

# ***Spokane County's***

## ***Drug Endangered Children Project:***

### ***How are the Children?***

#### **Final Report**

**By**

Sandra J. Altshuler, Ph.D., L.I.C.S.W.,

Amber Cleverly-Thomas, M.S.W.,

and

The Spokane County DEC Team

This project was supported by Cooperative Agreements Number 2003-JS-FX-K083 and 2005-JL-FX-K122 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. The Spokane County DEC Team stewards are: Spokane County Sheriff's Office, Spokane Valley Police Department, Spokane Police Department, Spokane County Prosecuting Attorney's Office, Child Protective Services (Washington Department of Social and Health Services, Division of Children and Family Services), Partners with Families and Children—Spokane (formerly Casey Family Partners—Spokane), Lutheran Community Services Northwest, and Counseling Resources for Youth and Families. The authors thank the myriad of EWU M.S.W. students who worked on sections of this project. We especially want to thank Katie Clemons for her excellent development of the original draft of the literature review.

## **Spokane County's Drug Endangered Children Project:**

### **How Are the Children?**

#### Abstract

The United States is facing an epidemic of manufacturing, trafficking and use of methamphetamine and other illegal inhalant drugs. While this epidemic has caught the attention of law enforcement and public health, the needs of the children living in the so-called "methamphetamine homes" have not yet been addressed. These children are endangered, not only from the chemicals involved, but also from parental abuse and/or neglect.

Communities are beginning to recognize the crucial need for inter-agency collaboration for addressing the myriad of consequences for children that are created by this epidemic. Spokane County, in the State of Washington, has created its own community response titled "the DEC Project," whose mission is to implement and evaluate a collaborative response among law enforcement, prosecutorial, medical and social service professionals to the needs of drug-endangered children.

This report presents the findings from the evaluation of the four years of the DEC Project, focusing specifically on the health status and well-being of the children involved. Overall, the subjects were found to be a highly traumatized, troubled, developmentally delayed group of very young children. Thus, this report concludes with recommendations for the future, to ensure that we protect the health and well-being of these vulnerable drug-endangered children.

## **Spokane County's Drug Endangered Children Project:**

### **How are the Children?**

#### Introduction

The United States is facing an epidemic of manufacturing, trafficking and use of methamphetamine and other illegal inhalant drugs (Lineberry & Bostwick, 2006). The epidemic is attributed to a combination of ease in obtaining precursor chemicals that are cheap and legal, and the simple, but highly dangerous, process of manufacturing the end product. In addition, methamphetamine has become a popular drug of choice because it is synthetic, easily manufactured, can be consumed in a variety of ways, including smoking, injecting, skin absorption, or snorting, and its "high" is long-lasting (Altshuler, 2005; Falkowski, 2004).

While the methamphetamine epidemic has caught the attention of law enforcement and public health [Miller & Schneider, 2003; National Conference of State Legislatures, 2004; Swetlow, 2003; U.S. Dept. of Justice (USDOJ, 2003), the needs of the children living in the so-called "methamphetamine homes" have not yet been addressed (USDOJ, 2002; 2003). These children are endangered, not only from the highly toxic chemicals involved, but also from parental abuse and/or severe neglect. Communities are beginning to recognize the need for extensive inter-agency collaboration for addressing the myriad of consequences for children that are created by this epidemic.

Spokane County, in the State of Washington, is facing a methamphetamine epidemic similar to the rest of the country. The number of methamphetamine labs and dump sites reported in Spokane County increased from 13 in 1999 to 123 in 2000 to 248 in 2001 (Washington State Department of Ecology, 2003; 2004). In response, Spokane County created “the Drug-Endangered Children” project (“DEC”), based upon an original DEC effort developed in San Diego (Manning, 1999). The mission of the Spokane County DEC Project is to develop a collaborative community plan for addressing the needs of drug endangered children in its community. The extent to which the Spokane County DEC Project achieved its collaborative goals has already been well documented (Altshuler, 2005). The overall aim of this Final Report is to document the health status and well-being of the children who became subjects of this project during its existence.

This report will provide a review of literature about the extant knowledge regarding the unique dangers of methamphetamine to children exposed to the drug. We will then describe our methodological approach to data gathering from existing sources by explaining who the project partners are and the types of information they routinely gather, in order to explicate the data we accrued in our goal of assessing health and well-being status of the children and families. After findings are presented, this report concludes with a thorough discussion of the findings implications, including limitations and recommendations for future community-based partnerships and research projects, designed to improve the well being of vulnerable drug-endangered children.

## Literature Review

### Increased Use of Methamphetamine

Between 1996 and 2000, the number of people who had used methamphetamine at least once doubled, from 4.8 million to about 8.8 million, with this trend appearing to continue into the 21<sup>st</sup> century (Brechet, Anglin, & Dylan, 2005; Murray, 1998; Rodriguez, Katz, Webb, & Schaef, 2005). While the vast majority of users are white males, groups whose use is on the rise include women, Hispanics, Asian Americans, and gay males (Hohman, Oliver, & Wright, 2004; Rodriguez, et al, 2005). The increase in women's use is an important concern because a majority of them are of reproductive age and/or are primary caregivers to young children (Colloff, 2004).

Methamphetamine is not only increasing in the number and type of users but also geographically across the USA. While methamphetamine had been primarily centralized in the West, especially Hawaii, it is now spreading and is becoming a serious problem in the Eastern states as well (McGraw, 1998; Lineberry & Bostwick, 2006). The number of methamphetamine labs and dump sites have increased as much as five times in the Spokane area between 1999 and 2001 (Altshuler, 2005). In some places such as California, methamphetamine use is the number one identified drug problem (Hser, Evans, & Huang, 2005). This increased use of methamphetamine is causing strains on programs, treatment centers, law enforcement and social workers.

### Health Costs and Risks of Methamphetamine Use

There is concern regarding health risks associated with methamphetamine use, production, and clean up. Methamphetamine is a Schedule II stimulant, meaning that it

has a high potential for abuse (NIDA, 2002). Exposure can occur via ingestion, injection, skin absorption, or inhalation, with the latter two being the most common (Irvine & Chin, 1991). Methamphetamine has a pronounced effect on the central nervous system as it stimulates the release of dopamine, which plays an important role in the regulation of feeling pleasure, and is manufactured in the nerve cells (NIDA, 2002; Pennell, Ellett, Rienick, & Grimes, 1999). Methamphetamine users can suffer from anything from brain damage and psychosis to abscesses and loss of weight (Colloff, 2004; Obert, London, & Rawson, 2002). Methamphetamine and related psychomotor stimulants have also shown to increase the libido in some users, in contrast to opiates which actually decreased the libido (NIDA, 2002).

*Risks in production and sale*

A primary explanation for meth's popularity is that it is easy to make, with cheap and legally accessible chemicals. During the 1980s, drug producers discovered that they could quickly manufacture a more powerful drug by using ephedrine. After ephedrine was taken off the market, they switched to pseudoephedrine, which can be found in most over-the-counter cold medicines which can be found in stores at relatively low prices (Hathaway, 2004). Basic ingredients for manufacturing methamphetamine can be found at hardware stores, farm supply stores, grocery, gas stations, and drug stores, including gas substances (anhydrous ammonia), muriatic acid, camping fuel, gun scrubber, matches, batteries, and iodine (Falkowski, 2004; Hathaway, 2004).

It costs approximately fifty dollars to produce about three thousand dollars worth of methamphetamine, or approximately one hundred dollars to produce about one thousand

dollars' worth of drug money (Chamberlain, McDonald, Torgensen, & Boozman, 2004; Colloff, 2004; "United States: High in the heartland," 1999). Once the ingredients are obtained, the cooking process is fast and easy, but highly dangerous due to the likelihood for an explosion or exposure to powerful fumes that can result in brain damage and chemical burns (Manning, 1999; Colloff, 2004). Methamphetamine can be manufactured virtually anywhere. Labs are located for the convenience of the methamphetamine cookers, so they can be found in their homes, apartments, offices, barns, workshops or even their cars (Falkowski, 2004).

*Risks and costs in lab clean up*

Methamphetamine production is extremely hazardous and required a trained toxic team to clean up (Colloff, 2004). When entering a home, some law enforcement and social workers are becoming ill due to the toxic fumes in methamphetamine homes (Rogers & Arias, 2002; Colloff, 2004). Even a small amount has been thought to cause cancer and lung problems. All workers who have the potential to come into contact with methamphetamine homes need to be aware and conscious of these dangers, since the porous materials left in a methamphetamine home may cause illnesses in the public. Carpets, clothes, toys, and furniture will absorb the toxic fumes and create a high risk danger to those people who come into contact with these objects (Rogers & Arias, 2002).

Often enough, social workers and police working with hazardous material such as methamphetamine become certified in handling the toxic and flammable chemicals. Companies that specialize in working with hazardous materials (HAZMAT) often are hired to clean up methamphetamine laboratories. These companies charge about five thousand

dollars per laboratory (Hohman, Oliver, & Wright, 2004). In Iowa, law enforcement officials found that every pound of methamphetamine left behind in a lab produces about five to six pounds of toxic waste ("United States: High in the heartland," 1999; Fleming, 2005).

Because handling hazardous material may be dangerous to oneself, HAZMAT professionals recommend that social workers and law enforcement wear protective equipment such as chemical protection suits and face masks with particle filters. The cost of the suits range from \$15-40, depending on the level of chemical protection provided while the cost of the face masks ranges from \$100-300 (Schanlaub, 2005). Ten years ago, the Bureau of Narcotics Enforcement spent about \$2.4 million for methamphetamine lab cleanups (Hohman, Oliver, & Wright, 2004).

#### Drug Endangered Children

There is a direct correlation between illegal drug use and childhood abuse and neglect (Semidei, Radel & Nolan, 2001). It has been suggested through research that as high as 80 - 90% of caretakers involved in the child welfare system for child abuse issues have substance abuse as one of the major personal issues that they face (Azzi-Lessing & Olsen, 1996; Gregoire & Schultz, 2001; Magura & Laudet, 1996; Maluccio & Ainsworth, 2003; McAlpine, Marshall & Harper Doran, 2001; McNichol & Tash, 2001; NCASA, 1999; SAMHSA, 2003; Trocme, MacMillan, Fallon, & DeMarco, 2003). Children whose parents abuse drugs and alcohol are three times more likely to be abused and four times more likely to be neglected. Neglect of children often occurs in the form of lack of food and an inattention to the child's medical, dental, hygiene, and emotional needs. Another common

problem is lack of proper supervision, which results in similar neglect issues and increases the risk of physical injury and sexual abuse. Substance abuse can ignite a violent and vicious intergenerational cycle of child neglect and maltreatment that leaves multiple layers of families lost to the experience of trauma and hopelessness. The following discussion will review what is known about the impact of parental drug use on the increased likelihood of child abuse and neglect.

*Children endangered by parental drug use*

Risks from direct impact: Chronic substance abuse by a caregiver can cause significant damage to the lives of children, including fetal alcohol syndrome, neglect of health and educational needs, or increased risk of harms related to poverty and homelessness (McAlpine, Marshall, & Harper-Doran, 2001). Children in parental drug-abusing homes are often the victims of child abuse and neglect (Semidei, Radel & Nolan, 2001). According to a survey of child welfare professionals conducted by the National Center on Addiction and Substance Abuse, substance abuse and addiction were the leading causes of a recent rise in reported cases of child maltreatment (National Center on Addiction and Substance Abuse, 1999). The number of abused and neglected children in the United States increased 114.3% from 1986 to 1997 to about 3 million reported cases, or 42 of every 1,000 children. The NCASA survey also determined that when children in our country are abused and enter the child protection system, 50-90% of their parents are likely to have used alcohol, cocaine, marijuana, or methamphetamine, or may have been suffering symptoms of withdrawal or a hangover (Ibid., 1999).

The consequences of parental drug use to maltreated children can be forever life altering. Bruce Perry and his colleagues (2003) discuss several long-term outcomes associated with childhood maltreatment: increased risk for neuropsychiatric disorders including PTSD, dissociative disorders, depression, substance abuse and dependence, increased risk for medical problems including asthma and various cardiovascular problems such as hypertension, permanent cognitive impairment or learning problems, endocrine problems, pervasive developmental delays, and other related developmental disorders.

Drug exposed infants are compromised in almost every developmental capacity and thus automatically have a higher number of developmental risk factors (Butz, Pulsifer, Marano, Belcher, et.al. 2001). Prenatal concerns arise as children exposed to substances have a number of negative effects, both behavioral and biological (Toomey, Lyons, Eisen, Xian, et al., 2003). Specifically, drug exposed children have had some association with low birth weight, smaller head circumference, and shorter infant length. This directly negatively affects motor skills, IQ, and attention span (Barth 2001). Drug endangered children often score lower on the developmental scales than a child not living in a substance exposing environment.

Parents who abuse drugs prioritize their addiction that relegates their caregiving to a secondary (at best) priority (Barnard, 1999; Mayes & Fahy, 2001) thereby compromising their ability to parent, which ultimately impedes healthy child development. Drug abuse lessens an adult's capacity to respond to children's needs and causes their activities to be impulsive and unpredictable (Mayes & Fahy, 2001). Many of these children feel out of control and helpless to change their environment (Dube, Felitti, Dong, Chapman, et al.,

2003). Children in drug-abusing homes tend to have more behavioral and adjustment problems (Semidei, et al., 2001).

Infants and young children are especially vulnerable to maltreatment that could likely rob children of their potential by altering the organization of the developing brain (Perry et al., 2003). Methadone-exposed infants showed more insecure attachment patterns, namely disorganized insecure attachment patterns (Mayes & Fahy, 2001). Children with disorganized attachment histories are accustomed to their caregiver's rejecting and insensitive care giving, and they may be more likely to use aggressive and hostile behaviors with their parents and peers to meet their needs (Weinfield et al., 1999). Many of these children have failed to obtain a workable attachment strategy with their caregivers, placing them at risk for various forms of pathology, but in particular, dissociation (Main & Hesse, 1990; Weinfield et al., 1999). In a study of mothers in a methadone clinic, addicted mothers were found to use commanding or threatening strategies of discipline that only complimented their children's troublesome methods of seeking attention (Mayes & Fahy, 2001). This is often carried on throughout children's lives and into relationships with others; they may actually favor relationships that are similar to their early, unsettled relationships.

Risks from indirect impact of parental substance abuse: Child maltreatment related to substance abuse is an intergenerational phenomenon. Children living with a caregiver who has a chemical dependency problem is more likely to be in an abusive and neglectful environment (Blau, Whewell, Gullotta, & Bloom, 1994), because parenting is relegated to a secondary (at best) priority (Barnard, 1999; Mayes & Fahy, 2001). Children exposed to

homes pervaded by substance abuse, violence, neglect, and sexual assault are more likely to develop their own problems with substance abuse as a juvenile and/or adult, and there is a direct link between childhood sexual abuse and the development of alcohol problems in women (Miller, 1991).

Other risks that children in substance abusing homes face are: exposure to violence, poverty, homelessness and intergenerational substance abuse (Barnard, 1999; Mayes and Fahy, 2001). Children with caregivers who are abusing drugs are at a high risk for exposure to the “drug-using world” (Catalano, Gainey, Fleming, Haggerty, & Johnson, 1999; Mayes and Fahy, 2001; Zuckerman & Bresnahan, 1991; Griffith et al., 1994 as cited in Catalano et al., 1999; Semidei, et al., 2001). Many parents who have a chemical addiction also have an extensive history of physical abuse leading to an increased likelihood of exposure to domestic partner and other violence in the home (Miller, 1991). Caregivers who use drugs, cocaine in particular, tend to be involved in a variety of other illegal behaviors (drug-dealing, theft, and/or prostitution) in order to maintain monetary support for their habit (Mayes & Fahy, 2001). This exposes the caregivers and their children not only to violence, but also to neglect, separation, and possible loss related to the incarceration of the caregiver (Barnard, 1999; Mayes & Fahy, 2001).

*Child endangerment due to parental use of meth*

Risks from direct impact: Research is beginning to demonstrate that children are at a higher risk of neglect or abuse if their parents are using methamphetamine as their primary drug of choice (Besinger, Garland, Litrownik, & Landsverk, 1999; Ritter & Dozier, 2000). Methamphetamine manufacturing poses a significant risk to children who are in a

home where it is being made, or who are being cared for by parents who are using it. Methamphetamine labs can be found in private residences, rental homes, motel rooms, garages, campgrounds, moving vans, storage facilities, horse trailers, houseboats, and commercial establishments; the chemicals used in making methamphetamine are highly toxic, corrosive, explosive, flammable, and possibly radioactive (Irvine & Chin, 1991).

Acute health effects from exposure to chemicals in methamphetamine labs can include: irritation to the skin, eyes, nose, throat, and lungs causing burning of the skin and eyes, coughing, chest pain, shortness of breath, conjunctivitis and corneal injury (Irvine & Chin, 1991; Martyny, Arbuckle, McCammon, & Erb, nd; Martyny, Arbuckle, McCammon, Esswein, & Erb, nd). Symptoms related to the inhalation of fumes can include dizziness, headache, anxiety, and lethargy. Some data also indicated that exposure to chemicals used in methamphetamine production may cause cancer, brain damage, liver and kidney problems, birth defects and reproductive problems (Irvine & Chin, 1991; Martyny, Arbuckle, McCammon, & Erb, nd; Martyny, Arbuckle, McCammon, Esswein, & Erb, nd).

The risk of lead poisoning is particularly devastating to children who, when exposed to lead (a by-product of methamphetamine manufacturing), will absorb it into their bones in place of calcium; lead also accumulates at a faster rate in children's bodies (Bearer, 1995). The increased potential for transmission of infectious disease is also high from exposure to needles and drug paraphernalia left on site by drug manufacturers (Irvine & Chin, 1991).

Children are often found in hazardous and unsafe environments: babies crawling on carpets where materials for making methamphetamine have spilled; children using the same microwave to cook their dinner as their caregivers used to cook meth; and open

containers of toxic products in areas where children play and eat. Chemical burns and exposure to hazardous chemicals and deadly gases represent injuries caused by living in a methamphetamine lab – injuries especially devastating to young children in the home (Manning, 1999; Martyny, Arbuckle, McCammon, & Erb, nd; Martyny, Arbuckle, McCammon, Esswein, & Erb, nd). Diseases and sicknesses related to poor hygiene are very common in children of users, caused by unclean homes without water or usable bathrooms. Homes used to produce methamphetamine are very unsafe and uninhabitable, due to the prevalence of toxic ingredients and by-products in bathrooms, kitchens and throughout the home (Rogers & Arias, 2002).

Bearer (1995) explains that children’s vulnerability to toxins in the environment is closely related to their stage of development – newborn (birth to two months), infant/toddler (two months to two years), preschool (two to six), school-age (six to twelve), and adolescence (twelve to eighteen). Fetal development is a separate category of consideration in relation to the toxins or drugs to which the mother is exposed. The ingredients of methamphetamine in the physical environment are highly toxic in nature, and when introduced to the child’s system during stages of development can eventually become fatal. The chemical ingredients can develop symptoms such as hypertension, seizures, cardiac death, respiratory asphyxiation, anxiety, and a variety of other symptoms that are shown to limit a child’s development through stress in the biological system (U.S. Dept. of Justice 2002).

Consideration of physical exposure is concerned with several areas – physical location, breathing zones, oxygen consumption, food consumption, types of foods

consumed, and normal behavior development (Bearer, 1995). As children develop, their rate of exposure in each of these areas changes. Mercury and other large breathable particulates (such as one might find in a methamphetamine lab) settle close to the floor and leave infants and toddlers at increased risk for exposure (Bearer, 1995).

Risks from indirect effects of parental methamphetamine use: Similar to the risks outlined above, children in methamphetamine-abusing homes face risks of violence exposure, poverty, homelessness, and increased likelihood of abuse and neglect (NIDA, 2002). The “drug-using world” in which the children are living is rife with domestic violence, illegal behaviors, and future likelihood of substance abuse (Catalano, et al., 1999; Mayes and Fahy, 2001; Zuckerman & Bresnahan, 1991; Semidei , et al., 2001).

One specific side effect of methamphetamine use is wakefulness. This means that while parents are on a “binge” of using, they can be sleepless for days. While under the influence of methamphetamine, it is hard for parents to supervise their children and while they are “crashing”, or sleeping for hours or days straight, it is impossible for parents to supervise their children. When a parent crashes, he or she is typically unable to be woken, and parents have been known to drug their children in order to “keep them safe.” These behaviors can increase the likelihood of child neglect (Dube et al, 2003; Wells, K. n.d.).

Another side effect of methamphetamine use is an increased libido. A heightened sexual arousal among men and women has been reported by users of methamphetamine (Rodriguez, Katz, Webb, & Schaef, 2005). Viewing pornographic material around children, unsafe sexual activity, increase of sexually transmitted diseased, increased risk of HIV, and child sexual abuse by parents, caretakers, or friends all can be a result of methamphetamine

use. Violent outbursts also may accompany methamphetamine use. When a person is high on methamphetamine, he or she may exhibit extreme behaviors for unknown reasons (Lineberry & Bostwick, 2006). When parenting, a child may become an easy target for these outbursts. This side effect may increase the likelihood of child physical abuse.

#### Law Enforcement and Prosecution Efforts

In 1995, the issue of children in methamphetamine homes finally gained national attention when a Riverside County methamphetamine lab exploded, killing three small children (Manning, 1999). Since this incident, legislation has been passed that adds prison enhancements for the presence of children at methamphetamine labs. As of January 1998, defendants found guilty of manufacturing methamphetamine in the presence of children under 16 face a 2-year prison enhancement. The methamphetamine producer can expect an additional 5 year penalty enhancement when a child is injured as a result of the methamphetamine production process. Unfortunately the laws have not been able to prevent more children from being injured. In 2002, for example, 26 children were injured and two were killed in methamphetamine lab incidents (Elliot, 2004).

In an attempt to respond to the growing methamphetamine crisis in Washington State, lawmakers have added additional sentencing to be added in some specific cases. If a child is present in the home of a parent manufacturing methamphetamine and that parent is found guilty of possession of an illegal substance, the Revised Code of Washington (RCW)9.94A533(6) allows an additional 24 months be added to the sentence (We Care, 2005). In addition the law allows law enforcement to make an Authorized Emergency Placement (AEP) if the law enforcement officer believes the child could be in danger of

imminent harm due to a parent's abuse of methamphetamine (We Care, 2005). Abuse or neglect as defined by RCW 26.44.020 means the injury, sexual abuse, sexual exploitation, negligent treatment, or maltreatment of a child by any person under circumstances which indicate that the child's health, welfare, and safety is harmed, excluding conduct permitted under RCW 9A.16.100. An abused child is a child who has been subjected to child abuse or neglect as defined in this section (Washington State Legislature, 2005).

### Development of the Spokane County DEC Project

Methamphetamine manufacturing in private homes has been increasingly problematic for over twenty years, though it has recently erupted with significant media attention. Since 1998, Manning (1999) reports that in San Diego, California, there has been a 500 percent increase in the number of cases where methamphetamine was reported as the primary drug problem, with an estimated 20% of these cases having children associated with them.

Manning (1999) detailed a tragic case from 1995 in which a methamphetamine lab explosion killed 3 small children and the mother was convicted of second-degree murder. The Governor's Office, together with the California legislature, authorized over \$3 million dollars for the development of county-based DEC Projects, and added prison enhancement sentencing for the presence of children found at methamphetamine labs. The counties created DEC protocols that required social workers and health care providers to work collaboratively with law enforcement in all meth-related arrests that involved children (Hohman, Oliver, & Wright, 2004; Manning, 1999), including an emphasis on expedited services for the children. This program served as a model for other projects throughout the

country (see, e.g., Office of National Drug Control Policy, 2004; U.S. DOJ, 2003), including the Spokane County Drug Endangered Children Program. An inaugural national Drug Endangered Children (DEC) Conference was held in June, 2004, sponsored by the newly developed national Drug Endangered Children Alliance (National Alliance for Drug Endangered Children, 2007), the goal of which was to support emerging DEC teams in their efforts to develop their own programs.

Similar to the rest of the country, the Spokane community recognized the value of replicating the California counties' models, while incorporating unique needs of Spokane County. A broad coalition of community stewards, including law enforcement and prosecution, child protective services, and social service agencies, joined together to create and implement an organized plan for supporting the health of their children. The Spokane County DEC Team added social service agencies in addition to CPS to meet the ongoing emotional needs of the children. The team initially invited a university-based research team to evaluate the project's two-pronged goals of interagency collaboration and addressing the needs of drug-endangered children (Altshuler, Black, Hatcher, Kriz, Mallonee, Reynard, & White, 2004).

The Spokane County DEC Team's approach to creating a smooth functioning, interdisciplinary collaboration has been in the process of development for over three years. The Team's first priority was to increase the collaboration between social services and law enforcement, so that children were not being overlooked in the frenzy of a methamphetamine lab raid. Thus, the Team members committed themselves to attending monthly meetings, during which coordination efforts would be developed and refined.

The Team's second priority was to address the psychosocial needs of the drug-endangered children. To accomplish this, the Team recognized the importance of gathering baseline information that details specifically what those needs are, so that they can then begin to develop and refine efforts for addressing such needs.

*Collaborative community models*

Collaborative models have demonstrated that agencies tend to become more aware of other available services to meet client needs and are more likely to make pertinent referrals, resulting in an increase in accessibility of services (Rivard, Johnsen, Morrissey, & Starret, 1999). Moreover, collaborative networks promote efficient methods of provider awareness through communication and coordination of services, which provides agencies with knowledge of external resources (Pennell, 1995). Therefore, provider recognition allows client needs to be streamlined, reducing unnecessary duplication of services.

Collaboration is quickly becoming the method of choice by professionals in dealing with various social problems because of the ability to combine resources, skills, and knowledge, which, in turn, create perceived solutions to service delivery concerns, such as: service fragmentation, inaccessibility to services, and duplication of services. Moreover, pooling resources and information via interagency collaboration allows two or more providers to develop novel programs, which are not logistically possible to create when working independently (Alkema, Shannon, & Wilber, 2003).

Collaboration is recognized conceptually as a process, in which groups work together to move through stages of development toward a common goal. And, as a process, collaboration has been extensively evaluated, and described throughout the

literature using qualitative/case study methods, in which participants have retrospectively identified elements that facilitated or impeded collaboration (Abramson & Rosenthal, 1995; Hodges, Hernandez, & Nesman, 2003; Alkema, Shannon, & Wilber, 2003; Nicholson, Artz, Armitage, & Fagan, 2000). According to the systematic evaluation of the Spokane County DEC Team's functioning during its first year, this Team is exemplary in its willingness and ability to work collaboratively, despite varying ideologies, approaches, and values (Altshuler, 2005). The stewards, representing diverse disciplines from social services and public education to law enforcement and prosecution, have worked diligently to ensure that the safety and needs of the children endangered by parental drug use are the highest priority in their work. The initial development of the Spokane County DEC Project offers an example of a successful community collaboration that promotes child well being for children endangered by meth and other inhalants. The DEC Team mobilized a variety of community resources, from law enforcement to social services, to design and develop improved services and supports for vulnerable children (Altshuler, 2005).

## Conclusion

To summarize what is known so far, parental drug use is significantly and consistently associated with the compromised safety, health and well-being of their children. Incidents of reported child abuse and neglect are strongly correlated with parental drug use. Over the past 10 years, the production, use and sale of methamphetamine has exploded throughout the county, moving geographically from the west to the east. The specific consequences for children whose parents are using methamphetamine are not yet well explicated. It is hoped that the remainder of this report

begins to fill that gap, by describing the psychosocial needs of children whose parents have been identified as methamphetamine users through law enforcement, CPS, or other community stewards.

## Methodology

The purpose of the Collaborative Community Response to Drug Endangered Children (DEC) project is to implement and evaluate a collaborative response among law enforcement, prosecutorial, medical and social service professionals to the needs of children endangered by exposure to substance abuse and manufacturing, trafficking, and use of illegal drugs, including methamphetamine, throughout Spokane County. A broad coalition of community stewards, including law enforcement and prosecution, child protective services, and social service agencies, joined together to create and implement an organized plan for supporting the health of their children. The Spokane County DEC Team added social service agencies in addition to CPS to meet the ongoing emotional needs of the children. The team also invited an external evaluation team to evaluate the project's goals.

The first priority of the research team was to secure Human Subjects Protection (IRB) approval from the appropriate governing bodies. When this research project began, Dr. Altshuler was working under the auspices of Eastern Washington University, and therefore, secured IRB approval from the EWU IRB. In addition, because CPS falls under the rubric of the State of Washington's Department of Social and Health Services, we secured IRB approval from their Human Subjects Protection Board as well. In subsequent years, Dr. Altshuler and Ms. Cleverly-Thomas have been providing evaluation services

independently of EWU, and therefore, have secured IRB approval yearly from the State of Washington's DSHS IRB.

### Subjects/Participants

Beginning in October 2003, the community partners have attempted to identify as many drug endangered children as possible. Children are referred into the DEC program through multiple systems. Most frequently, children are identified by CPS or law enforcement. Since June 2005, the DEC case coordinator has been co-located at CPS intake which has increased the promptness by which children can be more easily identified as "DEC" when the CPS referral arrives. In addition, the collaboration between CPS and law enforcement provides law enforcement with a mechanism to contact CPS personnel at the local DCFS office directly, even after regular business hours. In addition, we created a variable in our database to track which system initially identified each child as drug-endangered. After a child has been identified, the DEC case coordinator is then able to ensure immediate referral to the appropriate social services agencies [e.g., Partners with Families and Children (PFC) and Lutheran Community Services Northwest (LCSNW)] for medical, developmental and psychosocial assessments, safety plans and treatment.

One challenge we continue to face is how to prevent high levels of subject attrition. Three factors have accounted for the almost 40% attrition rate to date: 1) children are placed with relatives outside of a reasonable geographic area, 2) after being returned home, the parents are declining consent for retests and further involvement with the program, and 3) CPS has lost track of the children enrolled in the DEC program. While the first two

factors are out of our control, the Spokane County DEC Model, with its co-located case coordinator at CPS, is designed to minimize the impact of the third factor.

### Instrumentation

To assess the needs of the children, we began by following an already existing model of comprehensive assessment for maltreated children (Perry, Conrad, Dobson, Schick & Runyan, 2003). Perry and his colleagues identified six life dimensions for assessing child well being. The six life domains are (1) physical/medical, (2) trauma history, (3) developmental, (4) social/family, (5) mental health: emotional/behavioral, and (6) cognitive/academic: school functioning. Together with basic demographic information, we added a domain for child welfare history. In addition, we created a set of variables that addresses law enforcement and prosecutorial involvement. Because of the myriad of DEC partner agencies with their own plethora of individualized required documentation, we were strongly committed to collecting data from their already existing assessment and intake forms completed by workers at each participating agency, including social services and/or law enforcement. Please refer to Table 1, a list of the variables that comprise each domain, throughout the remainder of this explanation of how we compiled the information.

**Table 1**

*List of Child Well Being Variables, per Life Domain or Collaboration*

**Demographic Information**

Age (at referral to DEC)  
Gender  
SES  
Ethnicity

**Child Welfare History**

# of CPS referrals for each child  
# accepted for investigation  
Assigned risk tag  
Reason for referral  
Relationship to drug use  
Parent's drug of choice  
#, length of previous O-O-H placements  
Type of current placement  
Permanency plan and current legal status  
Family Structure at time of placement  
Was child placed with sibling?

**Physical/Medical**

Did DCFS complete a "Kids Screen"?  
Pediatric Exam  
Height  
Weight  
Head Circumference  
Does child have a "medical home"  
or identified pediatrician?  
Are immunizations current?

**Trauma History (TSCC or TSCYC)**

Anxiety  
Depression  
Anger  
Posttraumatic stress  
Dissociation  
Sexual concerns  
Aggression

**Development**

*Battelle Developmental Inventory (BDI)*  
Personal-social  
Adaptive functioning  
Gross & fine motor skills  
Cognition  
Expressive & receptive communication

*Ages & Stages Questionnaire (ASQ)*  
Communication  
Gross & fine motor  
Personal/social interactions  
Problem solving

**Table 1 (cont)**

*List of Child Well Being Variables, per Life Domain or Collaboration*

**Family History (ACE)**

- Parent report of growing up with:
  - Recurrent physical abuse
  - Contact sexual abuse
  - Domestic violence
  - Recurrent severe emotional abuse
  - Parental substance abuse
  - Imprisoned parent
  - Parental chronic mental illness
  - Loss of at least one parent during childhood

**School Functioning**

- Grades
- # of schools attended
- Attendance/truancy history
- Discipline history
- Special education status
- Retention history

DCFS report of female caregiver history of childhood abuse or neglect

**Mental Health: Emotional/Behavioral/Social Functioning**

*Child Behavior Checklist*

*and/or*

*Telesage (Mental Health Mgmt)*

Internalizing behavior

Internalizing behavior

Externalizing behavior

Externalizing behavior

Subdomains:

Subdomains:

Anxious/depressed

Hopefulness

Somatic complaints

Problem severity

Withdrawn

Delinquency

Attention problems

Aggressive behaviors

ASQ:SE

Sleep problems (1 ½ - 5 yrs)

Need for counseling

Social problems (6 - 18 yrs)

Thought problems (6 - 18 yrs)

Rule Breaking behaviors (6 - 18 yrs)

---

### *Measures of Demographics*

Demographic information about each identified child is first gathered from CPS. Age is identified as the child's age, in months, at the time of referral into the DEC Program. Gender is identified as either male or female. Race/ethnicity<sup>1</sup> is broken down into eight categories: Caucasian, African American, Asian/Pacific Islander, Hispanic/Latino, Native American, Former Soviet Union, bi- or tri-racial, and other. We created a family identification number to track family connections, because it is common for multiple drug-endangered children to be from the same family. Our measure of socio-economic status captures whether or not the family was receiving state financial assistance at the time the children were identified as drug-endangered.

We are also extracting other relevant demographic information: 1) the parent's drug of choice, including whether the parent is a poly-drug user, 2) whether an Authorized Emergency Placement (AEP) was filed on the children (occurs when law enforcement determines that a child is at imminent risk of harm for injury), 3) if this AEP was filed as a result of a referral to CPS or if it resulted from law enforcement action (e.g. a drug bust), and 4) family structure at time of removal from home (e.g., "mom only," "mom and paramour," "two parent household," etc.).

### *Measures of involvement with Child Protective Services (CPS)*

The Department of Social and Health Services utilizes a centralized database, called CAMIS, to track information on all involved families. The majority of variables from CPS

---

<sup>1</sup> Our race/ethnicity variable is a combination of two available race/ethnicity identifications that the CPS data collection system already tracks: "race" and "Hispanic ethnicity." For example, a child may be listed as White/Caucasian with no Hispanic ethnicity. This child would be identified as White/Caucasian. If a child is listed as White/Caucasian with Hispanic ethnicity, he/she would be identified as Hispanic/Latino.

are extracted from CAMIS. The CAMIS database includes a data screen with information on Child Abuse and Neglect (CA/N) findings. From this screen, information is gathered on the total number of CPS referrals for each child (until the date of DEC referral), the number of these referrals accepted for investigation, reasons for current and previous referrals, relationship of these referrals to drugs, an assigned risk tag, and findings for current/previous referrals. There are some cases where there is not a referral date corresponding to the date of DEC referral, because a DEC-related incident can arise within a family already active within the DCFS system. For example, if a family's case is already open to a DCFS social worker, and the child is removed due to parental drug abuse, a CPS referral is not always made.

For the majority of accepted referrals, the assigned social worker completes an "investigative assessment." This assessment provides information on the baseline level of risk for abuse or neglect, as assigned by the CPS intake worker. The level of risk is on a scale from zero to five: zero is no risk, one is low risk, two is moderately low risk, three is moderate risk, four is moderately high risk, and five is high risk. The social worker is required to complete a full investigation of the referral within 30 days, and then assigns a current level of risk based on the findings. Frequently, the current level of risk is quite lower than the baseline level of risk, because some caseworkers assign the risk tag based upon the foster care placement, not the original referral reason. Therefore, we decided to use only the original immediate investigation results to measure level of risk to the child.

CAMIS is also used to gather placement information for all children. This information includes the number of out-of-home placements, including placement at the

time of DEC referral. It should be noted that this number is strictly out-of-home placements, and does not include times when the child is “placed” with their biological parents during an in-home dependency. The length of time of last out-of-home placement is calculated in days. Information on the current type of placement is also gathered, in addition to information on previous placements. Occasionally, a child is referred to the DEC program without being removed from their parents’ care. If this child has prior out-of-home placements, those are counted and this child would have his or her placement at time of referral listed as “returned to parent(s).” We are also tracking if children who have siblings are placed together or separately.

Information on the primary drug used by the child’s parent(s) is extracted from CAMIS. The information is obtained by reviewing the referral history. As numerous families abused multiple drugs, an additional category was created to differentiate between methamphetamine and non-methamphetamine use.

DCFS also completes medical and developmental assessments, called Kidscreens, for some of the children. To qualify for a Kidscreen, the social worker must expect the child to be in a DCFS placement for over 30 days. At the end of 2006, Kidscreens were replaced by Child, Health, and Education Tracking (CHET) screens. While it assesses many of the same concepts, the CHET screen offers a shorter, more concise summary. When completed, this report was accessed to gather medical information such as immunization status, and height/weight/head circumference information. As discussed below, it was also used to collect information on children’s mental health and behavior.

Child information from DCFS is also gathered from Individual Service and Safety Plans (ISSPs), which are permanency plans completed when a child has been in a placement for 60 days. This applies to in-home and out-of-home dependencies, and also includes children who are on voluntary placement agreements. These ISSPs are updated prior to each court hearing, which is typically every six months. The first variable we have extracted from the ISSPs is whether or not a permanency plan was created. We also extract information on the legal status of a child at the time of each ISSP, filing dates for petitions for termination of parental rights, whether or not the child receives SSI or SSA, and whether the child currently has a visitation schedule with one or both parents. Finally, we track what the permanency plan is for the child, based upon the current recommendations for each ISSP (e.g., the recommended legal status of child as a dependent of DCFS).

There have been three main obstacles regarding DCFS. The first obstacle is access to CAMIS itself. Despite being co-located at CPS Intake, the DEC case coordinator has been repeatedly denied access to CAMIS, as she is not an employee of DSHS. This is extremely unfortunate, as access to this system is key to completing her duties. The DEC case coordinator receives copies of placement forms for all children placed through DCFS. She then needs to access referral history for each child to determine if the child is eligible for the DEC program. She must also look up placement information, including address and contact information, before making any referrals. Currently, since she does not have routine access to the CAMIS database, she must rely upon the intake workers to look up all of this information in CAMIS for her. This is a highly inefficient process, which requires

additional time for the intake workers, and makes it extremely difficult to extract the needed research variables, as the intake workers also have their own work load.

The second obstacle is data not being up-to-date in CAMIS, especially as it pertains to placement information. Children are frequently moved from an initial “receiving” home to a more permanent placement, without the documentation of such moves being promptly entered into the CAMIS system. The DEC case coordinator will contact the placement, such as the foster mother, only to be told the child “is no longer with me.” With a lag time from change to inputting averaging approximately 3 days, the case coordinator must then contact the social worker to get up-to-date placement information, which then delays service referrals even further.

The third obstacle is intake workers and case workers not responding to the inquiries of the DEC case coordinator. Typically, the case coordinator will identify a DEC child, and will leave a voicemail with the respective social worker requesting a call back and offering services through the DEC program. However, these phone calls are often not returned, resulting in numerous drug-endangered children not receiving available services. When the DEC case coordinator does not hear back from the social worker, the children do not become part of the DEC program. The exception to this is when the child was referred through a law enforcement drug bust. In this instance, the DEC case coordinator counts these children as enrolled in the DEC program, and tracks all other available data.

#### *Measures of physical health*

PFC provides medical screenings by specialized pediatricians for children suspected of having been abused or neglected. While all children enrolled in the DEC program are

referred to PFC for initial exams, only 29.1% have been seen there. Reasons for non-completion of the medical exam at PFC included children who have identified medical homes established elsewhere, and children whose foster parent wanted to take them to a specific doctor. Some children did not receive medicals within the first 30 days following placement due to lack of caregiver follow through.

Immunization status was especially difficult to gather. Often times, the CHET screeners were not able to determine whether or not immunizations were current, within their 30-day time frame. In fact, we only were able to determine immunization status on one-quarter of the children enrolled in the DEC program.

For those children seen at the PFC medical clinic, physical health data are compiled. Based upon the pediatrician's recommendations, we have extracted the measures of height, weight, and head circumference. In our database, these variables are set up as either "within normal limits" or not. "Within normal limits" is defined as between the 25<sup>th</sup> and 75<sup>th</sup> percentile on standardized height/weight/head circumference charts that are used by pediatricians throughout the world for each variable. Anything outside of those percentiles is "not within normal limits." While it has always been our goal to assess longitudinal changes in these criteria, we have had difficulty in doing so. The PFC clinic is not set up to be any child's permanent medical home. In fact, the clinic works to help families establish community-based medical homes for their children as quickly as possible. Unfortunately for research purposes, this has prevented us from being able to access follow-up measures of physical health.

*Measures of Trauma History*

Lutheran Community Services Northwest (LCSNW) provides mental health services to eligible drug-endangered children. Starting in February, 2006, LCSNW began completing the Trauma Symptom Checklist for Young Children (TSCYC) for all referred children enrolled in the DEC program. This checklist is supposed to be re-administered every three months. The TSCYC is a standardized, parent or caretaker report of trauma symptoms in children ages 3 to 12 years old (Briere, 1996).

The TSCYC provides scale scores for six different types of potentially trauma-related symptoms: anxiety, depression, anger, aggression, dissociation, and sexual concerns. In addition, the TSCYC assesses posttraumatic stress and subdivides it into intrusion, avoidance or arousal symptomatology. For all TSCYC scales, internal consistency, test-retest reliability, scale intercorrelations, convergent, predictive and discriminant validity all achieved accepted levels (Briere, 1996). The TSCYC has two built-in internal validity measures to assess subject's level of honesty.

Despite agency requirements, the LCSNW therapists were not ensuring completion of the TSCYC on a regular basis. This problem continues to be addressed by the supervisors at LCSNW, and a tracking system has been created which allows the therapists to be notified when a measure, such as the TSCYC, needs to be completed. Unfortunately, we are currently unable to track longitudinal changes in trauma symptomatology as a result.

*Measures of development*

Spokane Regional Health District (SRHD) was an original DEC community partner that provided developmental testing and gathered physical/mental health information. When SRHD discontinued their involvement in the DEC Project due to internal budgetary restraints, PFC took over administration of the developmental assessments.

The Battelle Developmental Inventory (BDI) is a developmental assessment for early childhood used to test children up to eight years of age enrolled in the DEC program. The BDI is a behaviorally-based, standardized assessment of developmental skills, and uses a combination of caregiver report, structured test times, and observations (Newborg, Stock, Wnek, Guidubaldi, Svinicki., 1984). The BDI was originally developed under a contract from the U.S. Department of Education Special Education Programs. Standard error of measurement (measuring degree of stability), test-retest reliability, content validity, construct validity, criterion-related validity, sex and ethnic validity, and screening test validity all achieved accepted levels for all of the included subdomains. The purpose of the BDI is the screening, diagnosis, and evaluation of early childhood development.

Children are assessed by the BDI across five domains: (1) personal-social, (2) adaptive functioning, (3) motor (broken down into total motor, fine motor, and gross motor), (4) communication (broken down into total communication, expressive language, and receptive language), and (5) cognition. The developmental tester seeks to determine the child's basal developmental level (where they can easily complete two consecutive items at an age level) and their ceiling developmental level (where they cannot complete two consecutive items at an age level) by assessing the child's ability to complete certain

tasks. For example, in the personal-social domain, a 6 to 11 month old child should be able play peekaboo. There is also a final category of Overall Developmental Percentile. Based on these scores, the BDI provides an age equivalent for the child's development in each domain. It also provides a percentile rank and a standardized score. For example, a 54 month-old child may be at a 43 month-old level in the total motor domain. This means they would be in the 12<sup>th</sup> percentile, and 1.18 standard deviations below the norm for a 54 month-old. For comparison purposes, we utilized the percentile scores to measure development across each BDI category.

It was the DEC program's goal to administer BDI retests every six months for all DEC subjects. Unfortunately, this became untenable for three reasons. First, after six months, the majority of the children enrolled in the DEC program were no longer dependents of the State, so we needed to obtain informed consent from the parents. This was only rarely accepted. Second, many of the children turned 8 prior to the retest. Third, because we had difficulty securing reliable developmental testers for a variety of different reasons, we chose to concentrate our efforts in administering initial BDIs to the children enrolled in the DEC program.

The developmental evaluators occasionally gathered additional demographic information that assessed the child's overall well being across multiple domains. When available, we categorized the information as either "within normal limits" or "not within normal limits." Unfortunately, we had only partial information for only 26 children.

Children enrolled in the DEC program under the age of 6 who received a Kidscreen/CHET screen from CPS, were administered the Ages and Stages Questionnaire

(Second Edition). The ASQ is a first-level screening program designed to quickly identify infants and young children (aged 4 months to 60 months) who are in need of more extensive evaluation for developmental delays or disorders (Squires, Potter, & Bricker, 1999). There are 19 separate surveys dispersed across various age intervals. Each questionnaire contains thirty developmental items from five domains: communication, gross motor, fine motor, problem-solving, and personal-social. Parents rate their child on each item by checking either yes (their child performs the specified behavior), sometimes (occasional or emerging response), or not yet (child does not yet perform specified behavior). These responses are then summed, and compared to a total cutoff point. A score above the cutoff indicates an area of possible concern. A number of studies have documented high levels of both validity and reliability for the ASQ, reaching acceptable levels of agreement on children's classifications, inter-rater and test-retest reliability, concurrent validity, specificity and internal consistency all achieved accepted levels for all of the areas; utility was also acceptable (Squires, Bricker, & Twombly, 2003; Squires, Potter & Bricker, 1999).

In addition to medical and developmental information, PFC also intends to gather data about the eight adverse childhood experiences (ACE) identified by Felitti, et al. (1998) that impact current parental functioning. These are: 1) recurrent physical abuse; 2) contact sexual abuse; 3) growing up with domestic violence; 4) recurrent severe emotional abuse; 5) parental substance abuse; 6) growing up with a parent in prison; 7) growing up with parental chronic mental illness; and 8) loss of at least one parent during childhood (Felitti et al., 1998). The current caregiver (birth parent, relative placement, foster placement, etc) is

asked about these experiences during a clinical interview at PFC, or the information is extracted from CPS, LCSNW, or PFC files. There are 16 variables relating to this information. For each experience, there is a variable for both the mother and the father identifying they either experienced or did not experience the particular event, or if it is unknown. Ultimately, we plan to sum the scores to derive an overall variable that identifies level of increased risk, based upon the number of ACEs a parent experienced. Our original intent was to gather information on this. Unfortunately, obtaining that information about birth parents that have just had their children removed from their care by CPS has proven to be more difficult than we had anticipated. Some of this information may be found in the hand-written CPS reports/files, and we hope to be able to access those files at a later date.

We were, however, at least able to gather some information about the mother's history of child abuse and neglect. Investigative assessments were completed by CPS for 80% of the DEC-involved families, in which the social workers ranked the caregiver's level of harm/risk based (partly) on their own history of child abuse and neglect (CA/N). The scale ranged from 0 (no risk) to 5 (highest risk). For example, a mother who experienced significant CA/N as a child would receive a higher risk level than a mother who had no history of CA/N (based on both CPS history and self-report). This information was analyzed on a family level.

*Measures related to school functioning*

We are continuing to try to access data from Educational Service District #101 (ESD 101) and Spokane School District 81 (Dist. 81) on childhood truancy and attendance. For

every state-dependent, school-aged child enrolled in the DEC program, we have been attempting to extract truancy and attendance (days absent) data at the time of referral and every 6 months thereafter. We have also been seeking to track the number of schools attended. In addition to truancy and attendance, we hope to extract grade point average, special education placement, and retention information at the time of referral and every 6 months thereafter.

Unfortunately, there have been numerous challenges to accessing school data. ESD 101 is a DEC Partner, and thus has readily provided information requested. However, because ESD 101 is a special education cooperative that primarily serves the needs of low incidence disabilities, very few children enrolled in the DEC program receive their services. In fact, the majority of children enrolled in the DEC program are placed in Dist. 81. The process of extracting school-based data from Dist. 81 has been fraught with difficulties, despite the significant amount of time attempting to access this information.

Our original intent was to utilize educational data that should have been available in the child's CPS file. Unfortunately, this information was so rarely included in the case files that we decided to send out surveys directly to the child's current school. This too proved problematic. First, much of the CPS information regarding current school attendance was outdated, making it difficult to know what school the child was actually currently attending. Second, once the current school had been identified, response rates from those schools to our requests for information averaged less than 10%.

Following discussions with CPS personnel and the DCFS CHET (Child Health and Education Tracking) screeners, we learned that school information is rarely received by

CPS in a timely manner. There were several internal meetings held with CPS staff, CHET screeners, the Child Well Being Program Manager, the DEC case coordinator, and the evaluator to address this ongoing problem. It was recommended that we work more closely with the CHET screeners in trying to obtain the school district information, since, as the DEC Program was attempting to gather similar information to what was needed by the CHET screeners for their reports.

We contacted the Dist. 81 Student Support Services Coordinator, who attended DEC meetings as a representative of Dist. 81, for assistance in data collection. Our third challenge emerged when Dist. 81 stated they did not have the ability to pay an employee to gather this information, nor could they give a non-employee (such as the evaluator) access to their system. Since the district is legally required to provide these data to CPS, as acting guardian for the children and the two agencies have a written collaborative agreement regarding information sharing for state-dependent children, an agreement was finally reached for Dist. 81 to provide these data. Our fourth challenge was the fact that the district still refused to release any data until we provided them with court documents proving that all of the children were indeed dependents of the state (which they were). Once the individual court orders for each child were secured through the intervention of the Attorney General's Office, they were immediately provided to Dist. 81.

Our fifth obstacle was in receiving usable information from Dist. 81. After more delay, we were provided with summary data on each child in the form of print-outs from database screens, but were not provided with any guide or codebook for interpreting the data, categories or coding schemas. In a final attempt to gather the information, the

Research Assistant met regularly with the Community Service/Mentoring Supervisor over the course of two months to secure the school data on children who were still dependents and enrolled in Dist. 81. Of the 399 DEC-identified children, 177 (44%) were too young to have school data. Of the remaining 222 children, we were only able to get school records on 100 children (45% of school-aged children). The vast majority (75%) of the 122 school-aged children for whom we were unable to secure educational records were no longer in state custody by the time the process of obtaining permission had been completed, so the District refused to provide us with any information. The other 25% of the school aged children for whom we were unable to secure records attended school outside of Dist. 81 and did not receive services from ESD 101.

#### *Measures of Mental Health*

Lutheran Community Services Northwest (LCSNW) provides mental health services to eligible drug-endangered children. The first variable measures whether the child became a client at LCSNW. For those children who became clients, information was gathered from the LCSNW computer system on therapist and paraprofessional contacts with these children. Printouts provided by LCSNW in this category were used to create a count of the individual sessions each child had with a LCSNW therapist. In addition to this variable, the printouts also provided a count of case management contacts and a count of therapeutic aide contacts. As the therapeutic aide contacts varied greatly in amount of time, a variable was created which measures the number of therapeutic aide "units." Each therapeutic aide unit is equal to thirty minutes. Thus, a child with 10 units had 300 minutes with a therapeutic aide. Two additional variables gathered from the LCSNW

printouts are if the child's case had been closed at LCSNW, and if closed, the reason for closing. The reasons for closure include successful completion of treatment, client discharged on client request or against agency advice, client failed to return, client moved away, and an "other" category. LCSNW is not currently providing drug treatment or family-based services to the families of children enrolled in the DEC program.

We are also extracting data from LCSNW regarding child well-being. LCSNW currently utilizes an online survey system called Telesage that is required by the State of Washington's Regional Service Network. Telesage is a mental health outcomes management system. The Telesage survey is supposed to be completed at intake and at three month intervals thereafter. This survey is typically completed by the parent/caregiver, although occasionally the survey is completed by the children themselves, depending on their age or developmental/maturity level. The survey asks a series of questions across multiple domains. In general, questions are asked for the domains of functioning, hopefulness, and problem severity. For example, some questions from the functioning domain ask the child's parent to rate how much their child's problems have interfered with things such as getting along with friends, getting along with family, and participating in hobbies. Problem severity is further divided into internalizing problems and externalizing problems. The questions from each domain are then compiled, and the child is given a "summary" score for each domain. These summary scores are then computed to z-scores, normed relative to the entire state at intake. As this survey is completed at regular intervals, we will compare summary scores to assess child well-being.

There have been two main challenges to utilizing the data from LCSNW. The most prominent challenge has been utilizing the Telesage information. Each Telesage survey printed for the children enrolled in the DEC program includes a bar graph at the top that charts “summary scores” of how the child is doing across the different domains (e.g. functioning). The bar extends across categories, from “extremely low” to “extremely high.” While this comparison data is useful, no one at Telesage was able to tell us specifically what number was being charted. It took months of dogged persistence to learn that accessing the exact “summary scores” is not possible. However, on a positive note, we were connected with a biostatistician (who, we were informed, was the only person in the country who could help us) who provided us with a full analysis of how the summary scores were derived. Through his help, we were able to understand the formulas for how individual questions were summarized into scales and subscales. Nonetheless, this became a time-consuming and ultimately frustrating process, given that Telesage is supposed to be providing outcome information relative to counseling progress.

The second obstacle to extracting information from LCSNW was the lack of completion of many of the measures. Despite agency requirements, the therapists were not ensuring the completion of these measures on a regular basis. This problem continues to be addressed by the supervisors at LCSNW, and a tracking system has been created which allows the therapists to be notified when a measure needs to be completed.

In addition, child functioning levels were assessed (on age-qualified children) by the Child Behavior Checklists and/or Teacher Report Forms (CBCL/TRF). The CBCL (Achenbach & Edelbrock, 1984) is one of the most common, standardized assessment

instruments used to measure behavioral functioning in children between the ages of 6 and 18. There are four versions of the CBCL/TRF, one for each gender at ages 6-11 and 12-18. The responses are summed, and the raw scores are converted to t-scores. Based on the t-score, each sub-scale score is ranked as either "normal," "borderline clinical," or "clinical." It is norm referenced on a variety of different child and adolescent populations. According to Berbube & Achenbach (2003), the CBCL has "extensive reliability and validity data and has been used in thousands of studies from 50 countries" (quoted from Achenbach, Dumenci, and Rescorla, 2003). For assessing behavioral functioning, we used the CBCL's "Externalizing Behavior" sub-scale score. For assessing emotional functioning, we used the CBCL's "Internalizing Behavior" sub-scale score. We also used the Syndrome scales of anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior.

For children enrolled in the DEC program under the age of 6, the Ages and Stages Questionnaire: Social-Emotional (ASQ: SE), was administered prior to or during the developmental administration. The CHET screeners also began to collect the ASQ:SE when they transferred from the KidScreens to the CHET screens. The ASQ:SE is another screening tool to help identify children who have a need for further mental health evaluation. Internal consistency, test-retest reliability, concurrent validity, and specificity all achieved accepted levels for all of the areas; utility was also acceptable (Squires, Bricker, & Twombly, 2003). The ASQ:SE, completed by the child's parents or caregivers, measures seven behavioral areas: 1) self-regulation, 2) compliance, 3) communication, 4) adaptive functioning, 5) autonomy, 6) affect, and 7) interaction with people. The survey is scored by

converting each response to a numerical value. These values are then summed, and the child's total score is compared with an empirically derived cutoff point. If the child's score is higher than the cutoff, it suggests the child should be referred for further mental health evaluation.

*Measures regarding law enforcement and prosecution*

There are six variables related to law enforcement agencies and prosecution. The first variable is whether or not law enforcement filed an Authorized Emergency Placement (AEP) on the children. Law enforcement is one of three agencies that can legally take temporary custody of a child (the other two are the court system and hospitals). Law enforcement files an AEP when officers determine a child is at imminent risk of harm for injury. This information is actually found in the DCFS CAMIS system. The law enforcement agencies also provide monthly reports detailing arrests made. When a law enforcement officer makes an arrest where children are endangered by drugs, the file is stamped "DEC" and the referral process to prosecution is thereby expedited. The DEC case coordinator attempts to link the parents' names, provided by law enforcement, to the children's names, as identified by CPS. Additionally, a student intern at PFC, who is also a reserve police officer, searched a database linking law enforcement and prosecution information. The second variable asks if a parent was arrested, which resulted in the child being identified for the DEC program. The third variable identifies which parent was arrested. The fourth variable details which law enforcement agency made the arrest.

The fifth through seventh variables relate specifically to prosecution. The fifth variable asks if the parent's case was sent for prosecution. The sixth variable asks if the

parent was charged with either a felony or a misdemeanor. Finally, the seventh variable relates to the outcome of prosecution. The possible outcomes are identified as pled guilty, found guilty, case was referred (e.g. to drug court), case is still pending prosecution, or case was dismissed.

#### Analytical/Technical Approaches

For tracking purposes, the DEC case coordinator has been consistently entering primarily demographic information into an Excel spreadsheet. In addition, we have created a statistical database using the Statistical Program for the Social Sciences, (SPSS, 13.0) to support analyses. For this final report, univariate analyses were completed to assess the normalcy of the data and to provide simple descriptive summaries. To understand the natural history of the study participants, baseline values for individuals were examined over time of admission to the DEC program to determine if characteristics of the population sample changed during the time frame of the study due to factors outside of our treatment condition.

Aggregate evaluation reports have been generated annually for the DEC Team and the funders. No identifying information is associated with any reported data, and all data are reported only in the aggregate. Dr. Altshuler and Ms. Cleverly-Thomas, in collaboration with Ms. Esther Larsen from the Spokane County Sheriff's Office, are responsible for the required grantee reporting of data.

## Findings

This area of the report will present the results of the statistical information available for the DEC participants. Each section highlights a separate category of the life dimensions noted earlier, identified by Perry and his colleagues for assessing the health and well-being of neglected children (Perry, et al., 2003). Additionally, we provide summary descriptions of demographic information regarding the children and their child welfare experiences.

### Demographic Information

Table 2 highlights the age range and family size of the 399 children enrolled in the DEC program from January, 2004 through December, 2006. After the first year, enrollment increased approximately 50%, from 100 children to 150 children each year thereafter. The children's ages ranged from newborn to 16 years old, with an average age of 5 years. Almost 73% of the children had siblings enrolled in the DEC program. The identified children comprise 220 unique families. Almost half (49.1%) of all families had only one child enrolled in the DEC program. Of the remaining families, 30.9% had two children identified, 11.8% three children, 6.4% four children, 1.4% five children, and 0.5% six children. There were slightly more boys than girls enrolled in the DEC program, the vast majority of whom were Caucasian. Over 10% of the subjects were identified as bi- or tri-racial, and slightly under 10% were Native American. Another 5.5% were African-American while almost 3.5% were Hispanic/Latino.

**Table 2**

*Demographic Information of DEC enrolled children, by Year of Enrollment*

	<i>All Years (2004-06)</i>	<i>Year 1 (2004)</i>	<i>Year 2 (2005)</i>	<i>Year 3 (2006)</i>
<i>Age (in months)</i>				
N	399	101	148	150
Mean	61.66	64.38	59.66	61.80
Standard Deviation (SD)	43.99	44.13	45.72	42.33
Range	0-197	0-181	0-197	0-195
<i>Number of Families</i>				
	220	50	87	83
	<i>N (%)</i>	<i>N (%)</i>	<i>N (%)</i>	<i>N (%)</i>
<i>Does Child Have Siblings?</i>				
Yes	291 (72.9)	80 (79.2)	101 (68.2)	110 (73.3)
No	108 (27.1)	21 (20.8)	47 (31.8)	40 (26.7)
<i>Number of Children in Each Family*</i>				
1	108 (49.1)	21 (42.0)	47 (54.0)	40 (48.2)
2	68 (30.9)	16 (32.0)	24 (27.6)	28 (33.7)
3	26 (11.8)	7 (14.0)	11 (7.4)	8 (9.6)
4	14 (6.4)	5 (10.0)	4 (2.7)	5 (6.0)
5	3 (1.4)	0 (0.0)	1 (0.7)	2 (2.4)
6	1 (0.5)	1 (2.0)	0 (0.0)	0 (0.0)
<i>Gender</i>				
Male	219 (54.9)	54 (53.5)	78 (52.7)	87 (58.0)
Female	180 (45.1)	47 (46.5)	70 (47.3)	63 (42.0)
<i>Race/Ethnicity</i>				
Caucasian	274 (68.7)	68 (67.3)	106 (71.6)	100 (66.7)
Bi-Racial/Tri-Racial	42 (10.5)	6 (5.9)	15 (10.1)	21 (14.0)
Native American	35 (8.8)	12 (11.9)	12 (8.1)	11 (7.3)
African American	22 (5.5)	3 (3.0)	9 (6.1)	10 (6.7)
Hispanic/Latino	13 (3.3)	5 (5.0)	3 (2.0)	5 (3.3)
Asian/Pacific Islander	1 (0.3)	1 (1.0)	0 (0.0)	0 (0.0)
Other	6 (1.5)	4 (4.0)	2 (1.4)	0 (0.0)
Missing (Race unknown to CPS)	6 (1.5)	2 (2.0)	1 (0.7)	3 (2.0)

## Child Welfare History

Table 3 describes the experiences of the children enrolled in the DEC program with the child welfare system prior to enrollment into the DEC program. Previous to the current referral to the DEC program, children averaged almost 6 previous referrals to Child Protective Services (CPS), with over one-half being accepted for investigation. Very few children, however, had previous out of home placement experiences, most of which were less than 3 months in length.

**Table 3**  
 Child Welfare History, by Mean and Standard Deviation (N=399)

	M	SD	Min	Max
Number of CPS referrals, per child (N=394)	5.82	4.57	0	24.00
Number of referrals accepted for investigation, per child (N=394)	3.81	2.86	0	14.00
Number of total out of home placements (includes current) (N=392)	1.44	1.19	0	7.00
Length of most recent out of home placement (in days) (N=112)	79.48	130.49	1	629

For all investigations, CPS workers assign a “Level of Risk” Tag to assess to what extent they feel the child is in imminent danger of being abused or neglected. The Risk Tag ranges from 0 (indicates no risk) to 5 (indicates serious imminent risk). For the children enrolled in the DEC program, the mean of the assigned risk tag is 4.55 (s.d. =0.73), indicating that virtually all of the children were assessed to be at high risk for imminent harm.

Table 4 summarizes other demographic factors regarding the subjects' current referral into the DEC program, including parental drug use history and family/sibling background and placement information. Over 80% of the children were referred due to neglect (which is typical for parental drug use), with another 8.2% involved due to a referral on a sibling. Slightly over 70% of referrals resulted in placements into foster care, either with or without relatives, while another 16.1% were placed into group homes. Almost 10% were not placed into state custody, and only 2% were placed, under state custody, at home with their parents. Of the 291 children with siblings, almost 80% were placed with their siblings within the first 30 days of placement. Predominantly, children were removed from either a mother-only family structure (48.2%) or a two-parent family (42.7%) structure, with very few being removed from the father as the primary identified caregiver. The CPS referral reason was related to parental drug use in 72.2% of the cases, with methamphetamine involvement in 67.7% of those cases.

**Table 4**

*Demographic Factors regarding enrollment into DEC program, by Number and Percent*

	N	%	Missing	
Reason for Referral			7	1.8
Physical abuse only	14	3.6		
Sexual abuse only	4	1.0		
Neglect only	320	81.6		
Neglect and other abuse	17	4.3		
Abandonment	5	1.3		
Referral on sibling	32	8.2		
Type of Current Placement			7	1.8
Non-relative foster care	151	38.5		
Kinship foster care	125	31.9		
In-home dependency w/ parents	8	2.0		
Group home	63	16.1		
Other (hospital)	7	1.8		
Not placed into state custody	38	9.7		
Child placed with sibling immediately	184	71.6	142*	35.6
Child placed with sibling within 30 days	192	77.7	152**	38.1
Was primary referral reason due to parental drug use?			10	3.9
Yes	281	72.2		
No	108	27.8		
Family Structure at Time of Removal			15	3.8
Mother	185	48.2		
Two parents	164	42.7		
Mother / Paramour	22	5.7		
Father	11	2.9		
Father / Paramour	2	0.5		
Parent's drug of choice			27	6.7
Meth only	195	52.4		
Poly-Drug, including meth and/or alcohol	115	30.9		
Alcohol only	13	3.5		
Other (heroin, cocaine, prescription, marijuana)	49	13.2		

\* Of the 142 missing, 108 children did not have siblings, and 38 were never placed, with an overlap of 15.

\*\* An additional 10 children were returned home within one month.

## Children's Well-Being at Time of Referral

As noted in the Methodology section, we were committed to using existing case record information for our goals of assessing children's well-being. As a result, the findings reflect varying degrees of missing data, based upon the agencies' production of information. This section summarizes what we know about the 399 children enrolled in the DEC program, and their 220 families, when they were first taken into care as a DEC-identified child.

### *Physical/Medical*

Table 5 provides the information regarding the children's medical information about their physical health, at intake into the DEC program. Approximately 2/3 of the children enrolled in the DEC program (N=241) had a Kidscreen completed by CPS, indicating that a CPS worker attempted to gather immunization status, height/weight/head circumference, and basic physical health information on the child. The assessment of height/weight/head circumference indicated that less than one-half of the children's measurements were considered to be "within normal limits," meaning that they were not between the 25<sup>th</sup> and 75<sup>th</sup> percentiles for their age. Of the 241 children who had a Kids screen or CHET Screen completed, only 102 had an identified determination of their immunization status. Almost half of the children whose status was known were behind on their immunizations at time of placement. It is very likely that a high proportion of the other 139 children with completed Kids/CHET screens are also behind on their immunizations, as the CHET screeners report the status as unknown if they are not able to find an immunization record. Overall, we were able to get information on identified medical homes for 82.5% of the

children enrolled in the DEC program, of whom the majority (62.0%) had an identified medical home. As with immunization status, it is very plausible that the 70 children with missing information did not have an identified medical home.

**Table 5**  
*Physical/Medical Findings of the DEC enrolled children, by Number and Percent*

	Yes		No		N/A or Missing	
	N	%	N	%	N	%
Was Kid Screen completed?	241	66.7	120	33.2	38	9.5
Was a medical completed following placement?	240	71.4	96	28.6	63	15.8
Was Height/Weight/Head Circumference “within normal limits”?	79	44.1	100	55.9	220	55.1
Were immunizations current at time of placement?	55	53.9	47	46.1	297	74.4
At placement, did child have identified medical home?	204	62.0	125	38.0	70	17.5

*Trauma History*

The TSCYC (Briere, 1996) was completed for 44 children enrolled in the DEC program seen at Lutheran Social Services Northwest for counseling. Four were not analyzable due to the child being out of the age range for the TSCYC. According to Briere, the T-scores are normed to have a mean of 50 and a standard deviation of 10. For the clinical scales below (excluding posttraumatic stress), a T-score less than or equal to 64 is considered normal, T-scores between 65 and 69 are potentially problematic, and T-scores greater than or equal to 70 are interpreted as clinically significant. As Table 6 shows, the children’s scores on the anxiety (M=64.63), dissociation (M=64.30), and sexual concerns (M=64.28) scales border on the cutoff between normal and potentially problematic.

Children enrolled in the DEC program indicate potential problems in both depression (M=68.93) and anger (M=67.63).

Briere (1996) states that for posttraumatic stress, T-scores greater than or equal to 70 suggest relatively severe posttraumatic disturbance, and T-scores between 65 and 69 are “often associated with at least one elevated PTSD symptom cluster, and thus suggests mild to moderate posttraumatic stress” (p. 15). Thus, the average score of 73.79 suggests that the children enrolled in the DEC program are a highly traumatized group, as this falls within the “severe posttraumatic disturbance” category.

Another way to understand the results from the TSCYC is to evaluate the frequency of responses within the sample of 40 children for whom it was completed. Table 7 shows that half of the children who completed the TSCYC were in the clinical range of a potential severe posttraumatic disturbance. Fully one-half of the children were in the clinically significant range for anger, 45% for depression and anxiety, and 30-35% rated clinically significant for dissociation and sexual concerns.

**Table 6**  
*T-Score Levels of Trauma Symptoms, by Mean and Standard Deviation (N=40)*

T-scores for TSCYC (35-110)	M	SD	Min	Max
Anxiety	64.63	19.00	40	110
Depression	66.93	18.44	41	110
Anger	67.63	17.44	41	110
Posttraumatic Stress	73.35	23.32	42	110
Dissociation	64.30	17.78	43	110
Sexual Concerns	64.28	23.60	46	110

**Table 7**  
*Levels of Trauma Symptoms, by category (N=40)*

Frequencies for TSCYC domains	<i>Frequency</i>	
	N	%
<b>Anxiety</b>		
Normal	20	50.0
Potentially Problematic	4	10.0
Clinically Significant	16	40.0
<b>Depression</b>		
Normal	20	50.0
Potentially Problematic	2	5.0
Clinically Significant	18	45.0
<b>Anger</b>		
Normal	19	47.5
Potentially Problematic	1	2.5
Clinically Significant	20	50.0
<b>Posttraumatic Stress</b>		
Relatively Normal	17	42.5
Mild to Moderate Posttraumatic Stress	3	7.5
Severe Posttraumatic Disturbance	20	50.0
<b>Dissociation</b>		
Normal	22	55.0
Potentially Problematic	4	10.0
Clinically Significant	14	35.0
<b>Sexual Concerns</b>		
Normal	26	65.0
Potentially Problematic	1	2.5
Clinically Significant	13	32.5

*Developmental or Social Functioning*

Table 8 summarizes the results from the Battelle Developmental Inventory (BDI) assessments, completed on 121 children enrolled in the DEC program, ages 6 months to 8 years old. For comparison purposes, we utilize both the percentile scores and the standardized z-scores to measure development across each BDI category. The percentiles show the children scored uniformly lower than average norms on every domain, with their cognition scores being the lowest. Their overall BDI scores for their percentile rankings reflect their functioning at 27%, significantly lower than the 50% average of the normed population.

**Table 8**  
*Assessment of Developmental Functioning, Based on the Percentile Rankings on the Battelle Developmental Inventory, by Mean and Standard Deviation*

	Percentile		Range	
	M	SD	Min	Max
BDI (0-100), by domain				
Personal-Social (N=114)	31.34	27.33	1.0	99.9
Adaptive Functioning (N=114)	29.39	28.86	0.4	99.9
Total Motor Skills (N=132)	33.29	31.68	0.4	98.0
Communication (N=134)	35.14	28.51	0.1	98.0
Cognition (N=132)	26.24	26.40	0.1	99.0
Overall BDI Score (N=111)	27.19	27.86	0.1	97.0

Newborg, Stock, Wnek, Guidubaldi, and Svinicki (1984) stated that a z-score of 1.5 or below indicates a performance deficit. Using this criteria, Table 9 shows that 33% of children enrolled in the DEC program who were administered the BDI qualified as having a “developmental deficiency,” when measured across all domains. The highest percentage of children qualified as “developmentally deficient” in the domains of adaptive functioning (29.8%) and cognition (29.5%).

**Table 9**  
*Children qualifying as having “developmental deficiencies”*

BDI (Z-score of 1.5 or below indicates a performance deficit) *	Yes		No		N/A or Missing	
	N	%	N	%	N	%
Personal-Social (N=114)	27	23.7	87	76.3	285	71.4
Adaptive Functioning (N=101)	34	29.8	80	70.2	285	71.4
Total Motor Skills (N=121)	35	26.5	97	73.5	267	66.9
Communication (N=121)	28	20.9	106	79.1	265	66.4
Cognition (N=121)	39	29.5	93	70.5	267	66.9
Overall BDI Score	37	33.3	74	66.7	288	72.2

\*(Newborg, Stock, Wnek, Guidubaldi, & Svinicki., 1984)

The Ages and Stages Questionnaire (Squires, et al., 2003) (ASQ) is another assessment that was used for assessing developmental and social functioning in 69 children enrolled in the DEC program. As noted in the Methodology discussion, CPS uses the ASQ in its Kidscreens to help them identify children who may have a need for further developmental screening, determined if the child’s total score is higher than the empirically derived cutoff point. As Table 10 shows, the ASQ indicated possible concerns in communication for 36% of children, personal/social skills for 30%, fine motor skills and problem solving for 28%, and gross motor skills for 20% of children.

**Table 10**  
*Assessment of Developmental Functioning, Based on the Summed Cut-Off Scores Indicating Concerns on the Ages and Stages Questionnaire, by Number and Percent*

ASQ, by domain (n=69)	Concern Indicated		No Apparent Concern	
	N	%	N	%
Communication	25	36.2	44	63.8
Gross Motor	14	20.3	55	79.7
Fine Motor	19	27.5	50	72.5
Problem Solving	19	27.5	50	72.5
Personal/Social	21	30.4	48	69.6

*Family History*

Table 11 summarizes the overall level of risk for birth/biological parents to have experienced child abuse or neglect in their own childhood. The average maternal level of risk was 3.07 (N=162, 75% of sample), indicating that these mothers showed moderately high risk of having experienced child abuse or neglect during their own childhood. More significantly, perhaps, is that 34% were rated at the highest level of risk. As expected from the above discussion about the lack of father dominated households, we had levels of paternal risk on 25 % of fathers (N=55). The fathers had an average risk level of 2.15, and 16.4 percent were labeled as high risk.

**Table 11**

*Parents' Childhood Experiences of Child Abuse or Neglect, by Risk Level*

Parental Risk Level (0=no risk, 5=high risk)	Risk Level		Range	
	M	SD	Min	Max
Maternal (N=299)	3.14	1.74	0	5
Paternal (N=108)	2.32	1.69	0	5

  

Risk level of parents	Frequencies		N/A missing	
	N	%	N	%
Maternal Risk Level (N=299)			100	25.1
No Risk	26	8.7		
Low Risk	42	14.0		
Moderately Low Risk	44	14.7		
Moderate Risk	48	16.1		
Moderately High Risk	30	10.0		
High Risk	109	36.5		
Paternal Risk Level (N=108)			291	73.9
No Risk	21	19.4		
Low Risk	18	16.7		
Moderately Low Risk	15	13.9		
Moderate Risk	31	28.7		
Moderately High Risk	5	4.6		
High Risk	18	16.7		

*Mental Health: Emotional/Behavioral*

CPS completed the Child Behavior Checklist (CBCL) for the 142 age appropriate children enrolled in the DEC program (45 children were too young). The normed cut-off score that indicates significant behavioral or emotional problems is 63. Table 12 shows that the majority of children scored within the normal range (M=55).

**Table 12**  
*Assessment of Mental Health: Emotional/Behavioral Functioning,  
 Based on the Child Behavioral Checklist T-scores, by Mean and Standard Deviation*

	M	SD	Min	Max
T-scores for CBCL/TRF (63=clinical cut-off) (n=122)			0	100
Total Problems	55.59	13.00	25	98
Externalizing	55.39	14.44	28	95
Internalizing	54.97	11.57	29	80

Another approach to understanding the results from the CBCL is to analyze the number and percentage of children enrolled in the DEC program who scored in the Normal, Borderline, and Clinical Ranges for the Internalizing and Externalizing scales, together with the Syndrome Scales. Table 13 highlights that almost ¼ of the children scored in the Clinical Range for Total, Externalizing and/or Internalizing Problems. Rule-Breaking Behaviors, Aggressive Behaviors, and Withdrawn Behaviors were the 3 Syndrome Scales in which children enrolled in the DEC program had the highest percentages of Clinical Scores, ranging from 25% to 19.4% to 15.2%, respectively.

**Table 13**

*Assessment of Mental Health: Emotional/Behavioral Functioning – Syndrome Scales, from the Child Behavioral Checklist T-scores, by Mean and Standard Deviation*

Child Behavior Checklist	Normal		Borderline		Clinical	
	N	%	N	%	N	%
Total Problems (N=145)	93	64.1	19	13.1	33	22.8
Internalizing (N=145)	96	66.2	17	11.7	32	22.1
Externalizing (N=145)	97	66.9	12	8.3	36	24.8
<b>Syndrome Scales</b>						
Emotionally reactive (1½ - 5 yrs) (N=83)	60	72.3	15	18.1	8	9.6
Anxious/depressed (N=135)	112	83.0	13	9.6	10	7.4
Somatic complaints (N=135)	128	94.8	6	4.4	1	0.7
Withdrawn (N=135)	103	76.3	6	4.4	26	19.3
Attention problems (N=134)	109	81.3	9	6.7	16	11.9
Aggressive behavior (N=135)	105	77.8	8	5.9	22	16.3
Sleep problems (1½ - 5 yrs) (N=75)	68	90.6	1	1.3	6	8.0
Social problems (6-18 yrs) (N=49)	37	75.5	8	16.3	4	8.2
Thought problems (6-18 yrs) (N=48)	42	87.5	3	6.3	3	6.3
Rule breaking behavior (6-18 yrs) (N=49)	32	65.8	5	10.2	12	24.5

The ASQ: SE was administered to 64 (16%) of the children enrolled in the DEC program to determine if there was a need for further mental health counseling (see Table 14). While this percentage appears low, there were 207 children (51.9%) who were not eligible as they were out of the age range (six to sixty months). Thus, of the 192 eligible children, 33.3% were administered the ASQ:SE. The ASQ:SE was collected from two

sources: developmental assessments and CHET screens (which mostly replaced the KidScreens). The ASQ:SE was not collected as part of the KidScreens (pre-CHET). Thus, the majority of the children who did not have a completed ASQ:SE either did not have a CHET screen or a developmental assessment. Of the 64 children who had an ASQ:SE administered, 42.2% indicated further mental health follow-up was needed.

**Table 14**  
*Ages & Stages Questionnaire: Social Emotional*

	Yes		No		N/A or Missing	
	N	%	N	%	N	%
Was ASQ:SE administered?	64	33.3	128	66.7	207	51.9
Need for further follow-up needed?	27	42.2	37	57.8	0	0.0

### Impact of the DEC Program

#### *Counseling Experience*

Almost 1/3 of children enrolled in the DEC program (N=115) were seen at least once at LCSNW for counseling or other social support services. Table 15 summarizes those experiences. The children received professional services from a qualified master’s-level counselor or social worker weekly for an average of 5 months, ranging from one week to almost 2 years. In addition, clients were provided therapeutic aides and case management, as needed. As of this writing, 47 children continue to receive counseling services and their cases remain open. Treatment was completed for 32.4% of the cases (N=22), while the other 2/3 discontinued treatment for a variety of reasons, ranging from a failure to return with no explanation (N=13; 19.1%), moving away (N=10, 14.7%), and client request (N=8, 11.8%).

**Table 15**

*Counseling Experience of DEC-enrolled children at Lutheran Community Services Northwest, by Number and Percent, or Mean and Standard Deviation*

	N	Percent	Missing	
Number of DEC clients who received counseling services	115	28.8	0	0
Number of Counseling Closures	68	59.1	0	0
Reasons for case closure				
Treatment completed	22	32.4		
Discharge at Clients request	8	11.8		
Discharge against agency advise	5	7.4		
Failure to return	13	19.1		
Moved away	10	14.7		
Other	8	11.8		
Discharge at Clinician Request	2	2.9		
	M	SD	Min	Max
Number of Individual Sessions (N=111)	19.09	21.89	1	107
Number of Case Management Contacts (N=111)	7.08	12.77	0	78
Number of Therapeutic Aide Contacts (N=111)	3.98	11.57	0	57
Therapeutic Aide Units (in 30 minute increments) (N=19)	114.63	86.77	3	241

The TSCYC (Briere, 1996) was intended to be completed in 3-month intervals for all of the children seen at LCSNW, but only approximately ¼ of them actually had at least one follow-up administration. A paired ANOVA test found no significant differences in initial mean scores between the clients who did and did not have a re-test. We used paired sample t-tests to assess changes in the levels of the subdomains of trauma symptoms in the children. As Table 16 shows, the t-scores for all children decreased after at least 3 months of receiving counseling services. Three domains showed a statistically significant decrease: anxiety (P=.006), depression (P=.01), and posttraumatic stress (P=.006).

**Table 16**

*T-Score Change in Levels of Trauma Symptoms, by Mean and Standard Deviation (N=25)*

TSCYC: Changes in t-scores by domain	Mean at time 1	Mean at time 2	Difference in means	T (df)
Anxiety	66.80	58.32	8.48	3.00 (24)**
Depression	68.40	59.48	8.92	2.63 (24)**
Anger	69.32	63.60	5.72	1.74 (24)
Posttraumatic Stress	75.04	64.52	10.52	3.00 (24)**
Dissociation	65.52	59.44	6.08	1.59 (24)
Sexual Concerns	65.52	59.92	5.60	1.34 (24)

\*\*p=.01; \*p=.05

Seventeen children were re-administered the Battelle Developmental Inventory. Of these children, there were significant improvements in adaptive functioning, total motor skills, and communication. As Table 17 shows, there was also a significant improvement in overall developmental functioning.

**Table 17**

*Z-Score Change in Levels of Development, by Mean and Standard Deviation (N=25)*

BDI: Changes in Z-scores by domain	Mean at time 1	Mean at time 2	Difference in means	T (df)
Personal-Social	-1.176	-.437	-.739	-2.11 (13)*
Adaptive Functioning	-1.113	-.118	-.995	-3.18 (15)**
Total Motor Skills	-1.411	-.283	-1.129	-3.55 (15)**
Communication	-1.068	-.141	-.927	-2.94 (16)**
Cognition	-1.451	-.946	-.505	-1.77 (16)
Overall BDI Score	-1.426	-.421	-1.005	-3.02 (13)**

\*\*p=.01; \*p=.05

Table 18 summarizes the case status outcomes by the end of the current DEC program. Almost 2/3 (N=258) of the children involved in the DEC program continue to be under state protection services, while 1/3 (N=137) have had their involvement with the state agency closed. Other than the 17 children who were adopted (12.4% of the closed cases), the closed cases were fairly evenly divided between those who had their dependency status dismissed and those who were never state dependent in the first place. Of the children whose cases remain open, approximately 15% appear to be headed for adoption or another type of permanency arrangement without state involvement.

**Table 18**  
*CPS Case Status by end of DEC Program, by Number and Percent*

	N	Percent	N/A or Missing	
Case Status			4	0.01
CPS case open	258	65.3	0	0.00
Dependent	203	77.9		
Shelter care	15	5.8		
Legally free (TPR)	34	13.2		
Guardianship	6	2.3		
CPS case closed	137	34.7	4	2.92
Returned, dependency dismissed	60	43.8		
Returned, never dependent	56	40.9		
Adopted	17	12.4		

## Law enforcement

Table 19 shows that law enforcement signed an authorization for emergency placement (AEP) for 72.6% of enrolled children enrolled in the DEC program. These AEPs resulted from both arrests and CPS referrals where law enforcement felt there was enough risk of imminent harm to place the children into care. Overall, 122 children enrolled in the DEC program had at least one parent arrested at the time of referral or placement. However, sixteen of these cases had a parent arrested for a non-drug offense (most commonly domestic violence). Of the children who were placed into care via an AEP, 86 had an AEP filed following a drug-related arrest. Of the children with at least one parent arrested, 15 children had both parental figures arrested, 75 had the mother figure only, and 16 had the father figure arrested. When broken down by family, 56 of the 220 DEC families had a parent arrested for a drug-related charge. Of these families, the mother figure was arrested 60.7% of the time, the father 21.4%, and both parents 17.9% of the time.

Table 20 summarizes the prosecutorial outcomes. Approximately three-quarters of the arrestees were referred for prosecution. All of the parents who were charged with a crime were charged with felony offenses, rather than misdemeanors. Over half of the mothers' court cases resulted in convictions by a guilty plea, thereby avoiding costly court cases. Another 12.5% of mothers were found guilty. Of the remaining cases, two mothers (6.6%) were referred for services (e.g. drug court), three had their cases dismissed, two were not adjudicated, and four cases were still pending resolution. For the seventeen fathers charged, 71% pled guilty, four still had their cases pending, and one dismissed by motion of the prosecutor.

**Table 19**

*Law Enforcement Arrests, by Number and Percentage*

	Yes		No		N/A or Missing	
	N	%	N	%	N	%
Did law enforcement file an AEP at time of referral or placement?	286	72.6	108	27.4	5	1.3
Was AEP filed as a result of parental arrest?*	86	30.1	200	69.9	113	28.3
Was the child's parent arrested (per child)?	122	30.8	274	69.2	3	0.8
Was at least one parent arrested (per family)? (N=220)	64	29.4	154	70.6	2	0.9
Was the arrest drug-related (per child)?	106	86.9	16	13.1	277	69.4
Was the arrest drug-related (per family)? (N=220)	56	87.5	8	12.5	156	70.9
		N		Percent		N/A or Missing
Which parent was arrested (per child)?					277	0.0
Mom/mother figure		75		70.8		
Dad/father figure		16		15.1		
Both parental figures		15		14.2		
Which parent was arrested (per family)?					164	74.5
Mom/mother figure		34		60.7		
Dad/father figure		12		21.4		
Both parental figures		10		17.9		

\* Not all arrests resulted in AEPs being filed (e.g. parent may have filed voluntary placement agreement)

**Table 20**

*Prosecution Outcomes, by Number and Percentage*

PROSECUTION (by parent)	N	Percent	N/A or Missing
Was the mother's case referred to the prosecutor's office? (N=44)			176 80.0
Yes	33	75.0	
No	11	25.0	
Was the father's case referred to the prosecutor's office? (N=22)			198 90.0
Yes	17	77.3	
No	5	22.7	
Was the mother charged with a felony or misdemeanor? (N=33)			187 85.0
Felony	33	100.0	
Misdemeanor	0	0.0	
Was the father charged with a felony or misdemeanor? (N=17)			203 92.1
Felony	17	100.0	
Misdemeanor	0	0.0	
What was the outcome of the mother's case? (N=33)			185 86.0
Convicted by plea	17	53.1	
Found guilty	4	12.5	
Not adjudicated	2	6.3	
Dismissed	3	9.4	
Pending	4	12.5	
Referred	3	9.4	
What was the outcome of the father's case? (N=17)			203 92.3
Convicted by plea	12	70.6	
Found guilty	0	0.0	
Not adjudicated	0	0.0	
Dismissed	0	0.0	
Pending	4	23.5	
Referred	0	0.0	
Dismissed by motion of the prosecutor	1	5.9	

## Children's Legal Advocate

The Children's Legal Advocate is a collaborative position between PFC and the Spokane County Prosecutor's Office. This position assists in the planning, preparation for, and implementation of, Kids' and Teen Court, both of which are educational experiences for children who may be going to court to testify. This position also helps the evaluators track the case status of DEC parent's who have been arrested and referred for prosecution.

The Children's Legal Advocate provides assistance and referrals to community resource for victims and families. The position provides support to victims and their families as they navigate through the court process. She attends interviews with prosecutors and defense attorneys with them, and ensures that the child's best interests are being met. This position has assisted in cases where the children have been endangered by their parents' drug use.

PFC offers Kids' and Teen Court to all youth who may be testifying in court (and their caretakers) to educate them about the court process and normalize the experience of going to court and testifying. A child entering a courtroom for the first time is entering an adult setting that can be overwhelming and confusing. The goal of the program is to lessen the anxiety about going to court by explaining all of the parts of the process and the role of each person involved. There is no discussion of individual cases as this is just an opportunity for children and adults to learn about court proceeding in general and also learn how a parent can support a child who will be testifying. Professionals from the fields of education, social work, and criminal justice all staff Kids' and Teen Court. Most of these professionals donate their time for this excellent and worthwhile program.

## Discussion

### Limitations

It is critical to highlight the methodological limitations that this study has faced. As delineated in the methodology section, the most significant limitation we faced was our inability to collect comprehensive data from all of the DEC Team agencies' records. As researchers, we continue to maintain our commitment to minimizing our "intrusion" into agency processes by increasing demands for data generation through additional, time consuming evaluations. In addition, we were requested to provide a "snapshot" of the collaborative process as it developed, rather than to provide an extensive evaluation of child well-being. As a result, we were completely reliant upon each agency's willingness and ability to provide us with access to their records, which in turn, were questionable regarding their levels of thoroughness, reliability and validity. This is not intended as a criticism of agency records; it is, rather, an acknowledgement of the ongoing difficulty with community-based research with agencies whose primary focus needs to be on service delivery over record keeping. An unfortunately all-too-common example of this is the lack of information regarding the birth fathers. For example, we are missing information regarding paternal risk levels for almost  $\frac{3}{4}$  of the children, but missing information on maternal risk levels for  $\frac{1}{4}$  of the children.

Even more disturbing, perhaps, was our inability to attain school records, despite our valiant efforts to do so. Given the recent plethora of attention to the need to attend to school functioning for foster care youth (see, e.g., Casey Family Partners, 2004; Krinsky,

2004; Zetlin & Weinberg, 2004), the reality of the difficulty in obtaining such records does not bode well for supporting the educational needs of children in foster care.

On a similar note, for the first 3 years of the project, the only children who received developmental evaluations were those for whom their CPS caseworker completed a referral. If the caseworker did not have serious concerns about the child's development, or for any other reason did not desire to have a developmental evaluation completed, it was not done. The frustration of the DEC Team about this – its inability to accurately assess developmental levels on ALL the children – finally led to a policy change at CPS, wherein the DEC case coordinator could directly refer the children to receive developmental evaluations. Thus, every child was referred to a developmental specialist for an evaluation.

Overall, we believe that our most serious limitation this study has is its inability to provide a “state-of-the art,” purely experimental research design or even a quasi-experimental design (Cook & Campbell, 1979) which would have clear pre- and post-test results and random sampling, all of which could enhance our ability to document changes in the levels of well-being of the subjects in this study. We had difficulty in being able to access consistent, reliable, baseline levels of functioning across domains of well-being, and have been unable to document thoroughly longitudinal changes for the subjects in this study. Because we feel that the specificities of the limitations belong in the Methodology section, as we described our attempts to gather data, the reader is referred back to that section for further explication.

This study occurred in Spokane, Washington, and may not be generalizable to other areas or regions of the country. Spokane County's ethnic diversity is not fully

representative of the U.S., because we have lower than average percentages of African-American and Hispanic/Latino citizens, together with a higher than average percentage of Caucasian and Native American citizens. Additionally, Spokane, Washington, was one area of the country in which the so-called “meth epidemic” exploded rapidly, which may or may not reflect the realities across the country as a whole.

### Summary of Findings

The children enrolled in the Spokane County DEC Project are a highly traumatized, troubled, developmentally delayed group. Of particular concern is the average age of children removed from drug environments. The children scored significantly and uniformly low on virtually all measures of functioning. Given both the developmental delays, and the average age of five years, the majority of these children do not have the capacity to protect themselves from the dangerous drug environments into which they are placed by their caregivers. On average, the drug-endangered children averaged 5.78 previous referrals to child protective services, with an average of 3.81 of those referrals being accepted for investigation. The majority (82%) of the referrals was for neglect, and 72% were related specifically to parental drug use. Parents predominantly used either meth (52.4%) or were poly-substance abusers (30.9%, including meth and/or alcohol). Almost half of the children were removed from mother only households, while 43% were removed from two-parent households.

Over half of the children were not up-to-date on their immunizations, and fell significantly lower than the 25<sup>th</sup> percentile for height, weight and head circumference. The children’s scores across domains for trauma symptoms, including anxiety, dissociation,

depression, anger, and sexual concerns were problematic. Potentially most concerning, the average score for post-traumatic stress suggests that the children enrolled in the DEC program are a highly traumatized group, as half fall within the “severe posttraumatic disturbance” category. On the plus side, there was a significant improvement in the categories of anxiety, depression, and posttraumatic stress for the children who received counseling services and completed a second TSCYC. Almost 30% (115) of the sample were able to receive mental health counseling from Lutheran Community Services. On average, these children received 19 individual sessions, and of the 68 children whose case was closed, 32% were closed due to treatment completion.

The children’s average level of developmental functioning was at the 27<sup>th</sup> percentile (significantly lower than what is considered “normal” at the 50<sup>th</sup> percentile) measured using five domains: personal-social, adaptive functioning, motor skills, communication, and cognition. While it is well documented that children placed into foster care often score significantly lower on standardized measures of well-being (see, e.g., Dubowitz, et al.,1994; Smithgall, Gladden, Yang, & Goerge, 2005), the pervasively low levels of functioning across domains for these children explain the label of “drug endangered,” meaning that parental drug use has significantly endangered the children’s health and well-being. In addition, their permanency status appears to be lagging behind federal standards: by the end of 2006, less than 1/5 of the children had achieved permanency through adoption or guardianship, while 1/3 of the children had been returned home.

The racial breakdown of identified children reflected the overall demographics of children placed into foster care throughout Spokane County, with higher than average

representation of children of color and Native Americans. Children were predominantly Caucasian (68.7%). The next largest segment was children who were identified as being bi-racial or tri-racial (10.5%). Also represented were Native Americans, African Americans, Hispanics/Latinos, and Asians.

Almost three-quarters of the enrolled children enrolled in the DEC program had a law enforcement-signed authorized emergency placement (AEP). These AEPs resulted from both arrests and CPS referrals where law enforcement felt there was enough risk of imminent harm to place the children into care. When broken down by family, 54 of the 215 DEC families had a parent arrested for a drug-related charge. Of these families, the mother figure was arrested 59.3% of the time, the father 22.2%, and both parents 18.5% of the time.

The majority of the parents' cases were referred for prosecution, with all those referred being charged with felonies, rather than misdemeanors. The most common result of these referrals for prosecution was the parent being convicted by entering a guilty plea. These numbers coincide with discussions at the monthly DEC meetings, where the Prosecutor's Office stated most cases involving DEC parents do not go to trial, and the majority of parents plead guilty. As a result, none of the subjects in this study ever had to go to, testify at, or observe a court hearing at which their parents were the defendants. We believe that one of the reasons for this incredibly successful rate of prosecution is the development of standardized guidelines for all agencies, including law enforcement, to follow when confronted with drug endangered children and their families. The DEC Team spent approximately the first 18-24 months of the project in developing of the guidelines

(which are attached to the end of this final report) to ensure successful standardization of procedures and expectations.

### Implications

As we know, before this project began, the needs of children enrolled in the DEC program were not even being identified by agency workers. The various agencies involved were therefore not communicating with each other to coordinate services. Many of the cases had been closed or never referred to other agencies and the children did not receive any services. Most disturbing, perhaps, was the fact many CPS files lacked requisite safety or investigative assessments, medical information or treatment referral information (see, Altshuler, 2005).

While this lack of a baseline assessment was disturbing, it was also highly commendable that the agencies themselves, including CPS, responded to this with concern and a commitment to change. From having partial information on only 14 children in 2003, to having systematically gathered much standardized assessment data on 399 children by 2006, clearly highlights the significant changes that have been occurring across all the partner agencies. We attached a copy of our "Flow Chart" to the end of this report that indicates the stewards' responsibilities that have developed over the past 4 years. We all note that this is a huge step in progress, and we also recognize how much further we have to go.

Since the inception of the DEC grant funding from OJJDP, we have addressed issues of sustainability, especially in terms of federal, state and local institutional support. As the grant monies have dwindled to support our DEC Team, we have had to increase our

attention to sustainability issues. The partner agencies from the Spokane County DEC Project have made various commitments to ensuring the continuation of their collaborative efforts, despite the lack of continued funds, including submitting grant applications, realigning budget priorities, and reallocating already highly limited resources.

The law enforcement agencies have secured local funding to support two DEC detectives for the 2007 calendar year and have requested that the funding continue for the 2008 calendar year. PFC has met with leaders from the Children's Administration and honed out a process for billing medical examinations and developmental evaluations through a professional services contract. This has allowed the DEC Team to continue to provide medical exams and developmental evaluations, for as long as this process can be accessed. LCSNW has been successful in utilizing the Regional Support Network (RSN) funds provided to Spokane County via the state of Washington to pay for the mental health treatment for our DEC clients.

The only person not fully covered is our all-important DEC case coordinator who works for PFC, but is housed at the local DCFS intake office. This position is the lynchpin for all that happens for our children. The DEC case coordinator ensures that the children receive immediate medical and developmental assessments, as well as needed counseling. These children would not be identified as drug endangered without this position and would not receive the needed services. This position provides an invaluable service to Children's Administration, DCFS, the community, but most importantly, to our smallest and neediest victims, our children. During the first quarter of 2007 the DEC Team was able to convince the Children's Administration to fund this position for a trial period for six

months in 2007. As the grant funded award period draws to a close, continued funding has been requested, because the DEC Project would not function without this liaison position.

One of the most critical lessons learned from this project is the absolute necessity of having a DEC case coordinator, who is co-located at CPS, but is an employee of the child advocacy agency. For the Spokane County DEC Project, this role was filled by a master's level social work professional who oversaw the coordination of all services, from the moment of law enforcement contact through the achievement of permanency, for all children identified as drug endangered. This professional is also available to the CPS Intake staff in order to assist in the identification and immediate placement of drug endangered children, integration of all subsequent services, and to review placement forms for drug endangered children who are placed in CPS care. The DEC case coordinator is also available on-site to respond to law enforcement requests to accompany them on calls for immediate response in cases where children may be living in a drug endangered environment.

The DEC case coordinator works with CPS social workers on an ongoing basis to obtain whatever services are necessary to meet the needs of drug endangered children, including medical examination referrals, developmental assessments, counseling services, parenting classes, and other appropriate social services. In addition to referral and appointment scheduling for services needed, the DEC case coordinator can arrange for transportation to initial appointments, when needed. We believe that this position is an absolutely pivotal position, the "hub" of the entire DEC Project, because the DEC case coordinator ensures the integration of the programs and services for the child and the child's family. The coordinator met regularly with all DEC Team members to ensure all

eligible children were initially identified, tracked all children by securing necessary agency data, including CPS and law enforcement involvement.

In the final year of the project, we were able to include the Washington State Department of Corrections (DOC) as a DEC partner. This provided the Spokane County DEC Team with another pivotal element for ensuring integration of cross-disciplinary efforts. Not surprisingly, perhaps, CPS and DOC often serve the same clients. A parent may be under court intervention due to criminal matters and child dependency matters at the same time. Sharing information provides greater client accountability and more efficient use of services. In cases where a DOC client is not legally involved in a child dependency court action, but CPS is investigating allegation of child abuse, neglect and/or endangerment, DOC has been able to provide access to the home and provide current information as to the client's status. When DOC has a client who is CPS involved, the DOC officers are able to add additional requirements and/or services, such as educational programs, chemical dependency treatment programs, relapse prevention, victim awareness, and stress/anger management programs.

Both CPS and law enforcement report the Spokane County DEC Project has dramatically increased collaboration between the two agencies. Prior to program inception, law enforcement virtually never notified CPS in advance of a potential drug bust, even if they suspected the presence of children. Often times, the children discovered in drug homes were not referred to CPS at all, and were instead spontaneously "given" to whomever the parent requested. For example, they may request the parent call a grandparent, aunt, uncle, or friend to take the children following the parent's arrest. Conversely, CPS seldom invited law enforcement to investigate drug abuse, due to

suspicions of child neglect. Law enforcement and CPS were both very territorial about the information they were gathering, and very little information was shared between the two agencies.

The success of the Spokane County DEC Project has changed all of this. The DEC Project arose specifically to ensure these children were being identified, protected, and receiving needed services. Information is now freely exchanged. Law enforcement often contacts CPS in advance of drug busts whenever possible. Both agencies have learned their respective investigations are strengthened by this collaboration. Now, if CPS is receiving allegations where there is not enough information to open a CPS investigation, they contact one of the designated DEC detectives, who can follow up with the information from their end. In turn, law enforcement views CPS as a resource that can provide necessary additional information for case investigations, such as how many people are living in the home (including children), and if CPS is currently involved. If CPS is involved, they are often able to obtain additional documentation to support their investigation. Most importantly, both agencies have discovered they have a common goal: protecting children. The DEC Project has greatly increased the trust between these two agencies.

This collaboration makes everyone's jobs easier. For example, when CPS is notified of a drug bust, they are able to immediately meet law enforcement at the location, have law enforcement sign an AEP, and place the child into protective custody. This relieves law enforcement of the burden of trying to find a place for the children to stay. This is an improvement over prior cases where it could take over an hour for CPS to arrive. It ensures the children are placed into a safe environment, rather than potentially being placed with a friend or relative of the parents who may also be abusing substances. CPS is

now willing and able to directly contact designated detectives to request assistance on cases where substance abuse is suspected. For example, if a CPS worker notices drug paraphernalia in a home, they are able to contact one of the designated detectives. This results in a much quicker response than when contacting either 9-1-1 or a tip hotline.

An important implication that has arisen from this program is the awareness of the extensive medical needs for the children. It is crucial for the children to receive an immediate medical evaluation by a pediatric specialist knowledgeable about child maltreatment, especially neglect. It is critical for the children removed from these drug environments to receive a medical evaluation the same day as removal, ideally even before the child has been “cleaned up.” Medical personnel specializing in neglect are able to complete thorough examinations beyond the “is anything broken or bleeding” exams these children may receive in an emergency room setting. Our DEC medical team documents the results of medical exams knowing their reports are going to be used by judges and in court proceedings. As a result, these reports go beyond whether the child is sick and if their growth is within normal limits to document signs of neglect (e.g., a child with thin, fragile hair suggests serious malnourishment). The DEC pediatricians document how dirty and hungry these children often are, they order lab work and other screenings for such concerns as anemia, shaken baby syndrome, past injuries. The reports provided by these medical exams can be key pieces of evidence used by CPS to justify placement of these children, and to document the pervasive neglect they have suffered.

Along with the necessity of immediate medicals, dental care should be added to the list of services provided by DEC programs. During the final year of this grant, numerous children were documented to have severe dental problems. The oral health of these

children was so poor that many required hospital dentistry to correct the problems. “Bottle rot” was noted in the medical exams of many of the infants enrolled in our program.

We now know more about Drug Endangered Children: they are severely harmed by parental neglect, the easily accessible exposure to toxic chemicals, the long-term developmental and emotional consequences, and the trauma symptomatology. What we do not yet know is how these children differ from other neglected children, other traumatized children, other children whose parents use other harmful substances that lead to neglect. This information can then help guide policy, legal, and practice decisions to support children’s recovery from such pervasive harm. For example, our preliminary results found that counseling seemed to help decrease trauma symptoms, but of course, the methodology cannot justify any such associational conclusion at this time. What do these children need? And, how can we provide it for them efficiently, effectively, and expediently?

Interestingly, while the needs of children were constantly addressed, there was little focus on the needs of parents. Indeed, issues regarding parents emerged primarily in the context of ensuring successful prosecution and expediently terminating their rights. This attitude toward parents is reflected in the emerging DEC-related literature as well (see, e.g., Hohman, Oliver & Wright, 2004). Addressing parental needs, however, is not yet identified as a priority for DEC programs. Programs such as substance abuse treatment, housing, and employment are all needed supports for helping parents. This is an area where social service providers, including child welfare workers, social workers, and even school personnel, should be advocating for the needs of parents who want to return to parenting their children. While the DEC programs are certainly focused on improving the

lives of children, they have not yet expanded their focus to recognizing the impact of the social environment around these children.

Despite this, we believe that the Spokane County DEC Team nonetheless offers an example of a successful community collaboration that promotes child well being for children endangered by meth and other inhalants. This Team has been able to mobilize a variety of community resources, from law enforcement to social services, to design and develop improved services and supports for vulnerable children. It is apparent from this report that drug endangered children absolutely need a collaborative community response in order to ensure that they are safe, protected, and healthy.

References:

- We Care (2004). Recommended best practices addressing the needs of drug-endangered children. *Washington's Endangered Children's Assessment and Response*.
- Achenbach, T.M., Dumenci, L., & Rescorla, L.A. (2003). Are American children's problems still getting worse? A 23-year comparison study. *Journal of Abnormal Child Psychology, 31*(1).
- Achenbach, T.M. & Edelbrock, C. (1984). *The Child Behavior Checklist*. VT: Author.
- Abramson, J. & Rosenthal, B. (1995). Interdisciplinary and interorganizational collaboration. *Social Work Encyclopedia (19<sup>th</sup> ed.)*, (2), 1479-1489.
- Alkema, G.E., Shannon, G.R., & Wilber, K.H. (2003). Using interagency collaboration to serve older adults with chronic care needs: The care advocate program. *Family and Community Health, 26*(3), 221-229.
- Altshuler, S. (2005). Drug-Endangered children need a collaborative community response. *Child Welfare, 84*(2), 171-191.
- Altshuler, S.J., Black, B., Hatcher, N., Kriz, D., Mallonee, C., Reynard, A.B., & White, A. (2004). A collaborative community response to drug-endangered children. Spokane WA: Eastern Washington University School of Social Work.
- Azzi-Lessing, L. & Olsen, L. J. (1996). Substance abuse-affected families in the child welfare system: New challenges, new alliances. *Social Work, 41*(1), 15.
- Bada, H.S., Bauer, C.R., Shankaran, S., Lester, B. (2002). Central and autonomic system signs with in utero drug exposure. *Archives of Disease in Childhood, 87* (2), p. F106.

- Barnard, M. (1999). Forbidden questions: Drug dependent parents and the welfare of their children. *Addictions*, 94 (8), 1109.
- Barth, R. P. (2001). Research outcomes of prenatal substance exposure and the need to review policies and procedures regarding child abuse reporting. *Child Welfare*, 80(2), 275-296.
- Bearer, C.F. (1995). Environmental health hazards: How children are different from adults. *The Future of Children*, 5(2), 11-26.
- Berube, R. L., & Achenbach, T. M. (2003). *Bibliography of published studies using the Achenbach System of Empirically Based Assessment (ASEBA): 2003 edition*. Burlington, VT: University of Vermont Research Center for Children, Youth, and Families.
- Besinger, B.A., Garland, A.F., Litrownik, A.J., Landsverk, J.A. (1999). Caregiver substance abuse among maltreated children placed out-of-home care. *Child Welfare*, 78(2), 221-240.
- Biederman, J., Faraone, S.V., Monuteaux, M.C., Feighner, J.A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics*, 106 (4), p. 792-797.
- Blau, G. M., Whewell, M. C., Gullotta, T. P., & Bloom, M. (1994). The prevention and treatment of child abuse in households of substance abusers: A research demonstration progress report. *Child Welfare*, 73(1), 83.
- Brecht, M. L., Anglin, M.D., & Dylan, M. (2005). Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *The American Journal of Drug and Alcohol Abuse*, 31, 337-356.

- Brecht, M.L., Mayhauser, C.V., & Anglin, M.D. (2000). Predictors of relapse after treatment for methamphetamine use. *Journal of Psychoactive Drugs*, 32(2), 211-221.
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) Professional Manual*. Odessa, FL: Psychological Assessment Resources.
- Butz, A.M., Pulsifer, M., Marano, N., Belcher, H., et al. (2001). Effectiveness of a home intervention for perceived child behavior problems and parenting stress in children with in utero drug exposure. *Archives of Pediatrics & Adolescent Medicine*, 155 (9), 1029-1038.
- Casey Family Partners (2004). *A roadmap for learning: Improving educational outcomes in foster care*. Seattle, WA: Author. Retrieved September 16, 2007, from <http://www.casey.org/Resources/Publications/RoadMapForLearning.htm>.
- Catalano, R.F., Gainey, R.R., Fleming, C.B., Haggerty, K.P., & Johnson, N.O. (1999). An experimental intervention with families of substance abusers: One-year follow-up of the Focus on Families project. *Addiction*, 94(2), 241-255.
- Chamberlain, J., McDonald, S., Torgensen, K., & Boozman, F. W. (2004). Methamphetamine: Tools and partnership to fight the threat. *The Journal of Law, Medicine & Ethics*, 32(4), 104-106.
- Clause, T. (2005) Grant targets kids who live with methamphetamine abusers; Detectives to build cases against adults who put children at risk. *Spokesman Review*. B3.
- Colloff, P. (2004). Life and Meth. *Texas Monthly*, 32(6), 1.
- Cook, T.D. & Campbell, D.T. (1979). *Quasi-experimentation; Design & analysis issues for field settings*. Boston: Houghton Mifflin.

- Dube, S. R., Felitti, V.J., Dong, M., Chapman, D.P., et al (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, 111(3), 564-572.
- Elliot, V.S. (2004). Methamphetamine use increasing. *American Medical News*, 47(28), 23-24.
- Ells, M., Sturgis, B., and Wright, G. Behind the drug: The child victims of methamphetamine labs. National Center for Prosecution of Child Abuse Update.
- Falkowski, C. L. (2004). Methamphetamine across America: Misconceptions, realities and solutions. *Spectrum*, 77(4), 30-32.
- Fleming, S. (2005). The methamphetamine effects. *The American City & County*, 120(1), 42-46.
- Gregoire, K.A. and Schultz, D.J. (2001). Substance-abusing child welfare parents: Treatment and child placement outcomes. *Child Welfare*, 80(4), 433-452.
- Hathaway, M. (2004). Main methamphetamine ingredient has changed over years. *St. Louis Post*, A4.
- Hodges, S., Hernandez, M., and Nesman, T. (2003). A developmental framework for collaboration in child serving agencies. *Journal of Child and Family Studies*, 12(3), 291-305.
- Hohman, M.M. and Butt, R.L. (2001). How soon is too soon? Addiction recovery and family reunification. *Child Welfare*, 80(1), 53-67.
- Hohman, M., Oliver, R., & Wright, W. (2004). Methamphetamine abuse and manufacture: the child welfare response. *Social Work*, 49(3), 373-382.

- Hser, Y.H., Evans, E., & Huang, Y. (2005). Treatment outcomes among women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment, 28*, 77-85.
- Irvine, G. D. & Chin, L. (1991). Methamphetamine abuse: Epidemiologic issues and implications. *National Institute on Drug Abuse Research Monograph Series, 115*, 33-46.
- Krinsky, M. (2004). *Educating all foster children will require collaborative spirit*. Los Angeles: Children's Law Center of Los Angeles. Retrieved September 17, 2007, from [http://www.clcla.org/Images/pdfs/pdfs\\_whatsnew\\_columns/Collaborative.pdf](http://www.clcla.org/Images/pdfs/pdfs_whatsnew_columns/Collaborative.pdf).
- Lineberry, T. W. & Bostwick, J. M. (2006). Methamphetamine abuse: A perfect storm of complications. *Mayo Clinic Proceedings, 81*(1), 77-84.
- Magura, S. & Laudet, A.B. (1996). Parental substance abuse and child maltreatment: Review and implications for intervention. *Children & Youth Services Review, 18*(3), 193-220.
- Main, M. & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? (pp. 161-184). In M.T. Greenberg, D. Cicchetti, & E.M. Cummings (eds.). *Attachment in the preschool years: Theory, research, and intervention*. Chicago: University of Chicago Press.
- Maluccio, A.M. & Ainsworth, F. (2003). Drug use by parents: A challenge for family reunification practice. *Children & Youth Services Review, 25*(7), 511-533.
- Manning, T. (1999). Drug Labs and Endangered Children. *FBI Law Enforcement Bulletin, 68*(7), 10-14.

- Martyny, J.W., Arbuckle, S.L., McCammon, C.S., & Erb, N. (nd). Methamphetamine contamination on environmental surfaces caused by simulated smoking of methamphetamine. Author.
- Martyny, J.W., Arbuckle, S.L., McCammon, C.S., Esswein, E.J., and Erb, N. (nd). Chemical exposures associated with clandestine methamphetamine laboratories. Author.
- Mayes, L. C., Fahy, T. (2001). Prenatal Drug Exposure and Cognitive Development. In R.J. Sternberg & E.L. Grigorenko (Eds.), *Environmental Effects on cognitive abilities*. Mahwah N.J.: Lawrence Erlbaum Assoc., Inc.
- McAlpine, C., Marshall, C.C., and Harper-Doran, N. (2001). Combining child welfare and substance abuse services: A blended model of intervention. *Child Welfare, 80*(2), 129-149.
- McGraw, D. (1998). The Iowan connection. *U.S. News & World Report, 124*(8), 33-36.
- McNichol, T. and Tash, C. (2001). Parental substance abuse and the development of children in family foster care. *Child Welfare, 80*(2), 239-256.
- Miller, B.A. (1991). The interrelationships between alcohol and drugs and family violence. *NIDA Research Monograph Series, 115*, 177-207.
- Miller, J.Y. and Schneider, C. (Nov. 30, 2003). When methamphetamine hits home: Meth's forsaken children, when parents disappear into a chaotic world of drug abuse, danger, and heartbreak. *The Atlanta Journal and Constitution, A1*.
- Miller, M.A. and Kozel, N.J. Introduction and overview. Cook, C.E. Pyrolytic characteristics pharmacokinetics, and bioavailability of smoked heroin, cocaine, phencyclidine, and methamphetamine.

Murray, J. B. (1998). Psychophysiological aspects of amphetamine – Methamphetamine abuse. *The Journal of Psychology*, 132(2), 227-237.

National Alliance of Drug Endangered Children (2007). Rescue. Defend. Shelter. Support. Retrieved May 6, 2007, from <http://www.nationaldec.org/index.asp>.

National Center on Addiction and Substance Abuse (1999). No safe haven: Children of substance-abusing parents. Retrieved May 2, 2004, from [http://www.casacolumbia.org/publications1456/publication\\_show.htm?doc\\_id=7167](http://www.casacolumbia.org/publications1456/publication_show.htm?doc_id=7167)

National Conference of State Legislatures (2004). The methamphetamine menace. *Legisbrief*, 12(1). Retrieved June 5, 2004, from <http://www.ncsl.org/programs/cj/meth.pdf>.

National Institute for Drug Abuse (2002). Methamphetamine abuse and addiction. *NIDA Research Report Series*. NIH Publication #02-4210.

National Institute for Drug Abuse (2001). Methamphetamines and amphetamines. *CEWG Advanced Report*.

Newborg, J., Stock, J.R., Wnek, L., Guidubaldi, J., and Svinicki, J. (1984). *Battelle Developmental Inventory: Examiner's Manual*. Riverside Publishing.

Nicholson, D., Artz, S., Armitage, A., and Fagan, J. (2000). Working relationships and outcomes in multidisciplinary collaborative practice settings. *Child and Youth Care Forum*, 29(1), 39-73.

- Obert, J.L., London, E.D., & Rawson, R.A. (2002). Incorporating brain research findings into standard treatment: an example using the Matrix Model. *Journal of Substance Abuse Treatment*, 23, 107-113.
- Office of National Drug Control Policy (2004). Drug Endangered Children, 1-6. Retrieved on June 2, 2004 from [http://www.whitehousedrugpolicy.gov/enforce/dr\\_endangered\\_child.html](http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html).
- Pennell, S., Ellett, J., Rienick, C., and Grimes, J. (April, 1999). Executive Summary. National Institute of Justice, NCJ 176331, ix-xiv, Retrieved on June 1, 2005 from <http://www.ncjrs.org/pdffiles1/176331.pdf>.
- Perry, B. D., Conrad, D. J., Dobson, C., Schick, S., & Runyan, D. (2003). The children's crisis care center model: A proactive, multidimensional child and family assessment process. *Child Trauma Academy*. Retrieved March, 2003 from <http://www.childtrauma.org/print/print.as?REF=/CTAMATERIALS/adrenergic.asp>
- Rittner, B. & Dozier, C.D. (2002). Effects of court-ordered substance abuse treatment in child protective services cases. *Social Work*, 45(2), 131-141.
- Rivard, J., Johnsen, M., Morrissey, J., & Starrett, B. (1999). The dynamics of interagency collaboration: How linkages develop for child welfare and juvenile justice sectors in a system of care demonstration. *Journal of Social Service Research*, 25, (3), 61-82.
- Rodriguez, N., Katz, C., Webb V. J., & Schaefer, D. R. (2005). Examining the impact of individual, community, and market factors on methamphetamine use: A tale of two cities. *Journal of Drug Issues*, 35(4), 665-693.

Rogers, A. & Arias (2002). Health risks of methamphetamine use. *Journal of Substance Abuse Treatment*, 47(1), 223-243.

SAMHSA (2003). Children living with substance abusing or substance dependent parents. *The NHSDA Report, June 2, 2003*.

Semidei, J., Radel, L.F., and Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare*, 80(2), 109-129.

Schanlaub, R. (2005). Methamphetamine Hazards. *Law & Order*, 53(3), 98-105.

Schwartz, S.J. and Liddle, H.A. (2001). The transmission of psychopathology from parents to offspring: Development and treatment in context. *Family Relations*, 50 (4), p. 301 - 307.

Spokane Police Dept. Crime Lab. Methamphetamine Lab Busts in 2002: The cost of methamphetamine our region is paying the price. *Spokesman Review*. MAP

Squires, J., Bricker, D, and Twombly, E. (2003). *The ASQ:SE User's Guide*. Paul H. Brookes Publishing Co: Baltimore, MD.

Squires, J., Potter, L., and Bricker, D. (1999). *The ASQ User's Guide*. Paul H. Brookes Publishing Co: Baltimore, MD.

Swetlow, K. (2003). Children at clandestine methamphetamine labs: Helping meth's youngest victims. USDOJ ovc Bulletin, June 2003, p. 1-12.

Toomey, R., Lyons, M.J., Elsen, S.A., and Xian, Hong (2003). A twin study of the neuropsychological consequences of stimulant abuse. *Archives of General Psychiatry*, 60(3), 303.

Trocme, N., MacMillan, H., Fallon, B., and DeMarco, R. (2003). Nature and severity of physical harm caused by child abuse and neglect: Results from the Canadian incidence study. *Canadian Medical Association Journal*, 169(9), 911.

U.S. Dept. of Justice (2002). Children of risk. *Information Bulletin*, 1-8.

U.S. Dept. of Justice (2003). Combating methamphetamine laboratories and abuse: Strategies for success, 1-12, Retrieved on June 14, 2004 from <http://www.cops.usdoj.gov/Default.asp?Open=True&Item=776>.

Cops Innovations: A closer look. 1-12.

WA State Department of Ecology (2003). *Meth incidents reported by County\* Summary for 2003*.

Olympia, WA: Author.

WA State Department of Ecology (2004). *Drug labs by County, Reported to Ecology, 1990-2003*. Retrieved on June 16, 2004 from

<http://www.ecy.wa.gov/programs/spills/hottopics/druglabs/reported9003.htm>

Weinfield, N.S., Ogawa, J.R., & Sroufe, L.A. (1997). Early attachment as a pathway to adolescent peer competence. *Journal of Research on Adolescence*, 7(3), 241-265.

Wells, K. (n.d.) Methamphetamine Awareness and Prevention Project. Retrieved on June 1, 2005 from <http://www.mappsd.org/DEC>.

Zeitlin, A.G. & Weinberg, L.A. (2004). Understanding the plight of foster youth and improving their educational opportunities. *Child Abuse & Neglect*, 28, 917-923.

Zuckerman, B., & Bresnahan, K. (1991). Developmental and behavioral consequences of prenatal drug and alcohol exposure. *Development and Behavior: The Very Young Child*, 38(6), 1-20.