas, Sierra, Marin, Mariposa, and Mono, where the primary drug was alcohol, and San Francisco and Santa Cruz, where heroin was the primary drug of choice. Data regarding meth admission rates in California can be obtained through the California Department of Alcohol and Drug Programs at http://www.adp.ca.gov/. A slide presentation with California treatment maps is also available at that site, or may be accessed directly at http://www.adp.ca.gov/oara/pdf/Meth_Treatment_Demographics_CA.pdf.

As detailed by multiple sources, such as the California DoJ (2007), since the introduction of modern methamphetamine into the drug sub-culture, the drug scene has increasingly revolved around violence, theft, and hyper-sexual activity. This has led to significant declines in health and productivity, and increased risk to children and adolescents raised in drug homes. The methamphetamine epidemic has therefore made it necessary to increase funding for the corrections system, healthcare, and foster care. Timothy Kaumo, the mayor of Rock Springs, Wyoming, stated that at a time when they should be using funds to move the city forward, to do things like improve roads and recreation facilities, they are using money for police protection and rehabilitation, because of the meth epidemic (Timothy Kaumo, Justin Hunt, American Meth, DVD, 75 mintues, 2007).

Data from a study of 127 emergency room presentations (Derlet et al. 1989:157-161) indicate that in 53 percent of drug related cases, methamphetamine was the only drug involved. However, the use of other drugs while coming off of a high of meth is common, in order to maintain the high. Therefore, using meth may encourage,

and increase, the use of other drugs. Not only does this create an even greater burden on society, it can make it difficult to determine the full economic cost of meth use.

The executive summary of "The Economic Costs of Drug Abuse in the United States 1992-2002", Executive Office of the President, Office of National Drug Control Policy (EOP 2004:vii) states that the economic cost of drug abuse in general in 2002 was estimated to be $180.9 billion. This figure includes the cost of resources expended on health issues, law enforcement measures, and loss of potential productivity due to disability, death, and non-participation in the legitimate workforce. The study shows that the costs associated with drug abuse have increased an average of 5.3 percent per year from 1992 to 2002, a rate slightly above the annual gross domestic product growth for the entire economy (5.1 percent). Increases noted in particular are those dealing with law enforcement, including incarceration of drug offenders (EOP 2004:vi).

The 2004 EOP report indicates that the largest proportion of costs associated with drug abuse is the loss of potential productivity, followed by what are labeled as other costs and health-related costs. Productivity loss due to illegal drug activity jumped from $77.4 billion in 1992 to $128.6 billion in 2002 (EOP 2004:x). Other costs include money spent for the operation of prisons, state and local police protection, and federal supply reduction initiatives (EOP 2004:xi). In 2002 there were 1.5 million arrests on drug specific charges and half a million arrests for offenses connected to drug abuse, including sales, manufacturing, and possession (EOP 2004:xi).

More effective HIV therapies helped keep healthcare costs down, but there was still an increase from $10.7 billion in 1992 to $15.8 billion in 2002 (EOP 2004:ix). A 2009 National Center on Addiction and Substance Abuse (CASA) study at Columbia

University found that in 2005 federal, state, and local government spending on substance abuse and addiction was at least $467.7 billion. Federal and state governments spend almost 60 dollars to deal with crime and other issues related to substance abuse for every dollar spent on prevention and treatment of substance abuse. (CASA:2009:i-ii).

In 2009, the RAND Corporation released their findings of research funded by the Meth Project Foundation and the National Institute on Drug Abuse, presenting a national estimate of the economic cost of meth use in the United States. They concluded that the best estimate of the economic burden of meth use in the United States reached $23.4 billion in 2005. The estimate is based on a low of $16.2 billion and a high of $48.3 billion. The estimate includes costs associated with drug treatment ($545.5 million), crime and criminal justice costs (more than $4 billion), child endangerment ($904.6 million), and harms resulting from production ($61.4 million). The researchers determined that the most significant costs are due to the intangible burden addiction places on dependent users and premature mortality, an estimated $16.6 billion (Nicosia et al. 2009:iii, xii-xiii). It is estimated that there were 900 meth-related deaths and a loss of 44,000 quality-adjusted life years (QALY) in 2005. QALY calculations are used to determine the life expectancy and quality of a person's life (Nicosia et al. 2009:xii). The following sections in this chapter expand on the burdens meth abuse places on society.

Crime, Criminal Justice, and Productivity Costs

Meth related crime costs to society are significant. The EOP report (2004:xii) estimates that in 1992 $61.8 billion were spent in the United States on crime related costs for illegal drugs. The report indicates that by 2002 that cost rose to $107.8 billion. The

majority of the estimated costs are directly related to drug specific offences such as sales and manufacturing. This estimate also includes drug-related crimes committed to finance drug habits. The RAND report (Nicosia et al. 2009:xiv) estimates that annually meth specific crime and criminal justice costs rang anywhere from $2.5 billion to $15.8 billion, with a best estimate of $4.2 billion. This includes a best estimate of $1.8 billion associated with crimes committed by individuals under the influence of meth. It also includes a best estimate of $70 million for parole and probation violation costs. The use of other drugs in conjunction with meth, and a lack of previous in-depth studies focused on meth use, may contribute to a lack of consistent and precise estimates.

Meth is linked to 40 percent of violent crime on Indian reservations, and 74 percent of Indian County law enforcement agencies indicate that meth is the primary drug concern on reservations. The Bureau of Indian Affairs has determined that 90 percent of tribal police require additional drug investigation training as a result (Office of Community Oriented Policing Services 2010:1). In a survey (National Association of Counties [NACo] 2007) involving 500 counties from 45 states, 87 percent of law enforcement agencies reported increases in arrests involving meth between 2002 and 2005. 58 percent noted meth as their largest drug problem. On the low end, in 2005, half of the counties indicated that only one in five of their inmates were in jail due to meth related crimes. On the high end, 17 percent reported that more than half of their populations were incarcerated because of meth, and 24 counties reported that between 75 and 100 percent of their arrests were meth related (NACo 2007: 4). Only 16 percent of the responding counties reported that their county either facilitated or sponsored a meth rehabilitation center or program (NACo 2007:5). This increases the meth population in

local jails, therefore increasing crime related costs, as drug users are incarcerated, instead of referred for treatment. Also, as jail and prison populations increase in a society, productivity levels drop. Nicosia et al. (2009:xiv) reported that most of the productivity losses related to meth use are due to absenteeism ($275 million) and incarceration ($205 million). The cost of employer drug testing is estimated to be $44 million.

Environmental Hazards and Clean-up Costs

A United States Department of Justice bulletin reported in 2003 that approximately 15 percent of meth labs nationwide are discovered as a result of fire or explosion (Swetlow 2003:4). Nicosia et al. (2009:xv) estimated that $29 million are dedicated to the cleanup of hazardous waste at discovered meth labs, and that more than $30 million of the social costs associated with meth production are due to injuries and deaths resulting from exposure to hazardous substances, including explosions and fires. When meth labs blow up, not only people in the home where meth is being produced are placed at risk, but those in adjacent homes as well (Brown 2008). First responders, particularly police officers, suffer 51 percent of all injuries resulting from meth production incidents. However, bystanders and meth cooks sustain the most serious injuries (Nicosia et al. 2009:87). If a meth lab is not consumed in fire, clean-up costs for a home contaminated by vapors released during the cook average between $2,000 and $4,000 (Report to the Legislature 2007:3).

In addition, not all of the toxins remain near the cook site. Cooks in meth labs dump toxic waste into sewers and waterways. This increases the threat to not only the neighborhood where the meth lab is located, but entire communities (CA DoJ, Meth:

Where Meth Goes Violence and Destruction Follow, Video, 17 minutes, 2007; CA DoJ, Meth: Hidden Dangers, Video, 17 minutes, 2007; Report to the Legislature 2007:3). It was estimated that by 2007 California had already been contaminated with 2.8 million pounds of meth related toxins (Report to the Legislature 2007:3).

Almost all of the chemicals used to manufacture meth can be hazardous in one form or another. Specific toxins associated with meth manufacture and use include sulfuric and muriatic acids that can cause burns, corrosive Red Devil lye, Coleman fuel, and phosphorus. A primary method of meth synthesis is the reduction of ephedrine and pseudoephedrine with an alkali metal like lithium or sodium and ammonia (Martinez et al. 2008:1). Some laboratories use cyanide and hydrochloric acid. These chemicals make hydrogen cyanide gas, the chemical used in gas chambers. During law enforcement raids, all of these potentially lethal chemicals have been found in accessible containers in rooms where children sleep and play (various speakers at 2008 CAN conference; CA DoJ, Hidden Danger: Meth Labs, Video 17 minutes, 2007) (interviewed experts on CA DoJ 2007 meth trilogy videos include Sergeant Mike Bayer, San Bernardino County Sheriff's Department; Karl Palmer, Chief, Emergency Response Units, California Department of Toxic Substances; Mark Miller, M.D., M.P.H., California Environmental Protection Agency; and Guy Hargeraves, Supervisory Special Agent, Drug Enforcement Administration).

The chemicals used in the manufacture of methamphetamine are particularly dangerous to children. The solvents can cause pneumonia if inhaled. If ingested, they may cause liver or bone marrow failure. Chronic inhalation causes brain damage. The solvents are also highly flammable. Acid immolation (burning) causes respiratory

irritation, skin erosion, pulmonary edema, and death. Lye is caustic and can cause burns on the skin, eyes, mouth, and esophagus of toddlers. If inhaled, lye can cause upper airway edema, respiratory failure, wheezing, and pulmonary edema. Concentrated iodide causes irritation and burns to the skin, eyes, respiratory tract, mouth, and esophagus. Chronic ingestion can cause diarrhea, vomiting, pain, thyroid disease, and death (Grant 2008; CA DoJ, Hidden Dangers: Meth Labs, Video, 17 minutes, 2007; Swetlow 2003:3).

Data collected by the El Paso Intelligence Center (Swetlow 2003:3) shows that in 2000, 1,803 children were affected by meth lab-related incidents in the United States, while 345 children were exposed to toxic chemicals, 353 were taken into custody, 12 were injured, and three died. In 2001 the number of children exposed to toxic chemicals in meth lab-related incidents rose to 788, while a total of 2,191 were affected, 778 children were taken into custody, and 14 were injured. In 2002, 3,167 children were affected, 1,373 were exposed to toxic chemicals, 26 were injured, and 2 died. According to the Shasta County Drug Endangered Children Program statistics (2009), in 2004, 77 children were involved in 46 DEC (Drug Endangered Children) cases. 60 of the children were detained, 52 were tested for exposure. Of those, 38 tested positive. In 2005, 68 children were detained, 29 were tested, and 28 tested positive. Potential for injury during a sudden explosion is great, as is the risk of accidentally ingesting or inhaling a toxic substance, but perhaps the greatest risks to children in a meth home, particularly small children, involve chronic abuse and neglect. That topic is explored in the following section.

Health Issues Associated with Meth Use

There are many health issues associated with meth use. Nicosia et al. (2009:xiv) determined that almost all of the estimated $545 million in meth treatment costs, $491 million, are community-based. Federally funded treatment costs, mostly through Indian Health Services and the United States Department of Veterans Affairs, are estimated to be $39 million. Short-stay hospital treatment costs are estimated to be $15 million. The authors did not have access to non-hospital-based general treatment data, so those figures were not included in the RAND report. Additional health care costs among meth users are estimated to be $351 million, including $27 million for hospital admissions for conditions resulting directly from meth, $14 million for treatment of patients admitted for conditions exacerbated by meth use, and $14 million for costs associated with meth-related suicide attempts.

Experts maintain that addiction to meth is strong, because meth stimulates the central nervous system to activate multiple systems in the brain. When people do things that the brain wants to reward, the brain releases the primary pleasure chemical, dopamine. While natural rewards like food and sex elevate dopamine levels, levels are increased two to ten times the normal rate with methamphetamine use (Rawson 2009; Lowry 2008). The body is not equipped to handle that type of release. That is why people report having a euphoric experience while high on meth. The heightened level of dopamine changes how the brain's reward center works. The brain becomes re-wired by drug use. Meth addicts become unable to experience pleasure without methamphetamine, so the addict believes that the only way to feel good is to take meth. The purer the meth,

the higher the dopamine levels rise. As the dopamine levels go up, addiction increases (Rawson 2009; Lowry 2008; NIDA 2006:3; Taylor 2008).

People use meth to boost alertness, activity, and feelings of self-confidence. However, those feeling are fleeting, and the resulting health issues are severe. Symptoms of methamphetamine abuse include the following: blurred vision, dizziness, dilated pupils, welts on the skin, rotten teeth, severe weight loss, and liver failure. Drug use contributes to unplanned pregnancies and infectious diseases. Infants of drug addicts suffer due to premature delivery, low birth weight, and the slowing of intellectual development and behavior. This can lead to behavioral problems, depression, anxiety, and poor academic standing. Children living in meth homes may experience chronic rashes. They are at risk for molestation. They experience high levels of violence, and, as noted in the previous section, they are exposed to dangerous chemicals (Tully interview with author July 29, 2008; multiple papers and government reports, including Tyner and Fremouw 2008; Shasta County's Drug Endangered Children's Program 2009; Conger 1997; Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; CA DoJ, Meth: Where meth goes Violence and Destruction Follow, Video, 17 minutes, 2007; NIDA 2006:4-5; Conger 1997; Haight et al. 2005; Hohman et al. 2004; Smith 2008; Walsh et al. 2003; CASA white paper 2005; Swetlow 2003:3; and various presenters CAN 2008). For instance, many children in Oregon placed in foster care are examined for signs of abuse and neglect by pediatrician Carol Chervenak. She also gathers evidence for child endangerment charges by talking to children about what they have seen in the house. In one instance, a nine-year-old girl told her how her father taught her to make methamphetamine. According to Chervenak, the girl said her father stuck her finger into

the mixture and made her taste it, and that she felt woozy every time she cooked meth. The child also described how she witnessed her father pistol whip her mother in the driveway until her mother was bloodied. She talked about pornography playing on the television all day, and about sexual activities between herself and several adults in the home, while the adults were high on methamphetamine (Carol Chervenak, Frontline, The Meth Epidemic, DVD, February 14, 2006). Multiple sources (e.g. Brown 2008; Gerhardt 2008; Webber-Brown and Hirsch 2008) indicate that this is typical learned behavior within a meth home. They also indicate that some families have been involved in the meth trade three and four generations.

Different symptoms are associated with different phases of meth use, the binge, tweak, crash cycle. Binging is when an addict is re-dosing, in an effort to obtain the original rush. This never happens because their brain chemistry has been altered. Tweaking involves quick movements and paranoia. There are four crash phases. In the first crash phase, the addict experiences insomnia, exhaustion, fatigue, paranoia, auditory hallucinations, and irritability. They are also prone to aggression and violence. In the second crash phase the addict experiences intense sleep, up to three days, during which time their bodies can starve and begin to cannibalize the muscles. During phase three addicts experience intense hunger, become depressed, and experience disorientation. During the fourth crash phase depression becomes long term, and can last up to five months (Grant 2008; Lowry 2008; CASA white paper 2005:20; CA DoJ, Meth: The Great Deceiver, Video, 17 minutes, 2007).

During the first phase, children in the home are likely to be brutally abused by addicted adults. Any stimulant, such as coffee, can increase the effects of

methamphetamine, and create a crisis. Instead of doing simple discipline, parents get carried away. They forget about what they are doing during a release of tension that feels good to them, so they just keep doing it, to the extreme (Grant 2008; Lowry 2008; CASA white paper 2005:20). A case in point is that of four-year-old Genny Rojas. When her mother was arrested for cooking meth, police handed her off to her aunt and uncle. They were also meth addicts. While her mother was in rehab and her father was incarcerated for child molestation, Genny stayed with her aunt and uncle. Over the course of six months she was beaten, starved, hung by her hands from a hook in a closet, and burned with a hair dryer. On July 21, 1995 she was killed, held down in a bathtub of scalding water for two hours while her skin peeled away from her body (CA DoJ, 2007; Tully interview with author July 29, 2008; Los Angeles Times 1998).

During phase two there is a danger of coma and seizures for the addict. This is a time when children in the home are most likely to be neglected. They may starve, or suffer serious illness or injury because of a lack of appropriate adult attention and supervision (Grant 2008; Lowry 2008; CASA white paper 2005:20; CA DoJ, Meth: The Great Deciever, Video, 17 minutes, 2007; CA DoJ, Meth: Where Meth Goes Violence and Destruction Follow, Video, 17 minutes, 2007).

Justin Hunt was invited into a meth home while filming "American Meth" (DVD, 75 minutes, 2007). The family consisted of James and Holly, both active meth addicts, and their four small children, ranging in age from two to eight. When the production crew arrived at the home, police were there, and on the verge of removing the children from the home, in part because there was no running water. James and Holly had been fighting in the street, but the situation calmed down, and the children remained with

their parents. The children were dirty, and the two-year-old was naked in the middle of winter. James tried to explain how the water got shut off, but his explanation was disjointed and did not make sense. At 3 a.m. the parents were sound asleep in different rooms, but the children were up. One of the toddlers wore nothing but a diaper that looked like it needed to be changed. He went to the refrigerator, opened the door, and revealed that it was nearly empty. He stepped on a lower shelf in order to pull a gallon of milk off of the top shelf, and the door almost closed on him. He then dragged the gallon of milk through the living room. At 7:39 a.m. the television was on, the kids looked lost, and they were jumping all over the furniture. The oldest boy was asked if he was going to go to school. He told them he could not go to school because the bus had already passed. One of the toddlers found a bag of popcorn in the trash, and ate that for breakfast. At that point James was sound asleep in what appeared to be the boys' bedroom, despite the fact that the children were playing loud video games in that room.

In another example of neglect, a mother was unable to wake up during a serious crisis, which led to the death of her eight month old baby. The mother woke to find her infant in a walker, stuck over a floor furnace. The child did not have a pulse, had second and third degree burns to the upper aspects of both legs, and rigor mortis had set in. Initially, the mother stated that she had only been asleep for about an hour. Subsequent investigation revealed drug paraphernalia and an Altoid tin used to store methamphetamine. The mother later admitted to using methamphetamine at 8:30 p.m. on Friday. She stayed up until 3 a.m. on Saturday, then slept until 5:30 a.m. Sunday. She felt sick when she woke, so she took Tylenol PM, and then slept for about an hour. When she woke again, she found her baby dead (Grant 2008).

There is a demonstrably high correlation between parental substance abuse and health risks to children and adolescents. Over 70 percent of neglect related child fatalities have been attributed to parental alcohol and drug abuse. Substance abuse is a factor in at least 70 percent of child maltreatment cases. 13 percent of children nationwide live in a home were a parent or another adult uses illegal drugs. There were a reported 9.2 million drug endangered children living in the United States in 2005 (Stewart 2008; CASA white paper 2005:ii, 2, 20). Children in meth homes are 2.7 times likelier to be abused, and 4.2 times likelier to be neglected (Smith 2008; CASA 2005:2). Many child victims of abuse and neglect are placed in foster care.

Foster Care

Children are removed from meth homes by social services to save their lives, and to break the addiction cycle. Nicosia et al. (2009:xv) state that their child endangerment cost estimate likely underestimates the true cost to society, as it is limited to children removed from their homes by social services. Still, their estimate is significant. It includes $502 million for medical and mental health care, and quality of life losses suffered by children, as well as $403 million for costs directly related to the foster care system. Interviews in the rural Midwest with child welfare workers, foster parents, and other community professionals, such as police officers, led to the conclusion that children whose parents are addicted to methamphetamine are themselves prone to anti-social behavior and beliefs, such as lying, stealing, drug use, and acts of violence, thus perpetuating inappropriate and illegal behavior (Haight et al. 2005).

In a 2005 National Association of Counties Survey, child welfare officials from 303 counties in all 13 states where child welfare activities are performed at the county level were surveyed. 40 percent of officials reported an increase in foster care placements in 2004, with 59 percent reporting that meth increased the difficulty of family reunification efforts (NACo 2005:3). According to data provided for this thesis by Butte County Social Services, 62 percent of their total cases in 2004 led to successful family reunification, versus only 54 percent of cases opened as a result of DEC referrals. DEC referrals also have higher rates of adoption in Butte County, 12 percent of DEC cases versus 7.6 percent of the total number of children detained (data courtesy of Butte County CSD 2009). Overall, California counties reported a 71 percent increase in foster care placements due to meth between 2000 and 2005 (NACo 2005:3).

Modern social services systems in the United States operate on the belief that identifying potential hazards and removing children from meth homes in a timely fashion are important factors in mitigating health and safety risks to minors (Smith 2008; Ely interview with author April 23, 2009; Reyman interview with author March 29, 2009). That can be a difficult task. Social workers have to know how children are dying, in order to identify potential risks, so they can intervene and save them. Unfortunately, traditionally, child deaths in this country have been under-investigated and under-reported (SCDRC 2000). Attempts to rectify this shortcoming are ongoing.

In 1978, health professionals in Los Angeles County created the first multi-agency Child Death Review Team (CDRT). Currently all 58 counties in California, and many states across the nation, have active county level CDRTs (SCDRC 2000:i, Wirtz 2009). The function of these teams is to conduct systematic reviews of child deaths, in an

attempt to improve the identification, investigation, prosecution, and prevention of child abuse and neglect homicides (SCDRC 2000:I; Wirtz 2009).

National estimates of child abuse and neglect fatalities are believed to range anywhere from 1,000 to 2,600 deaths a year (SCDRC 2000:1). The lack of consistency in how deaths of children are investigated and reported makes it difficult to determine exact numbers. For instance, 1998 was one of several years that Sacramento Child Protective Services was under scrutiny by the Sacramento County Board of Supervisors, the Sacramento County Grand Jury, independent review panels, and the media, because they had repeatedly failed to accurately assess the threat level to children known to them. This resulted in the deaths of several children (Li 2009:1). That same year, 1998, Vital Statistics Death Records indicate that there were no child deaths resulting from abuse in Sacramento County, while the Child Abuse Central Index indicates there was one death from child abuse in Sacramento County, and the Department of Justice (DoJ) Homicide Files indicate there were six deaths resulting from child abuse in Sacramento County that year (SCDRC 2000:53).

In 1997 the State Child Death Review Council (SCDRC) initiated a pilot study involving CDRTs from Contra Costa, Kern, Placer, Sacramento, San Diego, Santa Clara, and Sonoma counties. The goal of the SCDRC was to acquire accurate, consistent information from all county CDRTs through the regular submission of a minimum set of data to be included in a statewide tracking system. The goal was to reduce the number of child deaths in California. In addition, the SCDRC, in conjunction with the California Department of Health Services (DHS), initiated an annual audit of the three existing

reporting systems, the DoJ Supplemental Homicide File, the Child Abuse Central Index, and the DHS Vital Statistics Death Records (SCDRC 2000:i).

In 1996, the same year it was reported that California had 48.6 amphetamine and meth admissions per 100,000 (SAMHA 2004:4), 463,000 of the three million children throughout the country reported to children's services as alleged victims of child maltreatment were reported in California. Nationally that year, approximately one million children were confirmed as child abuse and neglect victims. 182,000 of those were in California, which has the highest substantiated rate of child abuse and neglect in the nation (SCDRC 2000:1). Reports of abuse and neglect may not be substantiated for several reasons, including a lack of cooperation from family members during an investigation, a lack of sufficient evidence, jurisdictional issues, and agency manpower constraints (Finkelhor 2005:5). There are critics who maintain that California's rate of substantiated child abuse is exaggerated, and that children are often inappropriately taken into custody (e.g. Bacca 2004). However, higher rates of meth abuse contribute to higher rates of child abuse and neglect. California has one of the highest rates of meth abuse in the country. By 2002 the rate of amphetamine and meth admissions had risen to 200.1 per 100,000 in California. Only Oregon and Hawaii have higher rates per 100,000 of admissions for meth abuse each year (SAMHA 2004:4).

At the conclusion of the pilot program it was determined that the three existing statewide data systems do not provide an accurate picture of child deaths in California (SCDRC 2000:18), and that local CDRTs are a critical resource for the identification and tracking of child abuse and neglect fatalities (SCDRC 2000:17). During the pilot program, local teams reclassified six accidental child deaths as child abuse and

neglect fatalities. Local CDRTs can play an important part in encouraging law enforcement, child protective services, and the medical examiner's office to take a closer look at child deaths. CDRTs can do this in part by providing information, and improving communication, during child death investigations (SCDRC 2000:17).

It is important to note that it was determined that uninterrupted funding and staffing at the state level are required to implement a statewide data tracking system (SCDRC 2000:19). California's Child Death Review program was housed out of the Office of the California Attorney General and had an annual budget of approximately $325,000. Approximately $300,000 of that budget was used to provide support for local CDRTs (Wirtz 2009). According to the program description on the National MCH Center for Child Death Review: Keeping Kids Alive website (http://www.childdeathreview.org/), California no longer has a SCDRC. It was disbanded in 2008 when funds were cut. California counties still maintain CDRTs, but they are only authorized, not mandated, by Penal Code (PC) 11174.32 (Wirtz 2009).

Spending Money on Meth Treatment and Prevention Programs

Meth is costing taxpayers millions of dollars every year. The authors of the RAND monograph stated that the results of their study were surprising, considering the lack of national attention meth still receives compared to other drugs, especially marijuana. This is particularly true in light of the fact that there are far more meth-related deaths than marijuana-related deaths (Nicosia et al. 2009:xii).

Experts recommend extensive and drastic intervention and treatment in order to break the cycle of abuse. Although treatment can be time consuming and costly, when

considering the costs of multi-generational abuse, the consensus among professionals is that it would be less expensive to treat one generation, than incarcerate multiple generations. And simply removing children from an unsafe meth environment is not the answer. When children are placed in foster care, their families are affected for generations, and the overall costs to society increase (Governor of Montana, Brian Schwitzer, Justine Hunt, American Meth, DVD, 75 minutes, 2007; multiple presenters at CAN 2008).

For instance, a North State psychiatrist (personal communication October 18, 2009) noted the case of a 12 year old. His father is a meth addict with a history of violent behavior. His mother is bipolar and self-medicates with illegal drugs. The child presented with severe mood swings, irritability, depression, suicidal ideation, and incessant chattering. He was oppositional and defiant. He was treated with mood stabilizers and anti-depressants, and his treatment was carefully monitored. His socialization skills improved with treatment. However, when his mother is arrested, or released from prison and has contact with him, his behavior deteriorates. Ongoing treatment and support are therefore necessary to ensure his general health and wellbeing.

Does the Type of Treatment Even Make vva Difference?

In 2002 the editors of the Portland newspaper, *The Oregonian*, decided to go after the story on how and why the meth epidemic got out of control. Investigative reporter Steve Suo was assigned to the story (Steve Suo, Frontline, The Meth Epidemic, DVD, 60 minutes, February 14, 2006; Piccini 2010:49). According to Suo, records he gathered, including possession arrests and emergency room admissions, showed

addiction went up significantly from 1991 to 1992 (Steve Suo, Frontline, The Meth Epidemic, DVD, 60 minutes, 2006). SAMHSA data (2004) show that nationwide methamphetamine and amphetamine treatment admission rates for ages 12 and over was ten per 100,000 in 1992. There was a small dip during part of 1993, but the rates continued to rise during 1994 and 1995 (Steve Suo, Frontline, The Meth Epidemic, DVD, 60 minutes, 2006). SAMHSA data shows admission rates only increased to 14 per 100,000 in 1993, but rose to 22 per 100,000 in 1994, and 30 per 100,000 in 1995 (SAMHSA 2004).

Suo compared rehabilitation programs in Oregon with programs from other states, in an attempt to determine if some programs were more effective than others. He found that in every state, the number of people entering programs rose and fell in unison, even though different states had different programs, and different ways of dealing with addictions and addicts. Then he tracked the purity levels of meth during the same period of time. Over the years there have been simultaneous spikes and falls in meth use in all states, regardless of the type of program, but the rises and falls in use do correspond to the rises and falls in meth purity (Steve Suo, Frontline, The Meth Epidemic, DVD, 60 minutes, 2006). The data Suo gathered seems to support Haislip's assertion, as noted in chapter two of this thesis, that a significant key in decreasing meth addiction is to decrease meth production and purity, and the key to that is to cut off the supply of precursors. Graphs documenting admission rates and meth purity from Suo's 2004 meth series for *The Orgonian* can be accessed online at http://www.oregonlive.com/special/oregonian/meth/.

The next chapter explores cooperative program alliances currently in use to mitigate the impact meth is having on society. While some program changes require no significant additional funding, other changes are costing taxpayers billions in medical care, mental health care, toxic cleanup costs, lost worker productivity, and extended social services (Frontline, The Meth Epidemic, DVD, 60 mintues, 2006; CA DoJ, Meth Labs: Hidden Dangers, Video, 17 minutes, 2007; CA DoJ, Meth: Where Meth Goes Violence and Destruction Follow, Video, 17 minutes, 2007; CA DoJ, Meth: The Great Deceiver, Video 17 minutes, 2007; Conger 1997; Grant 2008; Haight et al. 2005; Lowry 2008; Stewart 2008; Walsh et al. 2003).

CHAPTER IV

PROGRAMS

Why Collaborate?

As noted in the previous chapter, as the problems generated by meth production and abuse increase, the need for services also increases, and more services tend to require increases in funding. Butte County, like every other county in California, is experiencing reductions in funding (Ely interview with author April 23, 2009). Despite budget cuts, a series of extensive programs have been developed in response to escalating methamphetamine production, distribution, and use. In addition, multiple existing programs have been modified to adapt to the changes in the drug culture since meth first emerged in Hawaii and on the West Coast. The most significant change in programming is agency cooperation. This chapter highlights professional collaborations and partnerships with community members.

A new approach, targeting and vilifying meth, instead of the meth user, has led to legislation focused on treatment, rather than punishment. For instance, Proposition 36 The Substance Abuse and Crime Prevention Act, passed by 61 percent of California voters November 7, 2000 allows first-and second-time nonviolent, drug possession offenders the chance to enter substance abuse treatment programs, instead of being incarcerated. In their final report evaluating Proposition 36, researchers Urada, et al. (2008:215-218) from the University of California, Los Angeles, Integrated Substance

Abuse Programs, summarized three studies assessing the cost implications and benefit-cost ratios of Proposition 36. In study one, costs for pre-Proposition 36 era comparison group offenders and all first year Proposition 36 eligible offenders over a 42 month period were compared. There was a net savings of $1,977 per offender. Two dollars were saved for every dollar invested. Study two found that there was a four dollar savings for every dollar spent on participants referred to the program who completed treatment. Study three examined follow-up costs for the succeeding year. It was determined that prison costs and costs for arrest and convictions have steadily declined since Proposition 36 was enacted. Researchers determined that prison costs in California were $4,302 lower per offender over the 42 month follow-up period. By providing treatment instead of incarceration for 61,609 offenders eligible for Proposition 36 in its first year, there was a total savings in state prison costs of $265 million, over a 42 month period (Urada et al. 2008:215-218). The act went into effect July 1, 2001. Details regarding Proposition 36 can be found at http://www.prop36.org. Considering the amount of tax money spent nationally each year on incarceration of drug offenders, as noted in the previous chapter, this significant piece of legislation may be a good template for other states to follow. The data seem to support the assertion noted in the previous chapter, that as long as treatment is effective, it is less expensive to treat a single generation than incarcerate multiple generations.

While treatment options for addicts appear to be increasing, so do programs that focus on the health and wellbeing of children of addicts. This view of children living in drug homes as victims is new to many public agencies. Karol Kumpfer, of the Center for Substance Abuse Prevention, in the United States Department of Health and Human

Services, insists that society has to start paying more attention to what is happening with the children of drug abusers, because these children need as much, if not more, treatment than their parents (Karol Kumpfer, CA DoJ, Meth: Where Meth Goes Violence and Destruction Follow, video, 17 minutes, 2007). As noted previously in this thesis, those who do survive childhood are at an increased risk of becoming addicts themselves, have more mental and physical illnesses, and use more public services than children who do not grow up in drug homes. As children they may exhibit low self-esteem, a sense of shame, and poor social skills. Overall, they will be absent from school more often, may feel isolated, and have poor peer relations (Swetlow 2003:4).

Arguably, the oldest, most expensive, and most widely used program for the mitigation of health and safety issues for children in meth homes, is the removal of those children from the home, for placement within the foster care system. Most programs designed to assist children in meth homes stem from this core program. A series of complex laws dictate how social services perform each of the necessary tasks to remove, place, and safeguard children. Everything they do is tied to at least one penal code (Nickelson interview with author April 28, 2009). Karen Ely, Assistant Director of Butte County Adult and Children's Social Services (interview with author April 23, 2009) stated that Butte County is higher than the state average for placing children in foster care, because of the amount of illegal drug use in the county. However, Butte County has relatively limited services for placement (Ely interview with author April 23, 2009, Nickelson interview with author April 28, 2009). Ely (interview with author April 23, 2009) indicated that as a matter of necessity, Butte County is actively seeking new community collaborations, in order to compensate for a lack of funding.

It is important to understand the foundation on which so many meth programs have been built, as well as how they are interwoven, and interact with other programs, within a new collaborative multidisciplinary approach to the meth epidemic. To that end, the following sections in this chapter begin with an overview of the various aspects of children's protective services. From there, the chapter continues with an exploration of collaborations designed to assist both meth addicts and children from meth homes. Many of those programs have either evolved from the foster care system, or have been adapted to work with, or within that system.

Mandated Reporting: What is it?

Generally, a child's journey into the foster care system begins when someone who knows the child contacts social services with a concern regarding suspected abuse or neglect of that child. Any private citizen may make an anonymous phone call to social services, to report suspected acts of abuse at their own discretion. However, certain classifications of individuals are mandated, required by law, to report suspected acts of abuse and neglect (Crime and Violence Prevention Center [CVSP] 2007, Tully interview with author July 29, 2008). Some mandated reporters, such as social workers at child protective services, are also required by their profession to act directly on that information to ensure the safety of children in jeopardy. As noted in the previous chapter, some mandated reporters, such as first responders, are at increased risk because of the meth epidemic. That risk, and how it is being mitigated, is discussed in greater detail later in this chapter.

It is the intention of the state that reports of child abuse become catalysts for change within the home environment, as child abuse in the home may be a cry for help from overwhelmed parents (CVPC 2007, various interviews). This view is relatively new. California enacted the first phase of the Child Abuse and Neglect Reporting Law in 1963. That first phase required physicians to report physical abuse. Since then, the law has expanded to include Penal Codes (P.C.) Sections 11164 through 11174.3. By 2007, P.C. 11165.7 listed and defined 37 mandated reporter categories, including teachers, foster parents, parole officers, school district police and security officers, licensed nurses, members of the clergy, custodians of clergy records, public assistance workers, social workers, probation officers, district attorney investigators, peace officers, firefighters, emergency medical technicians, and animal control officers (CVPC 2007:1-2).

According to the Office of the California Attorney General's Crime and Violence Prevention Center (2007:3), all mandated reporters must report the following types of child abuse: physical injury or death inflicted by other than accidental means (P.C. 11165.6), sexual abuse (P.C. 11165.1), and the willful harming, injuring, or endangerment of the person or health of a child (P.C. 11165.3). Sexual abuse includes sexual assault and sexual exploitation. Sexual assault includes sex acts with a child, lewd or lascivious acts with a child, and intentional masturbation in the presence of a child. Sexual exploitation includes the preparation and distribution of pornographic materials involving children, as well as employing or coercing a minor to perform in pornography or engage in prostitution (P.C. 11165.1). As previously noted in this thesis, children in meth homes are considered to be especially at risk for all types of abuse and neglect. When a social service worker is able to verify a significant and imminent threat to a

child, that child is removed into protective custody, and made a ward of the state (Ely interview with author April 23, 2009).

The Basics of How Children's Services Works

Butte County Children's Services Division (CSD) receives thousands of referrals each year, involving suspected abuse and neglect to minors. In 2008, there were 4,543 referrals, or reports, of suspected abuse, neglect and maltreatment (data provided by Butte County CSD 2009). Children identified as being at-risk because of drugs in the home are routinely removed from the custody of their parents (Walsh et al. 2003:1409; Haight et al. 2005). During the 1980s California saw a sharp increase in drug abuse, family violence, child abuse, neglect, and homelessness. As a result, foster care placements in California increased more than 80 percent (Ayasse 1995:208).

Social service employees are mandated by law to intervene and provide services to families who are abusing and/or neglecting their children. This forms the foundation for how Butte County approaches abuse and neglect referrals. There is an intake unit that receives phone calls, faxes, and walk-ins from people making referrals. Once the office receives an allegation, investigators go out into the field to do interviews. If it is determined that there is abuse or neglect in the home, there are different paths that they can take (Ely interview with author April 23, 2009).

For instance, when cases are determined to be serious, but have not risen to the point where children need to be removed from the home, social services will initiate a non-detained petition with the courts. The family will then receive court ordered services. The final choice is to remove the child from the home environment. In order to do that

there must be an imminent risk of some kind of harm to the child due to abuse or neglect, such as ongoing drug abuse in the home (Ely interview with author April 23, 2009).

Once children have been removed from the home, their parents are eligible to participate in a support group Butte County has developed to help them through the first eight weeks that the family is in the system. During the meetings, parents learn about children's services. They can decompress, deal with their anger, and learn what is going to happen to them and their family in the next few months. After that they have a selection of services, such as anger management, parenting classes, life skills and individual counseling, through partners such as Northern Valley Catholic Social Services (NVCSS) and Counseling Solutions, as well as behavioral health, public health, and individual therapists in the community (Ely interview with author April 23, 2009). For instance, in fiscal year 2004 – 2005 NVCSS, in partnership with Butte County Social Services, provided facilitation services to 135 families through The Facilitating All Resources Effectively program (NVCSS 2005:7). Also, NVCSS Court Appointed Special Advocates (CASA) provided services to more than 90 children in Butte County (NVCSS 2005:7)

While parents are decompressing, children placed into the system must adjust. Perhaps the people most important in helping children adjust are the foster parents. Foster parenting is about providing a safe, stable environment for children. But, foster care is supposed to provide more than that. If the cycle of abuse is to be broken, children must have support and options, interests beyond courtrooms and doctors' appointments (Multiple interviews, including Nickelson interview with author April 28, 2009). According to Donna Nickelson, the licensing evaluator for Butte County foster homes,

when you do the math, what foster parents are given for reimbursement generally does not cover what they will spend on each child. The expenses for a foster child do not just include basics like food and clothing. The foster parent is responsible for transporting the child to medical appointments, educational appointments, visits to incarcerated parents, court dates, counseling, speech therapy, whatever is necessary for their health and wellbeing, or for their journey through the system as a foster child. A foster parent also has to provide things like leisure activities. Nickelson feels foster parents need to promote the arts and music. These are good outlets for foster children, every bit as important as reading and math. Cultural activities and social interaction are things foster parents are expected to facilitate.

Children removed from drug homes have special needs. Butte is one of about half a dozen counties that has a program called Options for Recovery. The program includes specific training for foster parents on how to care for drug-endangered children. The program is for infants and toddlers of parents who have drug and alcohol issues. Often these children have more medical needs than other foster children. Options foster parents have 40 hours of specialized training, in addition to the training received by other foster parents, and they must retrain every year (Nickelson interview with author April 28, 2009).

When a child needs to be placed, children's services first looks at relative placement, both locally and out of the area. Some children are transported to relatives out of state. However, many of the families in the system are generationally involved. Past issues, generally criminal records, preclude the placement of children with relatives. It is the hope of social services when they remove children from their families that they will

be able to break the cycle of drug abuse and violence (Nickelson interview with author April 28, 2009).

Placements can be traumatic for children. No matter what has happened, children love their parents, even though they may have an abusive relationship with them (Nickelson interview with author April 29, 2008, Reyman interview with author March 29, 2009). And there can be a stigma attached to a child's removal, as though they are somehow responsible for their parents' actions. The term "meth orphan" has being used to negatively label children thought to be damaged by their parents' illicit drug use. This label is reminiscent of the term "crack baby" of the 1990s. Researchers Lester et al. (2006:30) fear similar consequences regarding prejudice against children from meth homes, if the label persists.

Silona Reyman is a licensed therapist in Butte County who was a CPS worker from 1979 to 1988. She left the county to go into private practice. She has worked with children as young as three, using play therapy. Reyman helps children understand that what happened in their homes is not their fault. She stated that directed, focused, play therapy has a healing component. It allows children to safely express themselves using surrogates, such as dolls, and plastic dinosaurs. The play eventually evolves into talking. She feels children tell you what they want to tell you when they think you are ready to hear it. She also believes that children have an intrinsic way of processing things that happen to them, but they need structure and consistency in their relationships. They need to trust (Reyman interview with author March 29, 2009).

Many children from drug homes have significant trust issues. Ostler et al. (2007:501) interviewed 23 children from rural meth homes. They state that 17 of the

children expressed clear emotional pain, including feelings of fear, intense anger, and aggression. Some reported nightmares about cutting themselves. 18 children directly expressed a lack of trust in their parents, indicating that their parents lied and broke promises. 13 children reported using avoidance techniques and passive strategies, including staying away from home and listening to music through headphones, in order to cope with their parents' meth use (Ostler et al. 2007:503).

Regardless of what the parents have done, the children identify with them. (Reyman interview with author March 29, 2009). Reyman feels strongly that one of the things that helps children trust therapists, is if the therapist likes the birth parents. Keeping children connected to their families in some way, even it if it is just a letter a year from a parent, is important. Reyman emphasizes, that too often children are placed in a new family and essentially told they must start over. Sometimes it is not just parents they have been separated from, but siblings as well. Reyman points out that they will grieve the loss of those family members. They will experience loss upon loss, and that sets them up to be the next generation who may deal with a lack of self-worth by using drugs.

Butte County Statistics

A report produced with the cooperation of Butte County Public Health and the Butte County Methamphetamine Strike Force states that approximately 90 percent of the children removed from their homes in Butte County are from meth environments (Communities Mobilizing Against Methamphetamine Addiction 2008:12). The report indicates that in 2007, there were 57 drug endangered children investigations in Butte

County involving 122 children. Children's Services Division (CSD) provided services to 110 of the children. 63 were removed from their homes (Communities Mobilizing Against Methamphetamine Addiction 2008:8). Somewhat in contrast to that data, data provided for this thesis by CSD indicates that on April 21, 2009 there were 609 minors in foster care in Butte County. Of those children, only 42 were removed from parental custody as drug endangered children (data courtesy of Butte County CSD 2009). The apparent discrepancies in how many children are in custody as a result of living in a meth environment may be due in part to how agencies collect data involving children.

Table 2 represents a summary of the children who were brought to the attention of Butte County CSD in 2004 because of suspected cases of abuse or neglect linked directly to drug abuse. However, the table does not represent all DEC children involved with CSD. When there is a report of suspected abuse or neglect, no matter how many children are in a home, the referral is only assigned to one child, usually the youngest. If detained, a file is opened for each child, but those numbers are not recorded in the table below. If drugs were not specifically noted as being the reason for the original referral, the case is not noted in the table. Therefore, the table is perhaps more representative of the number of families referred to CSD specifically because of drug abuse, than the specific number of children who were actually removed as drug-endangered children. Also, not all DEC cases involve meth. The table indicates that there were 133 DEC referrals (first time report of abuse or neglect), 169 DEC re-referrals (reports of subsequent abuse or neglect received by CSD through September 2006, following an initial 2004 referral), and 67 DEC cases opened in Butte County as a result of either a referral or re-referral (data courtesy of Butte County CSD 2009).

Table 2. *Drug-Endangered Children in Butte County*

Referral Findings	# Initial DEC Referrals	Re-Referrals	Case Opened	FR Successful	FR with Non-Offending Parent	PP	Adopt	FR Open	Guardian-ship	Unknown Sensitive
Evaluate Out	36	37	5	2	0	3	0	0	0	0
Inconclusive	20	57	5	2	0	1	1	1	0	0
Substantiated	69	78	55	27	4	11	7	0	3	3
Unfounded	6	19	2	1	0	1	0	0	0	0
Unknown	2									
Totals	133	191	67	32	4	16	8	1	3	3

DEC=Drug Endangered Children; FT = Family Reunification

Source: Table recreated from data obtained from Butte County Adult and Children's Social Services, Oroville, CA.

Column one represents various possible outcomes of referrals to CSD, while the top row indicates the status of the children. For instance, 16 children have open permanent planning cases. They were permanently placed in foster care and there are no plans to return them to their parents. Eight were either adopted or were freed for adoption. One had an open family reunification case. Three were placed with guardians. The status of three children is unavailable due to a sensitive nature.

Discrepancies in data, and incomplete records involving children, can make it difficult for researchers to determine the true scope of the problems faced by children living in meth environments. This may hamper the development of programs that might mitigate health risks. It may also contribute to delays in legislation that could benefit children found in meth homes.

The Parent's Day in Court: Advocating for the Child, and Mandated Reunification of Families

Tamara Mosbarger (interview with author April 13, 2009) is the supervising juvenile judge for Butte County. She handles all of the dependency cases. Any time children are taken out of their home by CSD, a detention petition is filed by the court. She hears those cases. If it is found that there is sufficient evidence to detain a child, there is a detention hearing. Then there is the jurisdictional hearing. After the jurisdictional hearing, if there is sufficient evidence to support the allegations of wrongdoing, there is a disposition hearing. At that time, CSD makes recommendations as to what should happen next with the family. They may recommend family reunification services to the child and his or her caretakers. Caretakers can be legal guardians, parents, or grandparents. If there

is a reason CSD feels reunification is not appropriate, such as continued drug use, they will give their reasons at that time. The family might be placed into planned family maintenance. That gives the family some level of services while the child remains in the home. That is usually not the recommendation at the disposition hearing. The child is usually made a dependent of the court, and the date for the six-month review is set (Mosbarger interview with author April 13, 2009; Ely interview with author April 23, 2009).

The direction from the California Legislature is to reunify families, if at all possible. With a child under three, the family has six months to make substantial changes. If they do not make substantial progress in six months, there is a chance there will be a recommendation to terminate services and place the child up for adoption. It does not happen often that a family is only given six months, unless they are actively using drugs and have made no effort to visit the child and participate in services. This is because the counterbalance to family reunification is finding a stable and permanent placement for the child. If the child is older than three, then the family has 12 months to make progress and reunify. Sometimes up to 18 months is permitted, if at the 12 month point it looks like the parents have made enough progress that the child will be able to return home in another six months. At the six-month review, the family might be placed into maintenance, allowing the child to return to the home of the parent, while the parents' level of sobriety is monitored. Most of the parents who have children in the system have alcohol and drug issues, little education, no employment, and unstable housing (Mosbarger interview with author April 13, 2009; Ely interview with author April 23, 2009).

Butte County has a dependency drug court program. Up to 20 families at a time are enrolled in the program and given intensive services. Usually parents start out with a residential treatment stay, which is separate and apart from their dependency action. They go to a treatment group about three times a week. In addition they have individual counseling sessions. They have to go to alcoholics anonymous or narcotics anonymous meetings. They must agree to be tested regularly. (Mosbarger interview with author April 13, 2009; Ely interview with author April 23, 2009). Currently in Butte County, drug court is reserved for parents with children ages zero to three. There are specific social workers assigned to dependency drug court. That is the only load they carry, so they are able to see those clients two to three times a week, instead of the mandated once a month (Ely interview with author April 23, 2009).

If parents do not complete the drug court program, it does not necessarily mean that the court will not give their children back to them. However, if parents do not complete the program, it is generally believed that they are not clean and sober, and the court will not give children back to parents who are using. According to Mosbarger, the incidence of child abuse and neglect when parents use methamphetamine is too high to risk sending children back into meth homes. Parents are concentrating on their addiction, instead of caring for their children. Mosbarger states that meth is an awful drug that ruins lives and puts children in extreme jeopardy. She is concerned about the risk of creating another generation who will abuse drugs (Mosbarger interview with author April 13, 2009). Even if a parent appears to be clean and sober, if they have not learned other ways to deal with stressors in their lives, and have not found friends and interests outside of the meth sub-culture, they are at extreme risk for relapsing (multiple interviews, multiple

CAN presentations 2008). Children are at continued risk if that happens. If the biological parents are unable to remain clean and sober, they are not available to parent the child, and the child cannot be in the home (Mosbarger interview with author April 13, 2009; Ely interview with author April 23, 2009).

However, just because someone uses or relapses, that does not necessarily mean that they are failing in the recovery process. Relapse is now considered to be part of the recovery process. The court looks at what the parent is trying to do, and whether they are honest. When relapses happen while the parents are part of the system, social services tries to support them through the recovery process. They do what they can to help parents get their children back. Children want their parents, and the ultimate goal of the state is to return children to their parents. But, the state is obligated to ensure the safety of those children.

Balancing the safety of children with mandated reunification is a complex business (Ely interview with author April 23, 2009; Nickelson interview with author April 28, 2009, Mosbarger interview with author April 13, 2009, Reyman interview with author March 29, 2009). Despite the state focus on reunification, Reyman says doing that has become harder, in part because the use of meth has created more violent, abusive, and neglectful homes than social services dealt with in the past, and in part because there are now time limits on reunification. When Reyman began working for social services in 1979, there were no time limits. So, while there is a press for reunification, and an understanding that relapse is part of recovery, there is also less time for parents to make progress (Reyman interview with author March 29, 2008).

Beyond Foster Care

According to the United States Census Bureau, in 2000 Butte County had 6,058 families (12.2 percent) and 39,148 individuals (19.8 percent) living below the poverty level. Research indicates that former foster children are among the most likely to be included in those statistics (Ayasse 1995, Whiting and Lee 2003), and the children of drug addicts are likely to become foster children (multiple interviews, multiple presenters at CAN conference 2008).

Teens aging out of the foster care system experience a number of problems, including homelessness, a lack of job opportunities, and an inability to form healthy relationships with others. Working against a history of failures they must form alliances and become self-sufficient without the same type of support systems other adolescents rely upon (Altshuler 2003, Whiting and Lee 2003). Again, in the case of children from meth homes, this can mean that the children will grow up to repeat the coping mechanisms they learned from their parents, continuing the cycle of drug abuse.

Tami Thompson is the Butte County Independent Living Program (ILP) Coordinator. The program is for teens emancipating from the foster care system (aging out). Foster children begin ILP when they are 16, in order to work on their foster care exit plans. They look at college, jobs, where they will live, and how they will pay for things they need. ILP is a federally mandated program, but Butte County is unique in California, because they provide services on an individual level. And unlike other programs for foster children, ILP works with them until they are 21. Thompson's observation is that whether or not drug-endangered children perform differently in the program depends on

how early they were removed from their homes (Thompson interview with author May 7, 2009).

The program is driven by the needs of the teens. They do workshops on things like grocery shopping, where teens are given five dollars and then taken to the store where they have to use that money buy food for three days. Caseworkers help teens explore careers, and find ways to help them get work experience. The program is about life skills and setting goals. Programs like this may help to better prepare foster teens to go out into the world on their own, but programs do not fully replace a strong family support network.

Opposing Views of the Foster Care System

While the intention of the child welfare system is to protect children by removing them from the unsafe and unstable environment found in meth homes, multiple studies question the effectiveness, and even the safety and viability of this country's foster care system and child protective measures. They claim the system is not a solution, but part of the problem (e.g., Walsh et al. 2003:1409; Lester et al. 2006). A recent study (Lester et al. 2006) strongly advocates leaving children in homes with meth addicts, instead of placing them in foster care. The researchers claim that better in-home services and increased monitoring of addicted parents are the better solution.

Lester et al. (2006) fear that misinformation about methamphetamine, and the prognosis of children exposed to methamphetamine, create an additional risk for children already at risk. During the course of their study of multiple sites in the United States and New Zealand, they determined that methamphetamine is the only illicit drug that does not

have a lower use rate for pregnant women than for non-pregnant women. They also found that 51% of meth users in the study had referrals to CPS, versus 6% of nonusers. They concluded that effective early intervention can be complicated in rural areas due to issues with transportation, income, and education. Shame and stigma regarding mental health and substance abuse issues can be amplified in small communities. There may be issues regarding non-English speaking users and those with non-mainstream cultural beliefs regarding medical care. Methamphetamine users tend to have a lower socioeconomic status. Meth users also may experience depression and paranoid symptoms that exacerbate their substance abuse, and give them perceived reasons for not leaving the house. Because of this, meth users may avoid prenatal care appointments. When they do seek prenatal care, they have fewer appointments than non-meth users (Lester et al. 2006).

Meth exposed newborns in the Lester et al. (2006) study had lower birth weights and were 4.5 times more likely to be small for gestational age than babies born to non-methamphetamine users. Methamphetamine use in the first trimester resulted in more signs of stress in infants. Meth use in the second trimester was associated with more lethargy in infants. Meth use in the third trimester was associated with poor quality of movement and greater physiological stress.

Infants born to meth users tend to be irritable as newborns, but swaddling soothes them, as does being held. This protects them from environmental stimulation. Most gain weight well, and do not appear to have more detectable malformations then children of non-users. No significant developmental delay was detected in methamphetamine exposed infants at the Los Angeles study site. When they were placed

in nurturing home environments they appeared to bond normally (Lester et al. 2006). The significant point of that finding though, is the importance of nurturing home environments. As clearly noted previously in this thesis, caregivers who abuse meth are not capable of providing safe, nurturing homes. Researchers at the Hawaii site for the Lester et al. (2006) study indicated it is difficult to distinguish between children who were prenatally exposed to meth and those who were not. The researchers concluded that families with meth issues should be provided with parenting, medical, and mental health support and care (Lester et al. 2006). The implication is that if intervention happens soon enough in a child's life, that child has the chance to grow and mature normally, and to become a healthy, productive citizen. Unfortunately, limited resources present a challenge in providing the services for intervention.

Many private and government studies have shown that placing children in foster care, especially if they are placed in multiple homes, can stunt their emotional development (e.g., Whiting and Lee 2003; Finkelhor et al. 2005; Ayasse 1995; Geroski and Knauss 2000; Jacobson 1998; Altshuler 2003; CA Department of Education 2005). They are less likely to make secure attachments. Most experts who question the effectiveness of the current foster care system advocate revamping the system to make it more child friendly. In contrast, Lester et al. (2006) claim that the developmental risks of insecure or disorganized attachments is greater than the risk of methamphetamine exposure in respect to the child's long term health and development.

They compare New Zealand's approach to women who abuse substances during pregnancy to that of the United States. There are two critical differences. Firstly, women who use in New Zealand, but who actively seek prenatal care, and participate in

drug treatment, or are actively monitored by social service agencies, are considered to be under treatment. They are not punished for their drug use by losing custody of their children. In contrast, 26 percent of the infants in the methamphetamine group in the United States sites for the Lester et al. (2006) study were in out-of-home placement by the age of one month. Secondly, most maternity care is free for citizens and permanent residents of New Zealand. If a woman is determined to be at high risk for drug abuse, a multidisciplinary and specialized care program provides them with comprehensive obstetrics, neonatal, and postnatal care, as well as psychiatric services and drug counseling. The range of social services is tailored to the needs of each high-risk pregnant woman in New Zealand. The researchers feel that the task in the United States is to develop treatment approaches that integrate substance abuse treatment, mental health, and early intervention services for families affected by meth abuse. Although methamphetamine use by pregnant women is an important health problem, so are things like lack of family support for parents, inadequate access to medical care, and untreated mental illnesses (Lester et al. 2006).

In contrast to that approach, in the United States thousands of children are permanently placed into the system each year. These children are likely to grow up to spend their adult lives at a lower socio-economic status than the average American adult. As a general rule only the youngest foster children are adopted. Many remain wards of the system and are often moved through multiple placements, including group homes. They are less likely to graduate high school and are more likely to be incarcerated. The trauma created through the mechanism of the system can exacerbate pre-existing, or even cause, severe emotional issues. Many foster children have psychological problems, as

well as problems regarding education. (Whiting and Lee 2003; Finkelhor et al. 2005; Ayasse 1995; Geroski and Knauss 2000; Jacobson 1998; Altshuler 2003; CA Department of Education 2005; Whiting and Lee 2003; Parrish et al. 2001). For instance, as they move from one foster home to the next, children may change schools, and even school districts. Karen Ely (interview 2009) stated that Butte County CSD works closely with the school district to ensure records of foster children are promptly transferred. However, that may not be the case in every county. In their report to the California Department of Education, Parrish et al. (2001:1-5) indicate that one of the obstacles faced by foster children is a 40 to 82 day delay of school records between schools.

Children from meth homes placed in foster care may also have trouble accessing services. According to the United States Department of Justice (Finkelhor et al. 2005:7), in 2003, more than $37 million was provided toward services for child abuse victims, including the children of meth addicts. More than half of that was spent in California. However, the Justice Department has no data available on how many eligible children apply for services each year. And there are multiple complaints regarding a lack of services for children in California. In documents filed with the California District Court, attorneys Newman et al. (Katie A., Mary B., Janet C. Henry D. and Gary E. vs Department of Health Services, Los Angeles County CV-02005662 AHM SHx [2005]) claim that the intervention programs that are proven to be most effective are not covered by Medi-Cal. Therefore foster children do not have access to those treatments. The suit claims that more than 50,000 children in foster care in California may be in need of mental health services that they are not receiving. As noted previously in this thesis, those

with untreated mental health issues may seek to self medicate with illegal drugs, perpetuating the cycle of drug abuse.

Most of the criticism of foster care seems to focus on complaints that children are removed from their homes too quickly and without cause. There are allegations of greedy foster parents and program administrators (Bacca 2004). But, is the social services system in the United States capable of monitoring members of the meth sub-culture well enough to ensure the safety of children, if they are left with their parents? Under current law, cases must be closed, if CPS workers are not able to find clear evidence that a child is in imminent danger (Reyman interview with author March 29, 2009, Ely interview with author April 23, 2009). The next section demonstrates the potential danger in leaving at-risk children in drug homes, by placing too much emphasis on maintaining family units. Policies, current laws, lack of funding, and lack of staff are significant barriers to properly monitoring children in drug homes.

Sacramento: Not Enough Children Removed Quickly Enough

Sacramento CPS had a long history of scrutiny and investigation behind them, when in 1996 the Sacramento Board of Supervisors created The Critical Case Investigation Committee to investigate the death of Adrian Conway, a child whose family was known to CPS (Li 2009:1). The panel of independent experts was tasked with determining if the death of Adrian was the result of systemic problems within the agency. Both the committee and the grand jury concluded that Sacramento CPS left vulnerable children at risk by placing too much emphasis on keeping troubled families together (Li 2009:1).

In 1997 Sacramento CPS was mandated by the board to be more aggressive in its removal of children from known drug homes. This mandate stemmed from the death of another child whose family's file with CPS had been closed after the risk to the child had been assessed as moderate to low (Li 2009:1). The Board of Supervisors also added 58 positions to CPS, and authorized the creation of a Child Protective Systems Oversight Committee (Li 2009:1).

Between 1997 and 2007, the oversight committee investigated 13 critical incidents and one near fatality involving children and families known to CPS. The committee issued eight reports with 281 recommendations for improvements to the system. Despite changes, the death toll of children who were killed by their parents or guardians, after they were known to Sacramento CPS, continued to rise. Between September 2007 and December 2008, 10 children known to Sacramento CPS were killed (Li 200:1, 4).

MGT of America, Incorporated was awarded a contract by Sacramento County to conduct a review of Sacramento CPS services between September 2008 and February 2009. The review focused on seven cases involving child fatalities (Li 2009:2-3). Although MGT stated that the staff they talked to demonstrated great commitment and dedication, the review determined that families involved in the Sacramento child welfare system are underserved, and that CPS is not doing enough to protect children from abuse and neglect (Li 2009:3-4).

Despite laws designed to protect children, and the best efforts of a diverse range of professionals, a significant number of children throughout the United States slip through the cracks every year. Too often abuse and neglect result in death (SCDRC

2000:i). Methamphetamine related child abuse and homicides are not just the result of a single act of violence. The violence escalates over a period of time. Someone knows a child is in jeopardy, before that child is seriously injured or killed (Dan Goldstein, CA DoJ, Meth: Where Meth Goes Vilnece and Destruction Follow, video 17 minutes, 2007).

The state of California views child deaths from abuse and neglect as preventable (SCDRC 2000:1). Important ways to ensure the safety of children from incidents in homes with meth use are to properly monitor circumstances, accurately assess their risk, and when children are removed from their homes, ensure that they are placed in safe environments (Smith 2008; Hohman et al. 2004:379). In order to meet this challenge, a growing number of communities have developed multidisciplinary teams of professionals who have previously worked independently of each other, and have sometimes even been at odds with each other.

The DEC Multidisciplinary Response

According to an FBI Law Enforcement Bulletin (Harris 2004:8), it is estimated that children are found in approximately one-third of all meth labs during raids nationwide. Approximately 35 percent of those children test positive for toxic levels of chemicals (Harris 2004:8). Also, when young children are detained, they often test positive for drugs, especially meth and marijuana, because they are exposed to it in the home (Mosbarger interview with author April 13, 2009).

Marci Caywood is a public health nurse in Calaveras County. She works with social workers to fulfill specific protocols that need to be followed when children are removed from drug environments. Drug-endangered children (DEC) are treated a little

differently. For instance, when they are removed from their homes they may need to get a clearance in the emergency room to ensure that there are no immediate medical issues, especially if they have been exposed to meth or the chemicals used to make it. Once that is done, the children are placed in a temporary foster home. Caywood provides consultation to the nurses regarding any ongoing health care needs the children may have, and she assists the social workers in trying to link drug-endangered children to care options. Developmental checks are done through Head Start, and Caywood works as a liaison between providers and the social workers, educating providers about the special needs of foster children (Caywood interview 2008).

Often when older children are detained, they test positive for marijuana or prescription drugs that have not been prescribed to them, because they are using. That is what is modeled for them in the home (Mosbarger interview with author April 13, 2009). Drug abuse, mostly prescription dugs, especially extremely addictive opiates like OxyContin, is one of the toughest issues junior high, high school and college campuses face (Mosbarger interview with author April 13, 2009, Beck interview with author February 4, 2009, and multiple interviews at university counseling center January 30, 2009). As more parents model meth, there is a risk of more adolescents using illegal drugs.

Despite this, prior to 1995, parents were generally not prosecuted for child endangerment if there were children present during a meth lab seizure (Hohman et al. 2004:377). Law enforcement personal have traditionally not raided meth labs with the intention of identifying children and their needs, but to look for drugs, guns, and bad guys. They were not trained to rescue or save children (Weber-Brown and Hirsch 2008).

The common response of law enforcement when they found children during a raid was to hand them off to any available neighbor or family member. The children were considered to be in the way. Rarely did law enforcement even call social services to let them know children were not with their biological parents (Gerhardt 2008).

In 1995 a home lab exploded in Riverside, California, killing three children. The mother was convicted of second-degree murder (CA DoJ, Meth: Where Meth Goes Violence and Destruction Follow, video 17 minutes, 2007; Hohman et al. 2004:377), and the California legislature enhanced penalties for adults caught manufacturing methamphetamine in the presence of children younger than 16 (Penal Code 273) (Hohman et al. 2004:377).

In 1997 the Governor's Office of Criminal Justice Planning in California awarded $3.2 million to seven counties to conduct a drug-endangered children's (DEC) pilot program (Hohman et al. 2004:377). Sue Weber-Brown, a Butte County Sheriff's Deputy, developed the DEC program in 1993. The DEC program goals are to rescue, defend, shelter, and support drug-endangered children. The program relies on a multi-agency approach. Partners in the DEC multidisciplinary effort include children's protective services, adult protective services, public health, Housing Authority, schools, code enforcement, probation, medical personnel, in-home care, drug court, law enforcement, fire department, Medi-Cal, rehabilitation and treatment services, researchers, community coalitions, parole officers, day care workers, mental and behavioral health professionals, animal control, tribal leaders, dentists, caseworkers, and child advocacy workers. The core of the DEC team though relies on cooperation among law enforcement personal, social services, and district attorney's offices (Weber-Brown

and Hirch 2008; Brown 2008; Gerhardt 2008; Tully interview with author July 29, 2008, Ely interview with author April 23, 2009, Butte County Methamphetamine Strike Force 2008, Butte County Public Health 2008, CADEC 2008:2). The state sponsored pilot program was to encompass a three-year period beginning in fiscal year 1997/1998. Each DEC unit was overseen by their County District Attorney's Office. This award also established a DEC resource center, in order to provide training and materials for professionals throughout the state (Hohman et al. 2004:377).

The DEC program has spread across the United States. Literature from the California Alliance for Drug Endangered Children (CADEC 2008:4) states that as of November 2007, there are at least 30 states that have DEC programs administered through state Attorney General's Offices, Governor's Offices, and non-profit organizations. Additional states, such as California, have programs at the county level.

Sergeant Jim Gerhardt (2008) of the Thornton Police Department in Colorado stated that when he initiated a DEC program in Adams County, collaboration was difficult. Traditionally, law enforcement and child protective services have held different roles, have had different goals, and have seen things differently with regard to children in drug homes. Law enforcement is taught to seek out and arrest offenders, not to look for victims. The view of social services was that law enforcement tended to escalate issues. They were hesitant to investigate jointly with law enforcement, in part because they feared the loss of autonomy in their own investigations (Gerhardt 2008).

The Spokane County (Washington) DEC project was initiated October 1, 2003. The first task of multi-agency participants was to gather baseline information regarding drug-endangered children (Altshuler 2005:176). An evaluation of the first year

of the project included findings from the baseline assessment, and looked at how well the various agencies that participated in the community-based collaboration interacted (Altshuler 2005:171-172). The baseline risk level of abuse and neglect for the 22 children assessed through the DEC project the first year was high, and the parents demonstrated a high risk of substance abuse (Altshuler 2005:181). Prior to the DEC project, the needs of drug-endangered children were not identified in Sponkane County, and the various agencies involved did not communicate with each other. Many cases were closed without referrals to follow-up services. Spokane County CPS files lacked necessary assessments and medical information (Altshuler 2005:185-186). During the first year evaluation, participating members of the DEC Team expressed satisfaction with their collaborative efforts (Altshuler 2005:185). Altshuler (2005:185) cautions that independent observers of team meetings did not appear to consider the collaboration to be as successful. For instance, they gave the team low marks for clarity of goals and team member communication. Altshuler (2005:185) notes that team members who are invested in the project may self-rank their levels of collaboration more highly than is accurate. However, Altshuler (2005:185) also suggests that there may have been higher levels of collaboration outside the meetings that the independent observers did not witness. Altshuler (2005:187) concluded that overall the Spokane County DEC Team is an example of a successful community collaboration.

Participants in DEC programs across the county seem to feel that the collaborations are successful, and the program is continuing to replicate (multiple interviews, multiple presenters at the 2008 CAN conference). Law enforcement has found the partnership has increased their arrest and conviction rate (Weber-Brown and

Hirsh 2008). Drug offenders are often able to plead down, and even eliminate drug charges completely. Child endangerment in California is a felony that carries a six-year sentence, and is often the strongest case against adults arrested in a drug raid. In fact, if the crime has been committed in an apartment instead of a single-family home, child endangerment charges can be applied for every child living in the complex (Weber-Brown and Hirsch 2008).

Social service workers only have so much power when it comes to encouraging parents to provide a safe environment for their children. Sometimes it is best to call on another agency for assistance. For instance, code enforcement can condemn a home for a fire hazard and force the adults to clean the home and make repairs (Smith 2008). Social workers can now count on law enforcement to protect them as they take custody of children. Their ability to ensure the safety of children has increased through cooperation with multiple agencies (Smith 2008).

According to Christine Smith, MSW, Orange County Children and Family Services, when they get a call related to child abuse or neglect, the first thing a social worker does is run a CPS history check. This is to determine if there have been prior child-abuse referrals, whether or not there is an open dependency case, and if there are other families residing in the home. This helps them decide if law enforcement should be called in to assist. Also, Smith advises her social workers to call law enforcement before going out to a home where there is a suspicion of drug abuse, in order to coordinate efforts. Apparently there was an incident that occurred while social workers were interviewing a family that unbeknownst to them was the target of a police investigation.

The social workers ended up face-down on the floor along with the family members during a raid.

As law enforcement and social services work together, and cross train, they gain new insights into their own jobs. For instance, police officers learn that maltreatment and neglect are primary causes of death, and that a child playing out on the street late at night can mean they live in a drug home (Brown 2008; Brown and Hirch 2008; Gerhardt 2008; Ostler 2007:5). DEC partners operate under the assumption that intervention is the key to saving children, and breaking the cycle of drug abuse and neglect. A study conducted by Gerra et al. (2007) suggests that children raised in neglectful homes with poor child-parent relations may be more likely to develop substance abuse problems as adults, the result of a neurobiological derangement, which includes a dopamine system dysfunction. As noted previously in this thesis, those who work with drug-endangered children fear that if there is no intervention, in addition to drug-endangered children becoming the victims of abuse and neglect, they may drop out of school, have lifelong health issues, be financially dependent and unemployable, become a drug dealer or gang member, and even become a child abuser or sexual predator themselves (e.g., Weber-Brown and Hirch 2008, Brown 2008; Haight et al. 2005).

By encouraging multiple disciplines to work together toward one goal, building a case together, communities are able to pool resources, and find more effective ways save to children. When a lab is raided and children are removed from the home, it is often the last, and perhaps best, opportunity for the members of a community to help one of their families (Shasta County's Drug Endangered Children's Program 2009; Weber-Brown and Hirsh 2008). Identifying drug-endangered children, intervening quickly, and

ensuring that children are placed in a safe environment once their parents have been taken into custody, are chief goals of DEC units (Brown 2008; Butte County Methamphetamine Strike Force 2008; Butte County Public Health 2008; Weber-Brown and Hirsch 2008).

Protection and Looking out for Each Other

Probation officers, public health nurses, child protection workers, and many others have a need to go into methamphetamine homes, which, as noted in chapter three, are toxic environments. This is a health hazard for them and those they subsequently come into contact with. For instance, if a social worker gets chemicals on her shoes, and then goes to her own home and walks across the carpet, and she has a toddler who is crawling on the floor, the toddler can be contaminated with methamphetamine (CA DoJ, Meth Labs: Hidden Dangers, video, 17 minutes, 2007). Also, as noted in chapter three, first responders receive half of the injuries sustained as a result of meth production.

Gail Beckham, Hazmat Specialist, Hazardous Materials Division, San Bernardino County Fire Department (Gail Beckham, CA DoJ, Meth Labs: Hidden Dangers, video, 17 mintues, 2007), states that one of the reasons training is so important to first responders is that they never know when they go to a fire if it is a drug lab. The calls just come in as fire and medical aid calls. Therefore, first responders are at the greatest risk for exposure, because they are unaware if the call they are going on is at a drug lab. If it is, they are running into it at a critical time. For instance, in the Midwest, using lithium or sodium is common in the production of methamphetamine. If you mix those two chemicals with water it will cause them to ignite. Traditional firefighting techniques are not recommended. A class D fire extinguisher should be used instead.

"Hidden Dangers: Meth Labs" (CA DoJ, video, 17 minutes, 2007) focuses on dangers to first responders, social workers, and others who might stumble into a methamphetamine lab during the course of their duties. The video details ways to determine if there is an active methamphetamine lab on the premises, or in a vehicle. It also describes what to do in order to avoid the physical injuries that can result from exposure to the chemicals used in making methamphetamine, as well as the violent and abusive situations that professionals might find themselves in if they walk into an active lab. Professionals who may find themselves in a drug home or lab need to know two words: recognition and protection. Recognition: remember that labs are found everywhere, from isolated farms in rural America to storage units in the big city. Everyone is at risk, so stay alert. Protection: if you suspect the presence of meth while on the job, stay calm. Keep your hands off and do not overreact. It is suggested that professionals do only what is necessary for their work and make a quick exit. Once they are out of harm's way, they should immediately contact law enforcement.

This philosophy is nicely illustrated in a case study from Hohman et al. (2004:378-379), which demonstrates appropriate, safe, handling and reporting of a suspected meth lab by a CPS worker. It also demonstrates how a collaborative approach, and good communication, can help effect the safe and timely removal of children who are considered to be in jeopardy.

An anonymous referral on a child abuse hotline regarding dirty, unsupervised children prompted a visit by an emergency response CPS worker. The CPS worker noted a great deal of garbage in the front yard of the home that included cold medicine pill blister packs and several cartons of camping fuel. While she stood outside the home at the

front door, she identified herself to the mother and inquired about the children. She learned that a toddler was in the home, and two children, ages seven and nine, were at school. When asked about the fuel and medication, the mother claimed that the family went camping a lot, and that they had been ill. Despite the fact that there were no odors, the CPS worker was suspicious. She did not enter the home. She left and immediately called her supervisor. The supervisor notified the DEC social worker. This put into motion a multidisciplinary DEC response team. Within a matter of hours, the older children had been interviewed at school, the home was confirmed to be a meth lab and raided, the mother and her boyfriend were arrested, and the children were removed from the home and taken to a shelter where they were examined by a pediatrician. Cases like this are why DEC units have become a preferred tool in the larger culture's attempt to protect society from the harmful effects of meth labs, and to safely remove children from meth homes.

The Benefits of Partnering with Programs Outside the Box: Community Members Rise to the Challenge

Because of a lack of funding, rural areas have to be particularly creative in how they use their programs and resources (Ely interview with author April 23, 2009). For instance, there is a walking support group for Behavioral Health clients in Butte County. They walk together and talk about life issues, and give each other support (Ely interview with author April 23, 2009). CSD used to hand parents over to behavioral health and then have little to no interaction with them. In a new era of multidisciplinary approaches, they have moved from traditional referrals to a team approach, working

together with families in drug and alcohol groups, utilizing individual intervention and case management tools. Every parent who enters into the system is given a behavioral health alcohol and drug assessment, then behavioral health and the social workers discuss the case plan for each client together (Ely interview with author April 23, 2009). That way, those who are overseeing the care of the children, and those who are overseeing the care of the parents, are on the same page regarding treatment approaches and goals.

Ely feels collaborations can go even further, past professional partners, to community partners. There are people in the community who have embraced social workers and what they do, and social services is looking to expand their connections with them, to have the community recognize that this is as much a community issue as it is a social services issue (Ely interview with author April 23, 2009). This was the topic of Nicholas Taylor's presentation at the 2008 CAN Conference.

Taylor (2008) discussed a community based treatment option used in a small town in Colorado. According to the United Nations Office of Drugs and Crime (2011), community based treatment programs integrate drug treatment and rehabilitation programs into community health and social services. Participation of all community members and organizations is encouraged. There is an emphasis on sustainability and accountability to the community. A focus of community based treatment is to make services available to people with limited treatment options. Taylor claimed the program he oversees is successful because volunteers from the community spend structured time with recovering addicts. They do things like model healthy behavior, help plan menus, and go to court to provide moral support.

Taylor (2008) states that drug testing is a necessary part of the overhead for any successful drug treatment program. If the client relapses, and those overseeing their progress do not know about it, drug behavior is reinforced. It teaches them to "work" the program, so the program makes the drug abuse worse, not better. However, just because someone is not using, that does not mean treatment is working.

Contrary to other experts at the 2008 CAN conference, Taylor claimed that it does not take a full year for treatment to work. Perceptions regarding treatment need to change. It takes behavior change for treatment to work. He stated that people in treatment are not like rolls in an oven, progress should be measured by objective behavioral benchmarks, as opposed to time spent in treatment.

Behavioral benchmarks can include verified periods of abstinence determined through random urine monitoring, use of a sweat patch, testing of saliva, and hair testing. However, benchmarks should also include verified behavior changes, such as stable sleep patterns and eating regular meals. Clients are instructed to be in bed by 11 p.m. The community verifies this with random bed checks. A police officer will knock on a client's door at a random hour in the middle of the night to determine if the client is asleep or awake. Whether or not clients are eating regularly and appropriately is monitored by assisting the client with diet and menu plans, checking food receipts, and doing random kitchen inspections.

Rewards given for good behavior, such as clean drug tests, are designed to help recalibrate a client's brain, in order to reverse the effect of elevated dopamine levels, as discussed in chapter three (e.g., Rawson 2008, Rawson 2009). A reward may consist of sending a mother, along with her child and a couple of volunteers to Chuck-E-Cheese.

While there, every 15 minutes an alarm will go off, and the mother will open an envelope. Inside each envelope will be a question that she needs to answer, such as, "describe something cute your child just did." Using this type of approach, Taylor says, not only are the pleasure centers of the brain recalibrated, but a connection is being forged between the mother and child. However, Taylor stresses the importance of ensuring that a mother is clean and sober before she is allowed to spend time with her child. If you send a mother out to have fun with her child while she is high, it will reinforce bad behavior, and there will be no pleasure recalibration (Taylor 2008).

Taylor likened the struggle for control over the drug addict to a tug-of-war. To join the user community you only have to use and not tell. In order for the sober community to win the tug-of-war, they have to outnumber and overpower the using community. They have to provide more support to the addict, give him or her more of a reason to stay clean than to go back to using. Taylor stated that in his community, the judge in drug court will often point out to the gallery, which is generally filled with volunteer community members, and remind the drug addict of all the people who are there to support him or her in their endeavor to stay clean, and become a productive member of society (Taylor 2008).

Faith Based Treatment

Residential treatment in the North State can cost $3,000 a month, and most experts agree addicts should be in residential treatment at least 90 days, at a cost of $9,000. But, for those who can afford it, private treatment can speed up the recovery process and allow greater access to children (Ely interview with author April 23, 2009).

An alternative to expensive in-patient care in Butte County is a 12 month faith-based program in Oroville on the campus of the Father's House Church, Life Recovery Ministries (LRM). The director is Danny Harp, and the assistant director at the time of the interview was Andy Engler. The program fee is $800 a month. The program has a maximum capacity of 27 participants at one time. Some clients have financial support, such as Social Security and Disability, but many arrive with no funds at all. When the economy was better, most clients worked regular jobs at sites approved by the program, to cover their costs, and the church was able to give the program some financial support. With the downturn in the economy, the program developed work crews to pick up odd jobs, such as yard work, car repair, and carpentry. The money earned is put into a pool and used to pay program fees. Sometimes they make enough to pay the full amount for each person, and sometimes they do not. If the work crew does not come up with the full cost for each person, they find ways to cut costs that month. People are never asked to leave for lack of funding, and participants do not begin working to help support the program until they have been there 30 days (Harp and Engler interview with author March 11, 2009).

The program has two houses for men and two for women. Each house has a house leader, and there are enough volunteers to ensure nearly round-the-clock supervision. For instance, in addition to supervision in the houses, there is a class each morning. Monday and Friday nights they have 12 Step meetings. The 12 Step program is the foundation of Alcoholics Anonymous. There is church on Sunday and Wednesday evenings. They also do Bible studies regularly during the week. And the director meets one-on-one with participants each week (Harp and Engler interview with author March

11, 2009). Although they do not require participants to be Christians, they say it can be difficult going through their program if participants are not. They use Jesus Christ as their "higher power", as participants advance through the 12 Step program. Church and Bible study attendance are considered an important part of the recovery process. The goal is to get each participant to become a part of the community, part of what is happening there, to get them plugged into the church and a community of people that will be a continuing support system for them (Harp and Engler interview with author March 11, 2009).

In March of 2009 half of their program participants were meth addicts. The majority of the clientele come from the immediate area, south Oroville. Some participants have dual diagnoses, with mental health issues complicating their addiction (Harp and Engler interview with author March 11, 2009). Mental health problems are a major issue for Butte County. Many people who use drugs have mental health issues, and social services tries to address those issues, but resources are limited. They have access to drug and alcohol services, but there are not many mental health services for adults who do not have private insurance. Most of the parents who are trying to retain custody of their children are on Medi-Cal (Ely interview with author April 23, 2009). However, most professionals working with addicts seem to feel counseling is a crucial factor in recovery, and in helping people break the cycle of abuse (e.g., Reyman interview with author March 29, 2009, Ely interview with author April 23, 2009, Taylor 2008)

In March of 2009, Life Recovery Ministries had one participant from drug court, under Proposition 36. There were also participants on probation and parole. The program often receives referrals from the domestic violence court. Many of the participants have no marketable skills when they arrive. Many have never had steady

employment. In addition to job training on the work crew, much of what participants in Life Recovery Ministries learn revolves around simple, everyday activities, like how to get up every morning, make their bed, shower, eat, get ready for work, and get to work on time. The program works on changing their behavior patterns, and they are set up like a small community. All the people in the ministry live in the community, and they have to learn how to act with one another and how to react to one another. When they are out in the world, in the drug sub-culture and someone does something, they react a certain way, but in LRM they learn how to react in a more positive way. There are licensed mental health professionals who volunteer there, and the program provides transport to county behavioral and mental health appointments (Harp and Engler interview with author March 11, 2009).

The program is also designed to modify down time behavior. For instance, they organize soccer and baseball games. In March of 2009, they were working on an ultimate Frisbee tournament. Once participants have been there for a while they are allowed to go home on the weekends, at the discretion of the staff. The amount of time a participant is in the program before they are allowed to leave the campus overnight is determined by the rate of individual progress. When participants are allowed to leave, Harp and Engler check to ensure they are going where they say they are. When they return they are tested. Tuesday night is a free night. They can watch movies at home, or go into town to do something.

Harp and Engler claim to have a 70 percent success rate. They say it is the Jesus factor that makes the difference, and the fact that they are a one year program. Most addicts have been using for years, so it is hard for them to turn their lives around in 30,

60, or even 90 days. At that point they are just getting to the heart of the issue of why they are using.

At the end of 12 months, participants do not have to leave Life Recovery Ministries. There is a one to two year apprentice program. For those who continue on to the apprentice program, the recovery success rate is 100 percent. Those in the apprentice program continue to live on campus. They do not pay a program fee. They are given room and board. According to Harp, each morning from eight to noon participants are in class "learning God's principles, and improving their relationship with God." In the afternoons apprentices work in the various ministries at the church. They also do outreach in the community (Harp and Engler interview with author March 11, 2009).

The director, Harp, understands how hard getting clean can be. He was addicted to meth. He started using in 1980. He was in an accident that left him in a wheelchair. He spent the first year drunk, then he moved on to meth for about seven or eight years. He stayed away from his family. The meth use prevented him from having a relationship with them. He decided to do something that many meth users do, get clean just long enough to give his body a rest. He intended to go back to using, but while he was clean, his ex-wife was murdered, and his 11 year old daughter moved in with him. He decided to stay clean and sober for her. At first it was difficult for him to work with meth addicts, because they reminded him of what he used to be like, but it also helped him stay clean. He would look at them and remember how he used to be (Harp and Engler interview with author March 11, 2009).

LRM volunteer house leaders come to the program in different ways. One house leader interviewed for this thesis (March 11, 2009) went through the program

himself. He was addicted to meth. He was living under a bridge when someone he knew from jail told him about the program. Another house leader (interview with author March 11, 2009) had attended church at the Father's House for about six years, when she became an intern there following graduation from high school. After a year as an intern she became a house leader. Both house leaders emphasized that part of their role is to help build participants up, and help them learn to weather crises.

All of the women in one house have children in relative and foster care. They generally do not see them. Even supervised visits are rare. Most parents with dependent children arrive there from jail. The children are already placed, and settled, in some cases, out of town and even out of state. The Father's House sends volunteers to the jail to visit with prisoners and conduct Bible study groups. That is how Summer learned about LRM.

Summer

Summer (not her real name) was a participant in LRM the spring of 2009 (interview with author March 11, 2009). She started using meth when she was 11 years old. By the time she was 13, she was in trouble for about $14,000 in check fraud, and transporting drugs over the border from Denver, Colorado into Wyoming. While she was still 13, she and a 22 year old friend stopped at a bar in a small town. They got drunk, and her friend got into a fight. Summer broke the end of a beer bottle off and handed it to her friend who used it to slice the face and neck of her opponent 47 times. Her friend was charged with attempted murder and served ten years in prison. Summer was charged with conspiracy, but the charges were dropped down to assault and battery with a deadly weapon, with intent to do bodily harm. She was sent to juvenile prison indefinitely.

She got out at 17, moved to California, and went back to school. She graduated high school with a 3.9 grade point average. She began working at Target and was promoted into a manager position when she was 18. She got into an argument with the store leader after being there for about a year, and she left to become a night manager at Burger King. That lasted about six months. Then she started using methamphetamine again. She sold drugs. She did not want to change. She did not care how much trouble she got into. She would steal from anyone. She was numb. At the age of 23 she was a major drug dealer, but she never got caught dealing. She was busted for having an assault rifle. It was her second weapons charge. She did a year in jail and counts herself lucky she did not go to prison. She says she had a good lawyer. For her, jail was a safe place, a clean bed and warm meals. She never slept at her house. She was always doing drugs, or selling drugs. While she was in jail, someone from the Father's House approached her. She started reading the Bible and accepted Jesus as her Lord and Savior. Church members showed up to support her in court, and she wrote a letter to her judge about how selfish and arrogant she was, but how she sincerely wanted to change. The judge knew her family well. He had sentenced them all at one time or another. He gave her a chance to break the cycle, by entering Life Recovery Ministries.

She struggled at first, and she relapsed. When she was interviewed for this thesis, she had 90 days clean, a crucial point for an addict. As noted by Summer and others interviewed for this thesis, that is when they start to think they are fixed, that they can do it without the program. Summer said the program was life changing for her. She says that with the help of Jesus Christ she manages to stay clean. She does it for herself, not anyone else. She says if you try to do it for someone else, you will fail.

Part of what worked so well for her is that she is kept busy. She has learned techniques for how to function when she leaves the program. Participants are given tools to help them integrate back into society. She says there is too much down time in other recovery programs. At Life Recovery Ministries she goes to Bible study, and the girls do things together, like clean house and go to the movies. There is an acceptance in the program, and a sense of family. At the time of the interview, she said she was working hard on building and sustaining relationships, especially friendships with the other women in the program and the house leaders.

Dean

Dean (not his real name) was a client in LRM the spring of 2009 (interview with author March 11, 2009). He stumbled upon them one day. Although he lived in the neighborhood, he did not know the church was there. He was walking his dog. He was in trouble. He knew he needed help, and he was praying to God for that help. That is when he noticed the church and the rehabilitation center. He never even went home, he just moved in. At the time of the interview he had been there more than nine months. He is divorced. He has six children he had not seen since the divorce. He said it was important to "have his apples all in the right crate" before he tried to get back in touch with them. He was a poly drug user, but alcohol, gambling and marijuana were his three main drugs of choice. He was starting to have black outs, and he stopped eating. He was in jail a couple times, but not for long.

Unlike Summer, Dean was entirely self-referred, in that he was looking for something or someone to help him. There was no outside intervention. He said he was "sick and tired of being sick and tired." He even gave up smoking while in the program.

He planned at the time of the interview to continue his recovery process by going into the apprenticeship program.

Each addict interviewed for this thesis covered similar topics, which included a feeling of helplessness, problems maintaining relationships, and having to find a personal reason for getting and staying clean, but meth addicts seem to have a harder time getting to that point. As demonstrated in the differences between the case studies involving Summer and Dean. The addiction is stronger, the effects on the brain greater, and the lifestyle of violence and drug use is more pervasive. At a time when budget cuts for public services are severe, and non-profits are having trouble securing private donations and grants, Butte County, and counties across the United States need programs to deal with an increasing number of drug issues brought on by meth abuse. Community based treatment approaches and increased professional collaborations can help economize resources. When community partners collaborate on treatment, they can avoid duplication of services, while providing a greater range of services.

CHAPTER V

WHERE DO WE GO FROM HERE?

Reducing the Purity of Meth and Enhancing Social Services

Data has been presented in this thesis that suggests that a key to stopping the meth epidemic is reducing the purity of meth. As noted in chapter two, significant efforts have been made in that direction. Methods will need to continue to adapt and change as the meth sub-culture adapts and changes based on available supplies. However, unlike Quaaludes, meth use became widespread before effective measures were taken to restrict access to precursors. The variety of legal chemicals and supplies that can be used to cook meth significantly hamper attempts to stop production, particularly at this point in the epidemic. It is widespread, and desperate cooks adapt quickly to losses of supplies. Even if pharmacies share records electronically, that will not stop smurfing entirely. If meth cooks buy from multiple smurfers, especially in different cities, or even across state lines, there is no way to link different purchases by different people. There is no way to monitor what happens to the precursors once they leave the store.

The meth epidemic can be seen as a cautionary tale. For years, lawmakers in unaffected states failed to rally behind efforts to stem the flow of meth. By the time the epidemic reached their states, it was too late for a quick fix to the problem. Perhaps, if we have learned anything from the "war on drugs" it is that when it comes to the spread of a

new and highly addictive drug, state and country borders only exist on paper. Drugs will be transported across borders, and abuse will spread. The next time lawmakers have the opportunity to cut off the supply of an illegal drug before it spreads across the United States, they should take it. They should follow the example set for eradicating Quaaludes. In the meantime, we, as a society, have to find ways to work with, and enhance, our greatly burdened social services.

Legislation and law enforcement techniques will only be effective if they are combined with effective treatment and prevention measures. Collaborative efforts, such as DEC programs, can stretch available resources, without significant increases in program funding. Those who have formed strong alliances with members of other agencies can address issues found in meth labs, and learn from them, as a team. They can share their knowledge and expertise, allowing everyone a new perspective. Team members from a variety of agencies and walks of life represent different services and authority levels within society. Police officers can make arrests. Social service employees can remove children in jeopardy. Hazmat units can make buildings habitable again. Medical and health care professionals can diagnose and test for meth related illnesses and injuries. Community members can visit inmates and support recovering addicts in court and in treatment. Disrupting the cycle of meth abuse should be a priority, and it should be a community effort.

Protect the Child. No, Keep the Family Whole. Wait, Protect the Child…

As noted in chapters three and four, the foster care system is probably the most widely used program for mitigating health risks to minors in meth homes. If the

meth sub-culture continues to grow and spread, under the current system, the number of foster children will continue to increase. It is obvious by looking at reports detailing the number of children taken into custody each year, that foster children and former foster children already make up a significant portion of our population. Multiple experts interviewed for this thesis, and many experts who spoke at the 2008 CAN Conference, emphasized that if services are properly administered, foster care can be an effective tool in breaking the cycle of meth abuse. Unfortunately, mandates to protect the child, and keep whole the family unit can place professionals working in social services in the hard position of having to serve two potentially opposing masters. How do professionals working within a fragmented child welfare system fulfill both these mandates, especially during a severe budget crisis? Some politicians and experts believe it is best to leave children in the home, even if their parents are using drugs. There is a belief that if enough programs are put into place, a safety net can be created for children in meth homes to protect them. Even if the money were made available for that type of program expansion, would it be the best approach?

In 1997, following investigations into the deaths of multiple children known to Sacramento CPS, the Sacramento County Board of Supervisors amended how cases are monitored and investigated, and they added 58 positions to CPS. Absenteeism and vacancy rates continued to increase, as did the rate of higher risk referrals. With those increases came caseload increases, to the point that it was not possible for social workers to adequately assess each child. It was determined that social workers were not consistently using the required risk and safety assessment tools for all referrals. Morale levels were low and frustration levels were high. An independent review determined that

structure and requirements within the system hinder the ability of social workers to complete required tasks. Staff lacked access to current, concise, and comprehensive formal guidelines. And the system was overly dependent on paper-based and manual systems, placing more emphasis on paperwork and deskwork than on children and fieldwork (Li 2009:1-5). More money and positions were added, and children known to CPS were still killed by their parents. How much money, and how many programs, does it take to save the life of a child?

During her interview, Ely (interview with author April 23, 2009) did indicate that social workers with Butte County CSD can choose to leave a child in the home while surrounding them with services, working with the family to deal with whatever issues brought them to the attention of social services. Social services will make referrals to appropriate agencies, in order to help the family. However, as both Reyman (interview with author March 29, 2009) and Ely (interview with author April 23, 2009) noted, there are time limits. If caseworkers are unable to find an imminent threat to a child, protocol requires they close the case, even if they suspect that something is going on in the home that could be a future threat to the child. In order for CSD to keep cases open longer, and provide services to families they suspect may be at-risk, without finding proof that those families are at-risk, laws would need to be amended. As Nickelson, Ely, and Mosbarger all indicated in their 2009 interviews for this thesis, state law directs every decision they make regarding a child.

Ely (interview with author April 23, 2009) stated that if she could expand anything, it would be services to families before they come into CSD. Prior to a few years ago, there was funding available for county preventative, or differential programs. There

is no more funding for that. Currently Butte County only has a $150,000 budget for prevention. Some of those funds are pre-designated for programs involving reunification and pre and post adoptive services.

Ely (interview with author April 23, 2009) thinks within the next ten years there will be significant changes in how we, as a society, help foster children become adults. Right now teens have to be 16 before they are eligible for Independent Living Programs. However, the stage can be set for adolescents earlier than that. She wants the ILP program to go into schools and foster homes, and talk to kids earlier than the age of 16. She wants the program to begin at age 12. Ely (interview with author April 23, 2009), Mosbarger (interview with author April 13, 2009) and Brown (2008) all talked about the importance of helping children and teens remain engaged in school. Mosbarger (interview with author April 13, 2009) and Ely (interview with author April 23, 2009) both indicated that junior high age is a critical time for intervention. Illustrating their point, is the fact that Summer stated she became addicted to meth at the age of 11. Mitch Brown (2008), former Chief of Police, Oroville, currently teaches criminal justice at his local high school. He stated that ten of the students in his fall 2008 class reported that they had previous experience with CSD. He believes strongly in community involvement and encouraging children to graduate from high school, stating that when high school graduation levels are up, crime levels are down.

One of Nickelson's (interview with author April 28, 2009) goals is to increase the number of homes in the county foster system that serve a broader population. Right now, about 75 percent of county homes serve infants and young children. She would also like to see more harmony between social workers and biological parents. She thinks it

would help facilitate things if they knew each other better. These comments echo those made by Ely (interview with author April 23, 2009) about social services and behavioral health collaborating on treatment plans, so there is a coordinated effort between the agency helping the child and the agency helping the parent. Nickelson's comments are also similar to those made by Reyman (interview 2009) about how children are more likely to trust those who actually like the children's biological parents. When these comments are taken into consideration with comments made by others interviewed for this thesis, and those who presented at the 2008 CAN conference, a trend appears. It has become less common to demonize meth addicts, and more common to view them as having connections, and potential connections, with their children, and with the community at large. There seems to be a trend toward viewing them less as a distinct sub-culture that threatens the larger culture, and more as members of a larger community who are in need of assistance.

Barriers to Treatment

The North State psychiatrist who provided case notes for this thesis (personal communication October 18, 2009) indicated that many addicts she works with, and their children after them, are on social security benefits. They are unable to maintain employment. They often live with grandparents, or move in with friends. Some go into board and care homes. They need the structure of day treatment programs or case managers, in order to insure they take their medications, and keep their medical and behavioral health appointments. She writes that if they fall through the cracks, miss

appointments, and begin using again, the cycle of drug abuse may continue. Ongoing treatment is viewed as essential for ensuring even the most minimal level of maintenance.

However, there are barriers to drug treatment. Drugs that assist in recovery, such as Methadone, are highly regulated and restricted. New drug therapies may be costly or difficult to obtain, or even prohibited, due to federal or state regulations. New treatment options may not be implemented or fully explored, due to a lack of communication and cooperation between researchers and practitioners. In some cases, clients have trouble getting to therapy sessions due to a lack of transportation (multiple interviews with professionals and addicts, Marinelli-Casey et al. 2002). Certain populations, such as Native Americans, migrant workers, Hispanics, and African-Americans have differing patterns of drug and alcohol abuse. They may require different types of services, and assistance with overcoming barriers to accessing services (Kushner interview with author February 4, 2009; Sloboda et al. 1997:5). Ethnic differences in meth use is one of the many aspects of the epidemic that limited time and resources did not allow greater exploration of for this thesis.

A primary barrier often noted in research, and by politicians, is a lack of available funding for programs, staff, and facilities, and a lack of access to existing programs. For instance, recommendations to the National Conference of State Legislatures (NCSL) (Colker 2004:6-7) included the need for increased treatment capacity in communities and correctional facilities, with appropriate follow-up services for former inmates. It also included a recommendation on improving insurance benefits. Although many drug users are uninsured, those who are insured generally find that their

coverage does not cover long-term drug treatment. Most experts interviewed for this thesis agreed that short-term treatment is not successful.

Nancy Morgans-Ferguson and Karen Kushner co-founded and run a free clinic in Butte County. The clinic is only open for three hours, one day a week. Clients who use the clinic appear to represent a broad population cross-section of a ten-mile radius in a small town. Despite the short hours of operation, 53 percent of 109 respondents of a self-administered patient demographic survey indicated that they consider the clinic their primary care provider. On a typical Sunday, their official patient count is somewhere between 20 and 50. That count does not include clients who attend various group sessions, or those seeking community resource assistance. More than 50 percent of respondents indicated that they use the mental health services available at the clinic. The survey indicates that 60 percent of the clients are female, ten percent are retired, ten percent are disabled, and 40 percent are employed. Approximately 75 percent of respondents own or rent their own home. 66 percent of respondents attended college. 33 percent of respondents reported having an addiction. The most common addictions listed were alcohol and nicotine. Three respondents admitted to an addiction to meth (Moran survey 2009).

When interviewed for this thesis (interview with author February 4, 2009 and January 14, 2009), both Kushner and Morgans-Ferguson indicated that they often have trouble finding an available bed in an in-patient drug treatment facility for their patients. When they do, the patient is routinely discharged in 30 days. Out-patient counseling is prescribed, but it can be difficult to find counseling services. When they do find counseling services, patients often stop attending sessions abruptly. Both women indicate

that short-term treatment is a temporary stop gap that gives an addict a warm bed for a while, but then puts them back out onto the street, where they experience the same pressures that contributed to their addiction. Newly released, they are ill-equipped to deal with those pressures. They often relapse, falling into familiar patterns of behavior, because they have not spent enough time working on new patterns of behavior.

When multiple counselors and a police detective from the North State university noted in chapter one were interviewed, they all indicated some level of frustration with what they feel is a lack of available drug treatment services. The drugs of choice on campus differ, leaning toward abuse of prescription drugs by students looking to boost their focus while studying for exams, and sorority girls who want to feel drunk without consuming the calories in alcohol. However, the treatment needs, as far as available facilities and staff, are the same. A sizable student population tapping into the same resources as the local population imposes additional stress on an already burdened system. The 2007 National Healthy Minds Study (Eisenberg 2008:7) indicates that, in comparison to the other 12 schools in the study, students in the North State have higher than average rates for binge drinking, self-inflicted injuries, and drug use. The study also indicates that there are more uninsured students from lower income homes in the North State (Eisenberg 2008:9). Multiple sources (e.g. multiple interviews, Urada et. al 2004) used to write this thesis indicate that most addicts seeking treatment are uninsured. Uninsured students tap into some of the services that other community members require, such as treatment and long-term counseling (multiple interviews 2008/2009). Students who are uninsured have no long-term treatment options available to them in the North State, and few short-term ones. Students who are covered with insurance have more

treatment options available to them, but they are still limited (multiple interviews). Students from the North State university reported greater dissatisfaction with available mental health service options than students from other universities (Eisenberg 2008:8). Many students leave school, often returning home to receive treatment.

A Perceived Lack of Treatment Options in Rural Areas and Complex Interdependent Issues

Health risks inherent within the rural meth sub-culture, and the reasons for them, represent a complex set of interdependent issues. These issues stem, in part, from the fact that health needs are different in rural areas than in urban areas. It has only been within the last two decades that attention has been given to the growing illegal drug use in rural areas, and their unique treatment needs (Sloboda et al. 1997:5). In addition to idyllic images, rural life includes closed factories, devastated communities, poverty, racial tensions, and hunger. The changing economy, which includes more efficient farming procedures, as well as the closure of mines and other industries, has impacted many rural areas in the United States. Those changes have created poverty, and prompted young people to move to nearby cities. That has changed the demography of rural areas. The lost jobs and migration to urban areas have depleted the available resources in the areas of health services, and drug and alcohol abuse prevention and treatment. Declining economic opportunities in rural areas are also undermining family structures and dynamics that previously helped to mitigate issues involving substance abuse (Sloboda et al. 1997:5).

In a report for the National Conference of State Legislatures (NCSL) (Colker 2004:4), it was noted that Midwestern meth cooks are typically white, unemployed males between the ages of 15 and 30. Meth production has replaced farming in some rural communities as an economic strategy for survival. Despite this, the NCSL report does not give recommendations specifically directed at finding alternative forms of income for those living in rural poverty. However, some of the recommendations may address this issue indirectly. These recommendations include involving entire communities in prevention efforts, and identifying the changing population and characteristics of users and their motivations.

Despite the oft-repeated warnings about a lack of treatment options in small town rural America, there are those who seem to be able to create viable treatment options in small towns. Also, as Ely pointed out in her 2009 interview, counties with large populations and major metropolitan areas create greater demands on social services. While a lack of funding may reduce access to some client services in Butte County, the impression given by Ely is that staffing at Butte County Adult and Children's Social Services is adequate to meet the needs of the county. She indicates this is due, in part, to a smaller population than other California counties. Small towns, regardless of financial resources, do have access to one important resource, community members.

Small Town Support and Community Coalitions

According to Taylor (2008), it can be easier to implement effective drug treatment in a small community, where everyone knows everyone else. It is easier to help clients avoid pitfalls, such as continued interaction with members of the using

community. Essentially, he seems to be indicating that it is hard to be bad when you are not anonymous. Taylor maintains that the real work is what happens in between the treatment sessions. That is why sustained community support and interaction is important in the treatment of meth addiction. As Summer pointed out during her interview, down time can be dangerous for recovering meth addicts. They need to find ways to occupy and enjoy themselves that do not involve meth.

Life Recovery Ministries took the concept of small town support one step further when they created an even smaller community inside a small town. They manage to run what appears to be an effective treatment program without federal funding, without large private grants, and without huge program fees. They keep their overhead low, focus on what they believe are the basics, and utilize the one resource they have in great abundance, their church members, and other people in the community who support their efforts.

The one goal those involved with cooperative multidisciplinary approaches and integrated services seem to be striving to achieve, is the ability to create a sense that the recovering addict is being brought into a strong, accepting community. There certainly appears to be merit in professionals working together, forming alliances with each other and community members. These alliances might have been unthinkable in many areas prior to the formation of a strong and growing meth sub-culture. Small communities, be it small town America or a close knit neighborhood in a large city, working together to build coalitions, might be the cure for the meth epidemic. It might also be the best preventative measure against future epidemics involving other illegal drugs.

Conclusions

This thesis was written to help fill the research gap involving children living in meth homes. It primarily explored three types of collaborative treatment efforts aimed at stopping the meth epidemic: a logical, but groundbreaking extension of social services in cooperation with law enforcement; a community based treatment option in Colorado; and a faith-based residential treatment option, which often helps former inmates avoid relapse following their release from jail. Only small portions of the complex set of interdependent issues involved in the meth epidemic have been explored here. As Agar notes (2004:412-413), if you sit in a room full of drug experts you will hear a multitude of reasons for drug use, including poverty, oppression, self-medication, availability, and marketing. None of the reasons given cause drug epidemics in any straightforward way, either singly or in combination, and the reasons change as the epidemic evolves.

A review of interviews, paper presentations, and articles referenced for this thesis certainly provide enough opinions to fill a thesis on why meth is so prevalent, and what treatment options do and do not work. Every expert and recovering addict seems to know what does and does not work. It takes at least a year. It does not take a year; it takes behavior modification. I did it for my daughter. If you do it for someone else you will fail. God saved me. It is not the recovery program that makes the difference; it is the purity of the meth. Control the precursors. Stop the flow of drugs from Mexico. Increase jail time. Improve and expand treatment programs. There is a lack of funding for programs. It takes a village. The federal government does not approve new medications fast enough. Researchers have no sense of what really works. Practitioners do not listen to us. Leave the children with their parents, but monitor them. Remove the children from

the home. Much as Agar found during decades of research in the drug field that there are countless reasons why people do drugs, I found while writing this thesis, that there seem to be countless, and sometimes contradictory, reasons why people can or cannot leave the meth sub-culture. So, where do we go from here?

Clearly, the economic and societal costs of meth abuse are rising in the United States. Multiple generations of abuse have taken a toll on meth families, and society in general. Each generation impacts the next. One therapist interviewed for this thesis likes to tell his clients that working on their marriage, creating good home environments, establishing appropriate boundaries, and modeling good behavior for their children, is a way to improve the home life of their grandchildren. What parents do, will have generational repercussions.

The makeup of neighborhoods, and even entire small towns, has changed because of the shift in public services and expenses. Meth is an awful drug that does awful things to people who use it, and the collateral damage is unacceptable. If people continue to use it they will die, and they may take others with them. Hands-on, individualized support and guidance, and a sense of community and involvement, seem to be effective in keeping people out of the meth sub-culture. Those are the broad strokes. What about the details?

Is more funding necessary, or can community coalitions form without additional funding, or with reduced funding? Can more programs that run on tiny budgets, like Life Recovery Ministries, be created? Can that type of program be developed outside of a church? Can a successful program in a small Colorado town be adapted to work in a large metropolitan area like Sacramento? Does every region need to

create its own individualized program? Does every community or neighborhood? Those are areas where more research needs to be done. How do we take the basic structure of successful treatment programs and rework them so that they can be fitted to other locations?

Community based treatment options seem to work. Spaces can be adapted. There are at least two free clinics in Butte County that are run out of churches. In one of them volunteer mental health professionals see patients in offices normally occupied by church staff, in the library, behind the piano in the sanctuary, and, during nice weather, outside under trees. Again, important resources seem to be less about available funds, and more about community members who are willing to step forward. Addicts interviewed for this thesis talked about feeling disconnected from society. They felt they were not a part of the communities they lived in. As much as possible, they lived within the meth sub-culture. Their lives revolved around meth related activities. Community based treatment may be effective because it helps recovering addicts feel that they are part of the larger community.

The DEC program clearly has had a significant positive impact on society. Although it is hard to determine how many lives have been saved by this new collaborative approach, it is not hard to imagine that Genny Rojas would still be alive if an organized, focused community collaboration had been in place when police raided her home. She might have had to deal with issues associated with foster care, but she would not have been tortured to death by relatives who should have protected her. In the approximately 13 months that 10 children known to Sacramento CPC were killed by their biological parents, research for this thesis produced no corresponding reports regarding

children killed by foster parents. While doing research for this thesis I found no empirical evidence that children are abused, neglected, or used by foster parents to make money. What little I did find that suggested that might be the case is primarily anecdotal. However, it is frightening to note that a common theme discovered during research for this thesis, is the lack of accurate and consistent data involving children, particularly with regard to how they die. Even with the efforts of existing child death review teams, so much data is still missing. More child mortality research needs to be done. The more communities know about how and why their children are dying, the more communities can do to prevent those deaths. The continuation and, if possible, expansion of child death review teams should be a priority. Collaboration does not always require more funding. Sometimes it just means making a phone call, or sending an email, to a colleague in another department, or another agency.

If well meaning, well-funded state and federal campaigns like billboard advertisements and "Just say no" worked, we probably would not have a meth sub-culture. Those types of campaigns have been running in this country for several generations now, and the drug problem has grown worse: more violent, more potent, more destructive. The United States has formed alliances with other countries and spent billions of dollars to stop drugs from coming into this country, and the drugs are still coming. There is a demand; therefore, there will be a supply.

The keys seem to be to stopping the demand, and stopping the desire. While this may not be an easy task, there are successful models to choose from. With funding to education and social programs cut to accommodate other government expenditures, it is incumbent on each community to fund and support programs uniquely suited to their

region. If each area of the United States can create enough community coalitions, and if there is enough focused effort, each community might be able to successfully stop the demand for meth in their corner of the world. If enough corners of the world do this, the demand nationwide will stop. When that happens, the violence, health issues, and death associated with meth will also stop.

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