Methamphetamine-involved parenting and the risk of child maltreatment: Family experiences and the child welfare response

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Tamara Kincaid

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Dedication

This dissertation is dedicated to all the kids just trying to survive in a world without love. You deserve better.

It is also dedicated to the memory of Jim Zetah. He was my guidance counselor, religion teacher, and lifesaver. He taught me the meaning of spirituality, compassion, and that all persons have dignity and worth. He lived his life as a model of all that is good in humanity. His memory is the star that lights up the darkness. I am forever indebted to him for his vision of what I could become.

Abstract

In the last two decades, methamphetamine-involved parenting has presented some unique challenges to child protective services social workers. In order for social workers to effectively intervene with these families, we must understand the experiences of those who have lived through this phenomenon. This mixed-methods study uses qualitative interviews of parents and children to identify maltreatment risks to which the children were exposed, and the parenting strengths that mitigated those risks. Quantitative measures of parent and child psychosocial functioning were used to understand the context of the risks and subsequent outcomes for family members. The typical child welfare response is described utilizing risk assessment tools. Family members described between 11 and 21 child maltreatment risks to which the children had been exposed. While the children as a group averaged near normal in psychosocial functioning measures, older female children seemed to demonstrate the most negative effects. The majority of parents scored in clinically significant ranges for both physical and mental health problems. At the same time, many of the family members were able to describe instances when the parents made efforts to protect their children from maltreatment risks. The Omaha System seems to be more flexible than other assessment tools in suggesting child welfare intervention plans which incorporate the risks and strengths that were identified by the family members. Overall, this study points to opportunities for child welfare interventions to focus on strengths of parents to protect their children from the child maltreatment risks due to methamphetamine-involved parenting.

Table of Contents

List of Tables

List of Figures

Chapter 1 Introduction

In the last two decades there has been an explosion of families impacted by parental abuse of substances, in particular methamphetamine or "meth" (CWLA, 2008). While parental substance abuse itself may be indicative of neglect (Child Welfare Information Gateway (CWIG), 2013), there are many other associated factors that contribute to risk of child maltreatment as well. In addition, there may be strengths within a family that mitigate those risks. Child welfare social workers hoping to effectively intervene must understand these risks and strengths, and create intervention plans that address the risks utilizing the natural strengths of the family. Given the power differential in the child welfare interaction, it is often difficult for assigned social workers to truly understand the complexity of the experiences of family members. This study provides a window into the perspectives of the parents and children themselves, using their own descriptions of how methamphetamine put the children at risk, and how the parents attempted to protect their children from harm despite their addiction. Psychosocial functioning measures of family members adds context to the experiences. Finally, child welfare responses that incorporate the family member perspectives are also explored.

Significance of the Problem

There are no accurate statistics kept nationwide about the number of children who are maltreated as a direct result of caregiver substance use generally, nor methamphetamine specifically (CWLA, 2008). In fact, recent research has indicated that parental substance abuse is often under-identified by child protective services workers

(Chuang, Wells, Bellettiere & Cross, 2013). In states that have collected this information, as many as 20% of all substantiated child maltreatment cases have been found to have substance abuse as the primary contributing risk factor to the maltreatment (ACYF, 2013). Substance abuse has been associated with up to two thirds of child maltreatment fatalities (Reid, Machetto, & Foster, 1999). Within this context of substance abuse, methamphetamine has been reported to be "a destructive force that is having tragic consequences for an increasing number of children, the child welfare systems that protect them, and America's families" (Generations United, 2006).

Methamphetamine use and abuse. Methamphetamine is chemically related to the drug amphetamine (Chen, Strain, Alexandre, Alexander, Mojtabai, & Martins, 2014). It is a highly addictive synthetic stimulant that impacts the user's central nervous system producing a significant high with extreme alertness, decreased appetite, and intense euphoria in the user for up to 12 hours (Cunningham & Finlay, 2013). This is followed by an extreme low of fatigue, depression, and lack of responsiveness to the environment that has been reported to last up to several days (Covey, 2007). Methamphetamine use has also been associated with poor judgment, exposure to environments that have high levels of violent activity, and general neglect of the person and their children (McGuinness & Pollack, 2008). Long term use has been associated with high rates of psychosis involving paranoid behavior, hallucinations, and aggression (Cunningham & Finaly, 2013), all of which can pose a danger to children in the home.

While the most widely abused substance in the United States is alcohol (NCADD, 2014), over the last few decades, methamphetamine abuse has skyrocketed. Meth is reported to be the primary drug of addiction for approximately 8% of people admitted to drug treatment programs, but was reported to have been used by 90% of those admitted for treatment (SAMHSA, 2009). The Office of National Drug Control Policy (2006) suggests that due to the high addictive qualities and relatively low price of meth, it is used more heavily than cocaine, ecstasy and inhalants. Methamphetamine users report more regularity to their use than those who use other substances such as cocaine (Covey, 2007). When one considers that methamphetamine is rarely used alone, but also within the context of other illegal substances such as marijuana, cocaine, and hallucinogens, the number of people impacted by methamphetamine abuse is overwhelming (Cunningham & Finlay, 2013).

Women are overrepresented as methamphetamine users more than as users of other drugs such as cocaine and heroin or even alcohol. In addition, women tend to have more severe levels of addiction than men (Cunningham & Finlay, 2013). They also report higher levels of sadness and anxiety than men (Chaplin & Sinha, 2013). This is significant when one considers that women tend to be caregivers of children at higher rates than men. Brecht, O'Brien, von Mayrhauser, & Anglin (2004) specifically looked at the differences between men and women and methamphetamine use. They found that while there are many similarities in methamphetamine use issues between men and women, there were a few significant differences. Specifically, women were five times

more likely to begin using methamphetamine in order to achieve weight loss goals and to get more energy overall. Women often initially view their methamphetamine use as a benefit to their children because they are able to get things done such as housekeeping and actively engaging with their children. The descent into addiction then catches them off guard and despite their intention to help their children, they often move into periods of severe neglect (Haight, Ostler, Black, & Kingery, 2009). Brecht, et.al.(2004) also found that women tended to transition from experimentation to regular use more quickly than their male counterparts, and were significantly more likely to be introduced to the drug by their significant partner. No significant differences were found in in the rates of dealing meth, carrying a weapon, violence rates, and rates of manufacturing. Women were however, less likely to manufacture in their own home than men.

Home manufacturing is one of the major concerns that is unique to meth as opposed to other illegal drugs, at least where children are involved. The drug is commonly manufactured in home labs, and if not by women themselves, often by their boyfriends or spouses who live with them (Covey, 2007). This puts children at risk in a number of ways. Most significantly, when methamphetamine is manufactured at home, children are exposed to the toxic chemical compounds that are used to manufacture methamphetamine. Given the lack of supervision common in homes of meth addicted caregivers, this has resulted in some especially dangerous situations in which children have died from the overdose of precursor substances or even from ingesting the subsequent methamphetamine powder itself (McGuinness & Pollack, 2008). Exposure to

the byproducts of the manufacturing process commonly referred to as “meth dust” that settles on all horizontal surfaces of the home, including cribs, beds, eating surfaces, and toys, which children then touch and inadvertently put in their mouth has also been found to be a common hazard. When ingested, this dust has been demonstrated to cause eye problems, seizures, and damage to kidney and liver functions in the children (Wells, 2007).

Poor, rural, white communities in particular are seeing the growth of methamphetamine use and manufacture disproportionately to communities in urban or suburban areas (Beckett, 2012). One of the reasons for this increase in manufacturing in rural areas is that many of the issues surrounding poverty in rural areas also contribute to increased substance use as a form of escape. The fact that methamphetamine is easily manufactured with ingredients that are widely available in the rural areas is a second reason. Finally, in rural areas, the manufacturing byproducts, smells and other indicators of a lab are more likely to go unnoticed for some time, at least in comparison to the likelihood of detection in urban areas (Covey, 2007). The recipe and cooking methods are easily obtainable on the internet, and a batch of homemade meth can be created in as little as 3 hours (Mighty, 2014). Distribution of homemade meth is also relatively easy, and tends not to follow typical drug dealing channels. This homemade meth is often sold cheaply to friends and acquaintances and outside the radar of typical law enforcement networks (Beckett, 2012). This ease of manufacture and difficulty of detection plus high poverty creates a triple incentive in the sense that the drug requires less of the user’s

limited resources than alternative substances, has a low likelihood of discovery, and there is (at least a belief in) a possibility that impoverished conditions can be improved by the income potential from selling the homemade meth (Haight, Ostler, Black, & Kingery, 2009). The lack of health and social services available in rural areas also makes it difficult to escape the involvement in a methamphetamine using lifestyle (Haight, Carter-Black, Sheridan, 2009).

While Brecht, et. al. (2004) did not find any significant differences in the rates of methamphetamine related violent behavior among men and women, they did find the rates of violence associated with methamphetamine use to be higher than 50% for both genders. All users reported a very high rate of use of firearms as protection. High rates of violent activities have been associated with methamphetamine use and manufacture Covey, 2007). This is problematic given the psychological condition that meth creates in the user. During methamphetamine use, the dopamine receptors increase production and subsequently decrease the release of serotonin, a biological process which has been found to increase impulsivity and violent behaviors. Damage to serotonin neurons has also been associated with a lack of impulse and increased levels of aggression among methamphetamine addicts who are currently abstaining (Halkitis, 2009). Increased paranoia and other psychological effects also increase the likelihood that a methamphetamine user could become violent (Covey, 2007). Increased incidents of robberies, murder, and other violent crimes have been associated with methamphetamine use (Vearrier, Greenberg, Miller, Okaneku & Haggerty, 2012). There have been

numerous reports in the news that associate the manufacturing of methamphetamine with increased violence. It is more likely however, that methamphetamine associated deaths are due to homicides, suicides, or accidental explosions connected to the manufacturing than to the use of the drug itself (Halkitis, 2009). As stated earlier, it is not unusual for methamphetamine producers to maintain a substantial array of firearms in an effort to protect their "investment." All of this can result in substantial danger particularly to children in this environment as they become both victims and witnesses to the violence.

Addiction and Methamphetamine. The DSM V does not use the word addiction but rather describes stimulant use disorder as "a pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress" and goes on to suggest that a disorder exists if 2 of 11 criteria are present, including "recurring stimulant use resulting in a failure to fulfill major role obligations at work, school, or home, as well as continued stimulant use despite having persistent or recurring social or interpersonal problems caused or exacerbated by the effects of the stimulant. (American Psychiatric Association, 2013). Parents who use methamphetamine and have come to the attention of child protective services can be considered to have met these criteria at a minimum, as well as many of the others. Certainly no one suggests that every use of a drug results in addiction, but methamphetamine use is known for its substantial speed and high susceptibility of addiction. Unlike other drugs that people seem to be able to experiment with and reject future use, meth addicts regularly report becoming addicted in as little as one use (Mettner, 2006).

Stress theory of addiction. A recent theory of addiction that can be applied to methamphetamine use, is a neurobiological model of addiction or stress model. While concerns about stress and substance abuse are not new, there is an improved understanding of the neurological responses to stress and drugs individually and in combination. This model characterizes addiction as "the dysregulation between the stress and reward neural systems." Stress is defined by Lazarus as "processes involving perception, appraisal, and response to harmful, threatening, or challenging events or stimuli" (Lazarus, 1999). Stress increases vulnerability to drug use, while the drug use can become a stressor itself that contributes to more use, however the exact mechanisms have yet to be significantly tested (Sinha, 2001). There is considerable research via prospective and retrospective studies that have established a correlation between acute or chronic stress and addiction (Chaplin & Sinha, 2013). Stress has frequently been identified as a risk factor for those who move from substance abuse to substance addiction and has also been considered a contributing factor in relapses (Sinha, R. 2001).

This stress response becomes even more pronounced when the drug user is a parent. When a caregiver uses drugs initially, the reward system of the brain is triggered. If the person continues to use the drugs, this reward may overshadow and diminish reward responses that would be expected to occur in the user's natural day to day life. This transaction leads to a reinforcement of the addiction. At the same time, drugs also give the user a sense of stress relief, further reinforcing the addictive feelings. Increases

in stress are well-known to result in cravings for substances in addicted individuals (Rutherford, Potenza, & Mayes, 2013).

This stress model has also been used specifically to explain why meth has become so prominent in poor rural white communities. The stress of living in poor socioeconomic conditions, the difficulty raising children under those conditions coupled with a lack of activities or other family supports, and the overall isolation from living in a rural area all contribute to the initiation of the use of methamphetamine (Halkitis, 2009). As stated earlier, these conditions have also been found to contribute to the desire to manufacture methamphetamine in rural areas. The stress cycle is then exacerbated even further by the drug itself, the lack of true financial gain, and subsequent familial problems. Use of methamphetamine then becomes the only perceived escape from this hopeless cycle of tension.

These general risks that are associated with methamphetamine use likely contribute to a significant risk of child maltreatment for the children of these people who use the drug. Yet the focus of previous research has been primarily on understanding the outcomes for these children after the harm has occurred. It is essential that social workers understand what exactly happens during the course of the parent's meth addiction that creates or mitigates the risks. This understanding then can contribute to new ideas of how to effectively intervene with these parents and their children before the harm occurs.

Goals of the study and research questions

The goals of the study are to:

- Increase understanding of child maltreatment risk in methamphetamine involved families as described by the family members themselves.
- Translate research into practice by evaluating the extent to which the Structured Decision Making (SDM) and Omaha System tools capture the risks and strengths of the families and suggest intervention plans that incorporate those risks and strengths.
- Make recommendations regarding ways that child protective services can respond to the child maltreatment risks for methamphetamine involved families with particular attention to utilizing the identified strengths of families.

In order to achieve these goals, this study seeks to answer the research questions of:

1.) How do family members and other professionals engaged with the family describe the experience of parenting while involved with methamphetamine, within the framework of child maltreatment risk?

2.) Are the reported risks of child maltreatment, addiction histories of the parents, and psychosocial symptomologies of family members unique for each family, or are there similarities across the methamphetamine-involved families participating in the study? Do other similarities or differences emerge from the analysis of the reported experiences across families?

3.) Do child protective services assessment tools prioritize and suggest interventions in a

similar manner to those intervention priorities discussed by the family members?

Summary

Children living with methamphetamine involved parents is a growing problem facing child protective services social workers in the United States. While we have some understanding of the methamphetamine addiction problem, there is little understanding of how the risks of child maltreatment are presented in these situations. This study seeks to add the voices of family members to the knowledge base and help child protective services practitioners understand how the child maltreatment risks and psychosocial contexts associated with methamphetamine involved parenting present so that they can effectively intervene and improve the outcomes for children growing up in these environments.

Chapter 2 Literature Review

Methamphetamine abusing parents whose children become the subjects of child welfare services are undoubtedly a unique group among substance abusers or child welfare parents in general. While a good deal of research has been done about substance abuse and addiction, very little research appears to have been done that specifically looks at the intersection of methamphetamine addiction, parenting, and involvement with child welfare. A search conducted using the University of Minnesota's MNCAT Discovery comprehensive database search tool for the terms "methamphetamine parent child welfare" among peer reviewed journal articles yielded only 16 results. Of those, two examined adolescent addiction to methamphetamine, two were documents produced by a governmental agency about the use of data with methamphetamine addicted parents as an example and were unable to be located despite a request through interlibrary loan. One examined the initiation of methamphetamine use by women and did not specify whether or not they were parents. Two other articles were information only articles intended to inform child welfare workers and pediatric nurses about the existence of meth abuse among parents but did not contain any original research. Those articles are not reviewed here.

Of the remaining eleven articles, six were from a comprehensive study conducted by Dr. Wendy Haight and other associate researchers. The subjects of this comprehensive study were families in the Midwest that were involved in child welfare

services, with at least one parent that was addicted to methamphetamine. This study collected both qualitative and quantitative data from the parents, children, child welfare workers, foster parents, and other collateral contacts. In addition, the researchers shadowed child welfare workers as they provided services to families that were methamphetamine involved. From the data collected, several sub studies were conducted.

The first study involved an analysis of qualitative interviews of 35 child welfare informants such as teachers, social workers, law enforcement officers, and treatment providers and foster parents (Haight, Jacobsen, Black, Kingery, Sheridan, & Mulder, 2005). These community professionals were interviewed about their experiences with parents who were involved with methamphetamine and their children. The researchers looked at the impact of parental meth use on the development and well-being of school-aged children. As the title "In these bleak days" suggests, the researchers found that the community members were very concerned about the well-being of these children. In some cases, the informants described meth-involved parenting as having destroyed the children's (and the parent's) lives. A major concern was the chaotic environment in which these children lived that involved high rates of domestic violence and criminal activity. Other observations included behavioral concerns that are consistent with the children having a post-traumatic stress diagnosis (PTSD). The community members stated they had observed the children to have nightmares, heightened fear and distress about their own or their parents' well-being, fear of law enforcement, and grief. They described some children as appearing flat or hopeless, or "emotionally dead." The

children were also described as being "socialized" into violent and criminal behaviors and were seen to have a difficult time following basic rules. One foster parent described a child in her home as manipulative and a compulsive liar who hoarded food and other items, and her brother was described as "vicious." These behaviors were attributed to be a direct consequence of the children's experiences (p. 961). The researchers also found that the community members were concerned that these families needed to be identified early and provided with a great deal of services through child welfare, education, and mental health agencies. They expressed frustration that neither timely nor adequate services were available and as a result children had difficulty overcoming the trauma they had experienced (Haight, Jacobsen, Black, Kingery, Sheridan, & Mulder (2005).

A second study examined the health and psychiatric issues that were apparent among the children in these families (Black, Haight, & Ostler, 2006). In this study, the case vignettes of two children were provided and an overview of available research consistent with the experience of these two children was discussed. Specifically, the researchers found that the children were at risk of neglect due to lack of supervision by parents and residing in an unsafe living environment. The children were also found to be at risk of abuse from the parents as well as the acquaintances of the parents.

A third study examined the perspectives of the children living in homes in which their parents used methamphetamine (Haight, Ostler, Black, Sheridan, & Kingery 2007). In this study, 18 children between ages 7 and 14 were interviewed using open ended questions about their lives in general and their views of their parents' methamphetamine

use if they were aware of it. While a majority of the children were wary about discussing their parents' methamphetamine use, and almost of a quarter of them flat out denied the use even if there was evidence that it had occurred, many of the children were able to give researchers insight into their experiences at home. Children primarily described situations which seem to concur with the trauma described by the adult service providers in the earlier study. Many of the children reported feelings of tension, fear, and misery. They told stories of chronic neglect, where they did not receive adequate food, supervision, or shelter. Children responded to questions about a "sad or scary" time in their family with stories of observing a considerable amount of illegal and or violent activity, either by their parents or by other adults who came and went from their home. Many children reported that they had "lost" their parents or lost trust in them as caregivers. Over half of the children interviewed felt they did not have access to resources that helped them to cope with the trauma they were experiencing. Involvement with law enforcement and child protective services was seen as particularly problematic as was the move to non-relative foster care. Understanding that children do not see the experience of being removed from their home environment as a positive experience is important when designing child welfare responses.

A fourth study involved in depth interviews of four of the mothers who were addicted to methamphetamine and were involved with child welfare services as a result (Haight, Carter-Black, & Sheridan, 2009). They found that all of the mothers reported using other illegal drugs before they started using methamphetamine, but then their lives

rapidly spun out of control as a result of their methamphetamine use. They reported loving their children deeply and having an ongoing concern for the children's welfare even if they had been removed from their care. In particular, the mothers expressed concern about the impact their addiction has had on their children's development. At the same time, although the mothers reported that they recognized that their use had negatively impacted their ability to parent, the researchers pointed out that the mothers also seemed to discount some of the dangers to the children. The women described trying to self-medicate with methamphetamine in order to address underlying mental health problems, particularly because in rural areas the resources for those with serious and persistent mental illness were severely limited. They described a great deal of stress from being poor in these rural communities, and this stress, in combination with the depression, contributed to multiple relapses among the women even if they participated in treatment programs. The stigma of admitting to abusing drugs while mothering was also found to be a barrier to many mothers seeking treatment even when they knew their children are being negatively affected by their use. (Haight, Carter-Black, Sheridan, 2009).

A fifth study used a mixed methods approach with qualitative and quantitative data to examine the extent to which the children used physical aggression different than their peers (Haight, Marshall, Hans, Black, Sheridan, Haight, Sheridan, 2010). Forty-one children were assessed using the Child Behavior Checklist (CBCL) and the Trauma Symptom Checklist for Children Alternate version (TSCC-A), as well as interviewed

about their family environment, where children spontaneously discussed issues of aggression within either themselves or their family members. From this data, researchers were able to identify that girls from methamphetamine involved homes in particular were more likely to have problems with physical aggression. Contrary to common beliefs, they found girls to exhibit more problematic externalizing behaviors than boys. The mean Child Behavior Checklist (CBCL) externalizing score for girls was within the clinically significant range while the mean score for boys was within the normal range. Even when the children did not exhibit behaviors within the clinically significant range, physical aggression was found as a theme among the children's behavior as well as within their narratives. More than half of the children described observing physical aggression toward their mothers by the mother's partner, and almost 90% children reported that they themselves had been the target of aggression by others. Again, girls in particular seemed to be vulnerable to abuse within their homes, both physical and sexual. This is suggested as a possible explanation for the increased rates of aggressive behaviors among the girls. This study suggests the need for further research into gender specific treatments for children from methamphetamine involved families in order to address the unique vulnerabilities of girls (Haight, Marshall, Hans, Black, & Sheridan, 2010).

Finally, Sheridan, Haight, & Cleeland (2011) looked at the influence of grandparents as a protective factor in minimizing the harm that children experienced. This study involved interviews with 41 children, their caregivers, and 19 of their parents. Both children and parents spontaneously reported that for many of them, the grandparents

had been a source of strength and the researchers theorized that the grandparents' involvement as a protective family member could explain why some of the children did not have significant negative symptoms from their traumatic experience of growing up with parents who were addicted to methamphetamine. The grandparents were described as caregivers as well as a "safe support" for the children when the parents are in the midst of their addiction. The researchers found that for rural families, this asset was particularly important. Children who perceived their grandparents as a source of support were found to have significantly lower scores on the Child Behavior Checklist (CBCL) scores of externalizing behavior, social problems, and aggressive behavior. Interestingly, this reduction in scores was not found to be significant when considering the support of other relatives. The researchers surmise that the children had developed secure attachments with the grandparents that (almost half of the grandparents had been primary caregivers) and this secure attachment provided a corrective experience that helped to minimize the negative experiences the children had in their parental home environment. These conclusions are similar to findings by Asanbe, Hall & Bolden (2008) who studied children in rural Tennessee from methamphetamine producing homes, many of whom had been placed in foster care with relatives, compared to a control group of children from non-methamphetamine-producing homes in the same community. The school aged children in placement with the relatives did not look significantly different from those who were in the non-methamphetamine producing homes on most emotional and behavioral measures.

This full study and the subsequent sub studies represent the most comprehensive investigations into the impact of methamphetamine addiction on parenting by those who are addicted and the subsequent outcomes for their school age children. There were a number of strengths of these studies. Given the context of rural Illinois, one of the areas hardest hit by the methamphetamine epidemic in the US, the researchers were able to get a sample size that was for the most part much larger than is commonly seen in many studies in rural areas. In addition, they created a partnership with local child welfare social workers and other associated professionals. This allowed the researchers to triangulate information among many participants as opposed to having to rely on the perspectives of just a few. They were able to use data collected in multiple ways that tells the comprehensive story of the meth involved parenting experiences. The use of mixed methods, both qualitative and quantitative, especially when examining the outcomes for the children also strengthened the research.

A limitation of the Haight studies may exist due to the lack of external supportive resources, especially mental health services for the children. This may be different from other jurisdictions, where children may receive services that reduces the impact of the methamphetamine involved family experience. It is possible that it is the environment of low services and an inability to address problems early on that explains some of the poor outcomes of the children.

In exploring this notion, Asanbe, Hall, & Bolden, (2012) examined the prevalence of mental health disorders in children in rural Tennessee and found that in an area similar

to the location of the Haight studies, children without substance abusing parents also had higher than expected rates of mental health concerns. Simply living in poor rural areas where methamphetamine use is prevalent seems to be associated with greater risk of mental health problems. The researchers hypothesized that children from methamphetamine abusing homes in rural Tennessee would have higher scores on the Behavior Assessment System for Children (BASC) a tool used to measure behavioral and emotional adjustment. While the scores in some areas were indeed higher, it was discovered that children in the control group, those from non-methamphetamine using homes, but living in the same communities, also scored higher on many measures than children in the general population. This finding suggests that it is critical for adequate poverty and mental health interventions to be available, as the benefits could go well beyond just meeting the needs of children in substance abusing homes. Children whose caregivers manufacture methamphetamine are faced with the double risks of poverty and substance abuse environments.

This finding also implies that there may be an environmental contributor to negative mental health outcomes for children that lies outside of the parent's drug use. This points to perhaps the biggest limitation of the Haight studies. All of the participants were already participating in child welfare services, meaning that essentially these were children living in the worst of the worst environments. It is nearly impossible to study families not already involved with child welfare services because of the potential risk of harm to subjects who report use and poor parenting behaviors. It is unknown to what

extent parents who use methamphetamine become involved in child welfare services. While it seems safe to assume that not everyone who uses methamphetamine subsequently gets involved in child welfare, we really do not know if it is a majority or a minority that does. If there are substantial numbers of parents who do not become involved with child welfare, we would want to know if their experiences and outcomes for their children are in some way different than the participants in the Haight studies. Overall however, the Haight studies took a comprehensive approach to data collection and analysis that gives the best picture of parenting within the context of methamphetamine abuse to date.

In an earlier study however, Asanbe, Hall, & Bolden (2008) found that young children who grow up in homes where parents are using methamphetamine seem to have higher rates of behavior problems. The researchers used the BASC-PRS-P, a clinical instrument that asks parents to assess behavioral and emotional concerns of children between 2.5 and 5 years of age, and subsequently identifies 8 clinical scales (hyperactivity, aggression, anxiety, depression, somatization, atypicality, withdrawal, and attention problems). After reviewing scores of children 31 children from methamphetamine producing homes and 27 children from non-methamphetamine producing homes, the researchers found clinically significant mean scores in the at risk range for hyperactivity, aggression, depression, and atypicality for the children in the meth homes and all mean scores in the normal range for children in the non-meth homes. In fact, the rate of behavior problems for the children from the methamphetamine

producing homes were as high as 3 times more problematic compared to the control group. Externalizing behavior problems such as aggression were found to be especially significant, as 42% of the kids from the methamphetamine-producing homes were reported to have clinically significant behavior problems. Of particular concern was the rate of negative attitudes toward teachers, which was three times as high as those in children from non-methamphetamine producing homes. This is important because teachers are relied upon by child welfare agencies as the first line of protection for children who are experiencing maltreatment, given their status as mandated reporters. If children do not trust or feel comfortable interacting with their teachers, an opportunity to intervene to protect the children may be missed. It is important to note that many of the concerns that occur with children living with parents who use methamphetamine seem similar to those for children living in poverty, and it may be difficult to discern whether the poverty or the methamphetamine abusing parenting is the leading contributor to negative outcomes is for the children. As stated earlier, the methamphetamine epidemic has had a significant impact on those living in poor, rural parts of the country.

Carlson, Rankin Williams, and Shafer (2012) studied parents that were involved with child welfare services and examined whether methamphetamine-involved parents were more challenging than other substance-involved parents. The researchers analyzed administrative data from state child welfare reporting databases. They found that meth-involved parents were significantly more likely to have their children in out of home placements, but did not have significantly more incidents of child maltreatment. They

also were not significantly more likely to experience domestic violence situations. Meth-involved parents did however have significantly higher rates of status risk factors such as unemployment and less likely to be in a committed relationship. The strengths of this study is that they considered data across child welfare jurisdictions both urban and rural. The sample size was large, 2, 465, and they used multiple tests for statistical significance to ensure meaningful findings. The biggest limitation of this study is that it relied on data that was entered by child welfare workers. As stated earlier in this paper, it has been found that child welfare workers as a group cannot be relied upon to identify substance abuse as a problem. In addition, even if they believe it is a problem, they may not document it as such. This could also apply to the other factors under consideration, it is possible that social workers identified the primary problem as substance abuse, and either did not identify or did not document other problems such as domestic abuse or unemployment, or even subsequent maltreatment incidents, thus skewing the results. It does not appear from reading the study that the case records were confirmed for accuracy in any way. This study does however indicate the need for further research about the negative effects of methamphetamine and if in fact parents using meth should be considered more at risk. The fact that children were more likely to be placed out of the home from meth involved families suggests that social workers do see meth use as contributing to an unsafe environment more than other substances and this may or may not be true in actuality.

The final study that specifically explored the subject of the intersection of meth abusing parents involved in child welfare was conducted by Altshuler, & Cleverly-Thomas (2011). These researchers studied children who were referred to the Spokane County Washington Drug Endangered Children (DEC) project. 450 children were referred to the program by either child protection social workers or law enforcement investigators. 399 children from 220 families subsequently participated in the program as determined appropriate by the assigned child protection social worker. A comprehensive evaluation of demographics and the circumstances of the alleged maltreatment and other risk factors was conducted for each child. In addition, biopsychosocial assessments were completed by trained personnel. As with the Carlson et. al. study, the analysis relied on comprehensive administrative data provided by the child welfare social workers. The authors report a limitation was missing data for many cases that may have contributed to skewed results. Overall however, they found that most of the children had experienced neglect, and while children from meth-involved parents had reported histories of trauma similar to the other children in the study, the children whose parents were meth-involved actually appeared to have lower (better) CBCL scores than children from other substance involved homes. Like the other studies, this one only considered children from families in which the maltreatment has been so severe as to result in a child welfare intervention. When considered in combination with the Carlson study, it suggests a need for further research that teases out the specific child maltreatment risk factors associated with methamphetamine addiction that contributes to the negative outcomes for children.

What we know about the intersection of substance use and parenting

While there have been only a few studies that have looked at the intersection of parenting and methamphetamine use (Suchman, Mayes, & Pajulo, 2014), there is a great deal we can learn and consider from the research on parenting while using substances in general. There are some unique factors to methamphetamine abuse as discussed above, but many of the risks of child maltreatment seem similar whether the parent is under the influence of methamphetamine or other substances.

Children living with substance abusing parents is a significant problem in the United States. SAMHSA (2008) found that 11.9% of all children were reportedly living with a parent who was dependent on substances. In fact, being a parent is one of the strongest reported motivators to get treatment for substance addiction (Suchman, Mayes, & Pajulo, 2014). Women tend to be the primary caregivers of children, both with and without another parent. Some research has indicated that as a group, mothers who abuse substances parent their children less successfully than parents in general, using harsher parenting interactions and in general being less attuned to their children's emotional needs. At least some of the overall differences has been attributed to the high rate of mental illness comorbidity however (Hans, Bernstein, & Henson, 1999). A recent SAMSHA report indicates that 5.2% of pregnant women report current or recent use of illegal drugs. Twice that many, 11.6% report recent alcohol use (Rutherford, Potenza, & Mayes, 2013). Even when mothers attempt to abstain during pregnancy, they often relapse after delivery, for perceived weight loss or energy needs (Rutherford, Potenza &

Mayes, 2013). Adolescent mothers have also been found to continue to abuse substances longer into adulthood than non-parenting teens (DeGenna, Cornelius, & Donovan, 2009). This may be due to the stress of having a new child as well as a lack of resources, physical and mental health issues, the lack of social support, and likely the addiction process itself (Swain, Lorberbaum, Kose, & Strathearn, 2007). Women tend to experience the stresses of parenting more strongly than men, and as a result, more frequently seek out substances to relieve that stress (Rutherford, Potenza, & Mayes, 2013). At the same time, many women consider their role as "mother" one of the most important in their lives, and it is the value of that role that often helps mothers to seek and/or complete treatment (Wells, 2009).

Although most recent substance abuse policy initiatives have focused primarily on pregnant women and mothers, there is reason to believe that there are some unique issues that surround the intersection of substance abuse and fathering. Close to 60% of men entering substance abuse treatment report being fathers to an average of two children with between 20-30% living with at least one of their children (McMahon, Winkel, Luthar, & Rounsaville, 2005; Stover, McMahon, & Easton, 2010). For some men, fathering can be a protective factor. Of fathers who enter treatment, over half reported being significantly involved in their children's lives (Collins, Grella, & Hser, 2003) and that greater involvement with children was found to correlate at admission with lower addiction severity levels and less reported stress at the 12-month follow-up. All is not positive across the board however. Studies that have looked at alcoholism and

fatherhood have found that alcoholic fathers show more negative emotions and have subsequent negative interactions with their children than non-alcoholic fathers (Edwards, Eiden, & Leonard, 2004). Some studies have found that substance abusing fathers report higher levels of stress than non- substance abusing fathers as well as an increase in negative father-child relationships. Of men who engage in substance abuse treatment, fathers report higher rates of posttraumatic stress disorder (PTSD) than men who are not fathers (Stover, Hall, McMahon, & Easton, 2012). In addition, neurobiological studies have found that fathers tend to respond more strongly to the reinforcing nature of drug seeking behavior than mothers (Rutherford, Potenza, & Mayes, 2013).

Parenting Knowledge. Very little research was found that examined the general parenting knowledge of parents who abuse substances and none was found about methamphetamine specifically. This is particularly interesting because a common approach of child welfare services is to provide parent education classes (Popple & Vecchiolla, 2007). Both fathers and mothers that enter treatment have reported being interested in parenting education but seem to be unaware of the extent to which their use has impacted their child's development (Thompson, Roper, & Peveto, 2013). At the same time, Rhodes, Bernays, & Houmoller (2010) found that parents regularly describe strategies in which they attempted to limit the damage of their use by such things as using when the child was not present. Klee (2002) however found that parents, once addicted, often underestimated the potential harm that the drug using environment can cause to their children. The attempt to protect children, however inadequate, seems to indicate

that there is at least some parental knowledge of the environmental factors that are indicative of childhood success. Substance abuse treatment programs that incorporate parenting education and or support models have seen some effectiveness over models that do not include parenting education, which implies that there may in fact be a deficit in this area (Ashley, Marsden, & Brady, 2003).

Parenting Behavior. Having the knowledge of what contributes to healthy child development and actually behaving in ways that promote that development are two different matters. Parenting behaviors that contribute to poor development have been studied, although still surprisingly not to a great extent. Much of what has been studied has been the negative outcomes for children and the parental behaviors that have contributed to those negative outcomes, with little focus on the things substance abusing parents do that protect their children or help them develop normally. Also, much of the research that has been done is primarily with parents who are alcoholic, with inferences made to similar outcomes for other children (Eiden, Colder, Edwards, & Leonard, 2009; Wells, 2009).

Parenting behavior as a response to stress is one of the areas that has been recently studied. It has been theorized that stress contributes to the movement from substance abuse to substance addiction, as well as contribute to subsequent relapses when the addicted person attempts to become clean (Sinha, 2001). Parenting is well known to contribute to increased experiences of stress (Chaplin & Sinha, 2013). Recent neurobiological research has indicated that parents in general experience a change in their

neurobiological reactions to infant cues which changes their behavior toward the children. This change results in behavioral differences in responses to infant verbal and nonverbal cues, with parents being more motivated to respond to the infant's needs than non-parents. Substance abuse interferes with this response, changing a biologically rewarding process to a stress inducing response. Because the substances drop a higher level of dopamine into the brain than the natural parenting response, the parenting response in comparison is no longer experienced as rewarding for the parent. Use of substances during parenting then becomes a reinforcing cycle of dysregulation, with substances providing the positive reward response and parenting responsibilities providing a negative stress response. Parents then seek to reduce the negative stress response with the substances, which become less and less likely to have the desired effect, elevating the parenting stress response and subsequently the drug seeking behavioral response. Researchers now speculate that at this point the drug seeking behavior rather than the drug itself becomes the rewarding experience, as the parent experiences some relief of the stress response as soon as they make the decision to use the substance. This creates habitual learning behavior cycles in which the parent learns to avoid parenting response behaviors and focus on drug seeking behaviors, which could include the manufacture of methamphetamine (Rutherford, Potenza, & Mayes, 2013). An example of the cycle goes as follows:

> Parent uses substance
> Parent feels the reduction in stress/also feels a decrease in feeling of rewards
> Baby smiles
> Parent does not feel the reward feeling they normally would and fails to respond

to baby
Baby cries because they do not receive a response
Parent has a heightened stress response to the cry due to the substance impact on the brain
Parent desire to reduce stress are increased
Parent uses substance (Rutherford, Potenza, & Mayes, 2013).

In addition, some parents with addiction problems have been found to have greater emotional, hormonal, and physiological arousal responses to the stressful responsibilities of parenting even after they stop using (Wells, 2009). Women in particular also report higher rates of depression, which by itself can increase stress and reduce positive interaction with their infants, and can compound the effect to the drug use (Laurent & Ablow, 2012). This can result in parents reacting negatively at best to situations such as when a child is disobeying or upset, and maltreating the child in the worst situation.

There are other behaviors of substance abusing parents that can contribute to a risk of child maltreatment. One of the problems associated with parents who are addicted to substances is that they often provide a chaotic household environment within which the children are expected to develop (Grant, 2000). Because their behavior becomes focused on drug seeking and using, parents are not able to proactively organize the home environment in a way that provides the children with necessary structure and routine. In addition, parents who are addicted to substances have been found to provide less supervision to their children, which contributes further to the chaotic environment where

the parents are reacting to problematic behaviors and crisis situations rather than anticipating and preventing them (O'Connor, Gibson, et. al., 2005).

Another area of impairment in parents with substance abuse issues is in the quality of parent-child interactions. Parents who are addicted to substances of any kind are have been found to respond to their children in less nurturing ways, if they respond at all. New mothers who admit to substance use have been observed to be less receptive to their infant's cues within the first 48 hours in the hospital, and have shown decreased attentiveness and less interactions than parents who do not use substances, when those children were 3 and 6 months old (Rutherford, Potenza, & Mayes, 2013). Arria, Mericle, Meyers, & Winters (2012) found that parents with substance use disorders were also less likely to use positive parenting behaviors and instead were more likely to use harsh discipline methods and lack consistency in their responses to child behavior problems. Less than one quarter of the respondents in this survey reported good or excellent parent/child relationships. Parents have also reported that when they were actively using, they would avoid their children altogether in order to not have to deal with them, which often inadvertently put their children into harmful situations (Woodhouse, 1992). Parents admit that when they are addicted to substances, there is a constant struggle between submitting to the pull of the substances and meeting the day to day needs of their children, and often the substances themselves make choosing to meet the children's needs less rewarding (Suchman, Mayes, & Pajulo, 2014).

Substance abusing parents are at another disadvantage when parenting, as they are unlikely to seek help or support for their parenting. In a recent survey, only a third of substance abusing mothers and half of substance abusing fathers reported that they would allow their children to participate in any form of mental health treatment. This response was consistent across types of substances used, and included a lack of willingness to allow family treatment as well (Kelley, D'Lima, Henson, & Cotton, 2014). This hesitation to utilize help can then contribute to a vicious cycle of problems becoming worse and not being addressed. The children may learn to cope with the problems associated with parental substance abuse in unhealthy or maladaptive ways (Thompson, Roper, & Peveto, 2013). This can then contribute to the stress response in the parents and increase their likelihood of continued use.

Parenting Status. Many status factors have been known to contribute to increased problematic parenting, as well as the ability to stay sober. Status factors refer to the "Condition of the client in relation to objective and subjective defining characteristics" (Martin, 2005). Examples of status factors include homelessness, being employed, educational attainment, etc. Homelessness contributes to stress and it has already been discussed how stress is associated with addiction to methamphetamine (Park, Metraux, Brodbar, & Culhane 2004). There are some who would suggest that this accumulation of status factor stressors that may be a significant contributor to the negative parenting interactions among drug abusing parents (Hans, 2004). Parenting status factors such as unemployment and having a mental health diagnosis and family

instability have also been found to contribute to significantly high rates of child maltreatment among drug abusing parents (Morris, Seibold, & Webber, 2012). This information underscores the importance of focusing on the environmental status factors during the child welfare response in addition to the more obvious biological and psychological effects of drug abuse.

Impact of methamphetamine involved parenting on children's development

At all stages of development from prenatally to adolescence, children are impacted by the substance use of their parents, particularly mothers (Hans, 2004). The impact of substance abuse on child development is in part dependent upon the frequency, intensity, and type of substances being abused (Child Welfare Information Gateway, 2014). It is not always clear however if the negative impact of the substance abuse by the parent, or the failure to provide a safe environment for the children to grow, is the cause of the negative outcomes seen among children of substance abusers.

Children exposed to drugs or alcohol in utero have been found to have higher rates of abnormal development, and to experience withdrawal symptoms at birth, and have numerous physical, emotional, behavioral, and cognitive delays throughout their lives (Child Welfare Information Gateway, 2014). Prenatal exposure has also been found to contribute to difficulties with the child's ability to regulate their attention and affect (Hans, 2004).

As children grow, the stress of parenting exacerbates even further the problems with the response/reward cycle of parent/child engagement among substance abusing

parents and can lead to additional problems. As stated earlier, substance abusing parents respond to their children's cues less frequently and with less enthusiasm than non-substance abusing parents. Substance abuse not only affects the parent's behaviors, but the child's as well. As children fail to get the desired responses from their caregivers, they respond either with more passivity, giving fewer cues for the parent to respond to, or conversely with more vigor, employing significantly more negative behaviors until a desired response is received (Rutherford, Potenza, & Mayes, 2013). Just as the parents learn a cycle of substance seeking behavior as a response to the responsibilities of parenting, children learn a cycle of negative behaviors to get the attention they need. Parents of children who display behavior problems are more likely to increase their use frequency and intensity as a result (Chaplin & Sinha, 2013).

Adolescents who live with substance abusing parents have been found to have negative outcomes as well, although it is difficult to separate out the outcomes that are due to the substance abuse alone, and those that are due to the increased experiences of trauma that occurs as a result of the parental substance abuse (Child Welfare Information Gateway, 2014). Adolescents from substance abusing families, particularly those who ultimately end up in out of home placements, have been found to become substance abusers themselves at higher rates than those from non-substance abusing families, even when placed in out of home care (Douglas-Siegel & Ryan, 2013, Haight, et. al., 2005). They also experience higher rates of delinquency and violent crimes than other children (Douglas-Siegel & Ryan, 2013).

Child Maltreatment risk from parents who use methamphetamine

When parents use substances, the risk of child maltreatment is significantly increased (Chuang, Wells, Bellettiere & Cross, 2013). Children who are referred to the child welfare system due to their caregivers' substance abuse, are more likely to meet the categories of severe abuse and neglect and tend to be younger than the child welfare population as a whole (Thompson, Roper, & Paveto, 2013). It has been reported that up to 20% of methamphetamine arrests are of adults with children involved in the case (McGuinnes & Pollack, 2008). Methamphetamine abuse in recent years has had a particularly large impact on the number of children experiencing maltreatment. Forty percent of surveyed sheriffs throughout the US indicated an increase in child maltreatment reports as a result of increased methamphetamine use by caregivers (NACO, 2007). In addition, each year, almost 4,000 children were reported to be present at the scene of a methamphetamine lab seizure (CWLA, 2008). The reasons given for the increased involvement with child welfare among methamphetamine using parents are increased rates of poor judgment and decision-making, increased levels of violence, and increased levels of neglect as compared to non- substance abusing parents (Cunningham & Finlay, 2013).

Neglect is the most frequent allegation of maltreatment among methamphetamine addicted parents. Specifically, these children suffer from a lack of food, adequate shelter, and supervision (Walsh, MacMillan, & Jamieson, 2003). It is not uncommon for children

to test positive for methamphetamine as a result of not being supervised around the drug (Pennar, Shapiro & Krysik, 2012).

While neglect is the most common concern for children of methamphetamine abusing parents, these children are also twice as likely to experience physical and sexual abuse as children in families without substance abuse (McGuinnes & Pollack, 2008). Some of these incidents are due to the actions of parents themselves, but much of the harm comes from the exposure to acquaintances of the caregivers who take advantage of the children. It is not uncommon for children to be cared for by total strangers while the caregiver is high, or the caregiver may trade sexual access to the children in exchange for methamphetamine (Haltikis, 2009). One of the least explored areas of child maltreatment, psychological abuse has also been associated with substance abusing parents. Palusci & Ondersma (2012) found that psychological abuse was one of the common reasons for initial referral to child protective services, and that 9.2% had an incident of recurrence even after services were provided. Again, this may be explained by the nature of methamphetamine addiction on impulse control and stress reactions of the parent.

Conclusion

Unfortunately, the lack of significant research that integrates both the statuses of "parent," "methamphetamine users," and "child welfare" has resulted in little progress in achieving improvements in outcomes for children maltreated within the context of their parent's methamphetamine use. This gap in research and subsequent interventions is

detrimental to both the parent and their children (Suchman, Mayes, & Pajulo, 2014), as well as to broader society that must deal with the fallout. Specifically, there are some research questions that stand out as crucial to explore if we want to improve these outcomes.

First, we need to improve our understanding of the experiences of parents who have been involved in methamphetamine use and the impact it has had on their parenting ability and other interactions with their children. When describing those experiences, do parents and children report experiences that are consistent with those the current child welfare knowledge base considers "risks of maltreatment?" If so, what can we learn about the extent that methamphetamine involved parents know about these risks, and to what extent does that knowledge influence their behavior as their addiction progresses? Understanding the types of trauma experiences that contribute to and or result from methamphetamine involved parenting may be important when considering prevention efforts. When considering child welfare interventions, it is important to understand whether the risks of maltreatment, the levels of addiction, and the levels of psychosocial symptomatology of family members are unique to each family, or are there similarities that occur across families? Finally, it is important that this new understanding is integrated into the everyday practice of child welfare workers. Currently, social workers use systematic tools to measure risks of maltreatment, and prioritize responses. After learning about the risks as described by the family members, are these tools still useful in identifying child maltreatment risks and prioritizing intervention needs?

In order to gain this knowledge, it is important that we start with hearing directly from parents and children themselves. Starting “where the client is” is a hallmark of social work practice and for good reason. When we expand our understanding of the experiences of methamphetamine involved caregivers and their children, we can work toward to developing effective interventions that will result in long term impact.

Chapter 3 Research Methodology

Approach and rationale

This study uses a mixed methods approach to explore and describe how methamphetamine use contributes to child maltreatment risks. It is important to have a holistic understanding of the context of the family members' experiences in addition to their reports. Understanding the psychosocial context of the meth-involved families requires that we consider that there is likely as much psychosocial variability among parents who use meth as there is among parents in general. There is also likely to be a great deal of psychosocial variability in the children who experienced the maltreatment and subsequently there is variability in the family systems. Using a mixed method approach allows for a deeper understanding of the qualitative responses by providing quantitative contexts that cannot be understood by the qualitative interviews alone.

Research questions

This study seeks to answer the research questions of:

1. *How do family members and other professionals engaged with the family describe the experience of parenting while involved with methamphetamine, within the framework of child maltreatment risk?*
2. *Are the reported risks of child maltreatment, addiction histories of the parents, and psychosocial symptomologies of family members unique for each family, or are there similarities across the methamphetamine-involved families participating*

in the study? Do other similarities or differences emerge from the analysis of the reported experiences across families?

3. *Do child protective services assessment tools prioritize and suggest interventions in a similar manner to those intervention priorities discussed by the family members?*

While the previous studies using this data were used to understand the experience of the children when their parents use methamphetamine, this study is unique in that it focuses primarily on the context of parenting while using methamphetamine in relationship to risks of child maltreatment. This study uses data from Dr. Haight's previous research and thus is a secondary data analysis. The focus falls within the aims of the original IRB approved study identified as:

1. To describe rural families involved with methamphetamine abuse, their physical and social ecologies
2. To describe the parents, their socialization practices and beliefs about methamphetamine abuse and the effects on their own lives, and their functioning
3. To describe the children, their experiences and beliefs about their parents' methamphetamine abuse and its effects on their own lives, and their functioning.

4. To explore, using case cluster analysis, any patterns emerging across families especially pertaining to possible risk and protective factors for children's substance use and mental health problems.

Design

The design of this study is a descriptive mixed methods design. This approach puts emphasis on qualitative methods designated as a QUAL→ quant design. A complementarity/concurrent design with a secondary purpose of triangulation is used to provide an in depth understanding of this complex phenomenon. This design is defined as one in which qualitative and quantitative data are collected simultaneously and the use of data from both methods contributes to a greater understanding of the phenomenon as a whole than could have been achieved by using only one data type (Haight & Bidwell, 2015).

Qualitative interviews are coded using a priori child maltreatment risk factors, and provide the unique experiences of parents and their children on each factor. Only risk factors that the parents, children, or other professionals discuss in the interviews are included in the analysis. Quantitative measures of the developmental and psychosocial context of the parent's and the children's functioning are used to suggest explanations for any consistent risk factor identification or the exceptional divergence from those themes, as well as to compare differences across cases.

In order to enhance dependability of the qualitative coding, two child protective services supervisors, familiar with providing child protective services to meth-involved

families, reviewed the de-identified case data for coding consistent with the a priori codes of child maltreatment risk factors. Differences in coding categories were discussed and the interviews were recoded according to consensus among the professionals and this researcher. Quantitative measures and qualitative statements by the professionals involved with the family were also used for triangulation of the family members' perspectives, ensuring further trustworthiness of the themes generated. In the third phase, the child protective services supervisors also provided feedback and guidance in the use of the risk assessment tools and proposed intervention plans. Again, any differences in ratings were discussed and adjusted by consensus.

Because this study is using secondary data, it is important to note that the qualitative and quantitative data were collected concurrently, but the analysis in this project happened sequentially and iteratively. There are three phases of the research, first considering each family as an individual case based analysis, a second phase involving cross case analysis, and the third considering case analyses using established child maltreatment assessment of risk and needs frameworks. The case based analysis aims to provide a thick description of the experience in these families, while the cross case analysis considers consistency and variability in the qualitative and quantitative data variables.

Site

This research study used secondary data that had already been collected from a larger study examining the experiences of children from rural methamphetamine involved

homes (Haight, Ostler, Black, & Kingery, 2009). The data is made available by the principle investigator of the study, Dr. Wendy Haight. The data was kept in a double-locked office at the University of Minnesota School of Social Work, and initial examination of the data occurred on site in the office. Due to the richness of the interviews and the array of quantitative assessments conducted with the parents and children, the research questions were answered with the data available, and there was no need to return to the original data collection sites. This study focused on 5 families consisting of 8 parents and 7 children that had a comprehensive set of qualitative and quantitative data elements. It should be noted that one family had only qualitative data available but the data was rich enough that it warranted inclusion in the thick case analysis. That family is excluded from the second and third phases of cross case analyses using the quantitative data.

The data was originally collected in the homes of child and adult participants living in a rural, Midwest community that has been especially impacted by a high number of methamphetamine related child maltreatment cases. All of the families were receiving child protective services, and at the time of the interview, at least some of the family's children were residing with their parents. Children and parents were generally interviewed privately, although the context of the home environment made it impossible to ensure full privacy, which may have had some impact on the outcomes. At the same time, it is likely that the family members were much more at ease in their home setting so they may have been able to feel more comfortable being forthcoming with the

researchers. It also allowed the researchers to describe the physical environment and the interactions among members of the families, as well as clarify any information they may have observed. The data was collected by PhD and MSW level professionals who were familiar with the measures and research methods, but not with the individual family members themselves. The researchers were accepted into the community as a result of pilot project work prior to the data collection period and so were familiar and engaged with the community as a whole.

Participants

For this study, participants were selected from a larger pool of families that participated in the original study. In that multi-phase study, families were selected if they had children between the ages of 7 and 10, had an active case with child protective services, and had parents who used methamphetamine. All of the children in the study had experienced child maltreatment, thus the involvement with child protective services. The families that participated included families with both mothers and fathers as well as single parent households. The majority of the families in the study as well as the community in which they lived are white and so the sample, while it may be representative of their community, may not be considered racially or ethnically diverse. The families that participated in the study were considered socioeconomically to be working class families, but the information reviewed indicated that all of the families in the study were living below the poverty threshold for families of their size and location. The five families that were selected for this study were chosen due to the completeness of

the record and the depth of the interview responses. It appeared that the five cases achieved the saturation point of information after which any subsequent information was merely repetitive.

Reflexivity Statement

In qualitative research, the researcher uses their own experiences and worldviews to ask questions, design the study, determine the data elements that are relevant and non-relevant etc. (Haight & Bidwell, 2015). It is therefore important to understand the researcher's context as an instrument within the study. In the study, the researcher is both an insider and an outsider to varying degrees.

First, the researcher experienced child welfare involvement herself as a child due to the drug use and neglect of her birth parent and abuse and neglect by her adoptive parents. This child welfare involvement resulted in extended periods of time in out of home care (seven of eighteen years of childhood) and involvement with child protective services both while living with her caregivers and in out of home care. This experience gives the researcher an appreciation for the nuanced perspectives of the children in the families in the study. At the same time, the researcher is over 50 years old and recognizes that her experience may in fact be very different from those of the children and families who are experiencing the phenomenon almost forty years later in a vastly changed social and political context.

In addition, the researcher has worked for twenty-five years in county child protective services as a social worker, supervisor, and agency director, working with

families such as those included in the study. These experiences occurred during the same general timeframe as the original study and also in the Midwest, but in a different geographical area. This experience provides the researcher with an appreciation for the variation in family systems and functioning levels in families involved with child protective services both with and without methamphetamine involvement. It also provides a contextual understanding of the child protection experience from the view of the child protection social workers working with the families. At the same time, there is no doubt that the understanding of families and family functioning afforded an active child protection worker is likely different from the unfiltered views of family members who are reporting their perspectives to researchers with no authority over the outcomes of the child protection case, or ultimately the parent-child relationship in that family.

In order to improve trustworthiness of the study outcomes, several safeguards were used. First, the data used was previously collected and scored and the researcher had no ability to influence the outcome of either the interviews nor the psychosocial measurement scores. The choice of interview questions and measurements were made by the previous researchers and all of the data that had been collected for each family was considered in this analysis. This researcher also used field notes as an instrument to document observations, thoughts, and reactions to the data as it was analyzed. These notes were used primarily to suggest further inquiry, particularly when some of the data seemed to be contradictory, and also to highlight observations that may not have been essential to the study but were suggestive of future research that is needed to understand

this topic even more. Finally, the interviews and subsequent coding themes as well as the final themes were reviewed by practicing child protection social work supervisors. This minimized the impact of the current researchers biased interpretation of the data. Nonetheless, clearly the primary lens used to analyze and interpret the data is one of an experienced child welfare professional.

Measures/Instruments

A priori coding list. Because family members were unlikely to use the term "risk of child maltreatment" in the original study and they were not asked specifically to identify or discuss their experiences within the context of child maltreatment risk, it was necessary to create a list of a priori codes to classify their comments into child maltreatment risk factor themes. Also, the questions asked of the family members were relatively open ended, and so family members often discussed experiences that could be considered maltreatment risk throughout their responses during segments that seemingly had nothing to do with child maltreatment. In order to create a systematic coding system that could be used across families, the researcher sought out pre-existing lists of child maltreatment risks, but there was no standard list found that presumptively declared something a risk, and something else not a risk. The researcher then determined that the *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms* (CWIG, 2013) factsheet describing the signs and symptoms of abuse and neglect gave a comprehensive list of factors that child maltreatment reporters should take into consideration when confronted with situations in which they believe a child may be maltreated. The items

discussed in this fact sheet were then used to create a list of child maltreatment risk codes. This list was chosen for a number of reasons. First, the Child Welfare Information Gateway (CWIG) is an information clearinghouse provided by the Children's Bureau, the federal agency responsible for ensuring that states are adequately responding to protect children who have been maltreated. As such, the documents included on the clearinghouse website have been vetted by both expert researchers and practitioners in the field of child welfare, and are seen as the most "definitive" knowledge in the current practice of child welfare. A second reason was that items included in this list were fairly comprehensive, including factors that are commonly used to determine that maltreatment occurred, as well as factors that, while not indicative of maltreatment in and of themselves, are items that could be considered likely to create an environment that could contribute to maltreatment in the future. Because of the comprehensiveness of the list, it was expected that it would be likely that all of the family member's statements could be classified within one of the categories, without the need for an overly generous interpretation of the statements by the researcher. This did in fact prove to be the case, and while the family members did not discuss every risk factor listed, all of the statements they made could be coded to a risk factor category. The CWIG list includes over sixty items that indicate there may be a risk of maltreatment for a child (CWIG, 2013). For the purposes of the study, only those factors that emerged from the family member interviews were included in the analysis and findings.

The second set of instruments involved those that describe the parents and the context within which they care for their children. These include both qualitative and quantitative measures.

Parent Interviews (Interview Questions included in Appendix A, Part I). Parents were interviewed using open ended probing questions about their methamphetamine use and parenting. Parents were interviewed by PhD or MSW level social workers or psychologists familiar with interviewing methods and the instruments used. These interviews were transcribed by researchers in the original study, and the transcribed interviews were the documents used to code the child maltreatment risks for the current study.

In order to understand the context of the parents' responses, several quantitative instruments were administered to the parents. First, the Shipley Institute Living Scale was used to measure the verbal capabilities of the parents. It is a 40 item vocabulary test that has been found to have good reliability and validity (Zachary, 1991), and can be an indicator of the parent's cognitive functioning levels, and their ability to understand the questions in the interview and other measures.

The Addiction Severity Index – 5th edition Baseline instrument was used to gather information about the parent's history of substance abuse, current use, and addiction severity. This is a widely used instrument that has been found to be reliable and valid (McLellan, et.al., 1992) in classifying and describing substance use and addiction severity. This instrument can provide a context for the methamphetamine abuse, and

help to understand the conditions and environment within which the parents have used methamphetamine.

In order to screen for psychopathology, the Symptom Checklist 90-Revised (SCL-90R) was used. This is an inventory of self-report of nine symptoms: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. This measure takes about fifteen minutes to complete and has been found to be reliable and valid (Derogitis & Cleary, 1977) for adult psychiatric and substance abusing populations. Measuring these symptoms can shed light on whether there are psychosocial contributors or consequences of the parents' methamphetamine use.

Finally, the Trauma Symptom Checklist-40 (TSC-40) was used to measure acute and chronic posttraumatic symptoms, from current or previous traumatic events. It has been found to have moderate reliability, with good concurrent and construct validity for adults (Elliot & Briere, 1992). Recent research has indicated that trauma experiences may play a unique role both as an underlying contributor to substance abuse and as a result of the experience of substance abuse (Suchman, Mayes, Pajulo, 2013). The parent interviews were reviewed for themes first, and the other standardized instruments were used to provide exploratory context for those emerging themes both within family case and across parent and child case analyses.

The third set of instruments involves those that describe the children and the context within which they interact with their parents. These include both qualitative and quantitative measures as well.

Child Interviews (Interview Questions included in Appendix A, Part II) were conducted with children, using open ended and probing questions about their families and methamphetamine use. Children were interviewed by PhD or MSW level social workers or psychologists familiar with interviewing methods and the instruments used. To describe and understand the broader context of the children's experiences, nationally normed quantitative instruments were used to measure the children's behavioral and emotional function in comparison to other children in the US.

The Peabody Picture Vocabulary Test-III was used to screen for language delays and measure the receptive vocabulary of the children. This test is used extensively with children and has been found to have excellent reliability and validity, and correlates well to measures of general intelligence. This test can suggest any problems with understanding the questions in the qualitative interviews or other standardized measures (Dunn & Dunn, 1997).

To understand children's emotional and behavioral functioning, the Child Behavior Checklist – Parent form (CBCL) was used. This is a checklist designed to measure children's internalizing, externalizing behavior and trauma symptoms and result in a total problem score. It was designed for children between the ages of 6 and 18, the

ages included in the study. This instrument has been standardized and provides adequate reliability and validity (Achenbach, 1991).

Trauma symptoms for the children were further explored using the Trauma Symptom Checklist for Children (TSCC). This instrument measures under-response and hyper-response across six clinical scales of anxiety, depression, anger, posttraumatic stress, and dissociation. The instrument was read to all of the children in the study to clarify responses and understanding of all questions (Haight, Ostler, Black, & Kingery, 2009). The TSCC is a widely used instrument that has been found to have moderate to high reliability and concurrent and construct validity (Briere, 1997).

Finally, two instruments were used that relate to the family as a whole. First used was a child welfare case summary written by the child protection worker that included reason for maltreatment determination, concerns for risk of further harm, and case plan goals and objectives. This instrument was incorporated into the thick individual family case descriptions, as well as cross case considerations. Information from these records was used in the discussion of the suggested response of the child welfare system to parents who are found to be using methamphetamine.

Another instrument, the Home Observation for Measurement of the Environment (HOME), Middle Childhood version for children between the ages of 7 and 10 was used to describe the physical and emotional environment of the family. The subscales assessed include, parental responsibility, physical environment, learning materials, active stimulation, encouraging maturity, emotional climate, parental involvement, and family

participation. This instrument is widely used and found to have good reliability (Caldwell & Bradley, 1984). This information can provide a picture of the environment that the children were living in at the time of the study, and be compared with descriptions of family members of the home environment during the period of active methamphetamine use.

Interviews with child welfare professionals and case record reviews were used to triangulate information provided by the parents and children, or to provide additional contextual information that included references to situations that could be considered maltreatment risks.

For each family, two instruments were used to consider how child protective services social workers would likely respond to the child maltreatment risks identified by the families. The Structured Decision Making (SDM) System, developed by the Children's Research Center (2012) is group of instruments that are used in over 25 states by child protective services social workers, in order to ensure safety, permanency, and child well-being in the delivery of child protective services. Each state implements the tools differently, although using the same actuarial basis for determinations. The version used in this study (the Minnesota model) consists of the Safety Assessment, the Risk Assessment, the Strength and Needs Assessment, and the Reunification Assessment Tool. For this research, only the Risk Assessment and Strength and Needs Assessment tools are used, as the others are outside the scope of this study. The SDM tools use empirical research methods to identify the risk, strengths, and needs factors that when present are

significantly associated ($p<.05$) (Baird & Wagner, 2000) with future child abuse or neglect. An actuarial instrument is a list of those factors weighted to predict the likelihood of the occurrence of a future event. The SDM tool uses risk, strength, and needs factors to predict which cases are most likely to result in future maltreatment. Examples of factors included are; reason for current maltreatment report, number of prior reports, number of children, number of adults in the home, a history of domestic violence, an alcohol or other drug problem, child has a disability (Loman & Siegel, 2004). Scores of "high" are associated with an 85% chance of future maltreatment, while scores of "low' are associated with less than 10% chance of future maltreatment (Baird & Wagner, 2000). The MN version of the SDM Risk Assessment tool was found to have general predictive validity and marginal interrater reliability, and has been in use since 2001 (Loman & Siegel, 2004). If the report is scored at high risk, state policy mandates that a child protective services case be opened and services offered to the family, as defined by the priorities in the Strengths and Needs Assessment. The strength of these tools is that they are designed exclusively for use by child protection social workers with child welfare clients focusing on those factors that have been actuarially evaluated to impact the child's safety, and minimize the likelihood of worker bias in these decisions.

A second tool considered was the Omaha System (Martin, 2005), developed in the 1970's, which is most commonly used by nurses and community based social workers in internationally to classify 40 environmental, psychological, physiological, and health related problems. This classification system provides "structure, terms, and system of

cues and clues for a standardized assessment of individuals, families, and communities" (Omaha System, 2015). These nurses and community based social workers also work with methamphetamine involved families as well as individuals and families with many other health related problems, often in partnership with the child protective services social workers. The Omaha System classifies identified health and social problems and intervention targets. There are 4 levels of classification; the problem, categories of interventions, target areas for intervention, and measurements of change (Martin, 2005). It also includes a Problem Rating Scale for Outcomes (PRSO), a 5-point criterion-referenced scale that provides baseline and progress measurements for each problem area (Martin, Norris, & Leak, 1999). While the SDM focuses on predicting further maltreatment risks, the Omaha system framework takes it one step further in that it also provides measures for parental knowledge, behavior, and status and suggests evidence-based interventions that are specific to that parent's functioning level. For example, for the problem of neglect, if a parent talks about feeling guilty that they left a young child home alone, the parent's *knowledge* score may be high, but their *behavior* score would be low. Subsequently, suggested interventions would focus on changing behavior such as helping the parent make proactive plans for supervision, rather than focusing on knowledge interventions like having the parent take child development classes. The Omaha System PRSO system has been found to have high reliability ($r=.7$, $p<0.01$) and content validity ranging from 0.68 to 0.85 (Martin, Norris & Leak, 1999).

Ultimately this study is designed to enhance the translational purpose of research to practice by evaluating these tools' ability to capture and suggest responses to child maltreatment risk. Both the SDM and Omaha System tools have been used by practitioners working with families under real world conditions similar to the families in this study.

Procedures

In the original study, child protective services workers referred eligible families to the researchers who then contacted the families and asked for their participation. In total, 50 children, 30 mothers, and 5 fathers agreed to participate in the research, and completed various components of the study. Once families agreed to participate in the study, the researchers were introduced to the parents and children in the family home by their child protective services social worker. The researchers then spent some time visiting with the parents and children in order to build rapport. There were multiple contacts with the parents and children, both in their home and in the child protective services offices, in order to build relationships and conduct the variety of interviews and standardized tests. The researchers were trained to engage with the family members in a respectful, non-judgmental manner that demonstrated a sincere interest in learning from the family member participants (Haight, Black, Greene, Hans, Ostler, & Tolan, 2006). Once data was collected, it was transcribed and scored by those researchers who had been trained to score the tests. Identifying data was removed and replaced with numbers and non-identifying information. For the purposes of the current study, to maintain the

humanness of the participants, the previously changed identifying data was transformed again, and family members were given last names starting with the letter A-E and first names starting with the same letter as the last name. Any location data and age data was also transformed again with minor information changed to further protect and ensure that participants could not be identified. The collection of data for each individual family member as well as families as a whole were then analyzed by individual, family, and cross case by instrument.

Analysis Plan

There were three "phases" to the analysis of the data in this study, in order to provide a comprehensive understanding of the experiences of the families in the study.

Phase 1. In the first phase, a descriptive-case-oriented analysis was conducted in which a "thick" description of each family was created using the qualitative and quantitative data elements. The case records were reviewed first for a basic understanding of the family and the dynamics they described. A narrative of the parents' substance abuse history and interactions with family of origin was created if that information was available within the interview data, to provide a context to the methamphetamine and child maltreatment risk related discussions. A narrative of the current family dynamics as described in the interviews was also added if available.

Then, for each family, the documents were reviewed for the individual family members' statements and descriptions of events that contributed to maltreatment risks. Each statement was matched against the a priori child maltreatment risk codes, and then

added to the coding list. An example of the coding list is shown below. The coding list was then used to create a narrative of each risk item category, using the actual words of the person making the statement. The focus of the narrative analysis was on those elements that describe methamphetamine use in the context of the risk of child maltreatment.

Type of Maltreatment	Risk item	Family	Reporter	Location/comment	Strength/Risk
Neglect	Substance Use Prenatal Exposure	40	401	when I was pregnant, um, I'd stop my using when I found out that I was pregnant. (p.16)	Strength
Neglect	Substance Use by Parent	40	999	HOME . None of the adults in the home displays obvious signs of recent alcohol or non-prescriptive drug consumption. Answer Yes	Strength
Neglect	Substance Use by Parent	40	401	when I was drinking, um, probably more laid back then anything else. You know, and when I was strung out on meth, you know, I'm very agitated, very nervous, very stressed.(p.17) Um, and when I was drinking very mellow, very calm, unless it was tequila and then, you know, I was ready to fight about anything. Um, and a, you know, I think they probably get away with anything.	Risk
Neglect	Substance Use by Parent	40	401	, I think they remember more of the alcohol being around, then, allot of, there's been incidences where Danny has come up, and do you remember when you were drunk. (Laugh) And I don't ever recall being, you know, drunk in front of my kids, but their idea of me being drunk is, you know, and mine are completely different.(p.16)	Risk
Neglect	Substance Use by Parent	40	401	I was using methamphetamines, that's my drug of choice . . .but I also drank, um and before I got up here um meth wasn't um as available (p.1)	Risk
Neglect	Substance Use by Parent	40	401	C: We would be in the bathroom, the bedroom, or the garage or somewhere. (p.2)	Risk
Neglect	Substance Use by Parent	40	401	I was tired of hurting so much, my pattern in my using was I'd get high and everything in the House would be gone (P.4)	Risk

Table 1: Example of Interview Coding document

The quantitative data for each family member was reviewed and individual items then also incorporated into either the comprehensive family narratives or the risk category discussions if it directly related to the item being discussed.

Phase 2. The second phase was a cross-case descriptive analysis. In this phase, the families' experiences of child maltreatment risks were compared to understand generally how methamphetamine use may contribute to child maltreatment risk. A table was created to quantify the risk factors across families and detect the most common risks

and least common risks identified. Similarities and differences in the number and types of risks each family identified were reviewed and described. The actual results are included in Appendix B.

This was followed by an examination of the similarities and differences in the standardized instrument scores that provided a deeper understanding of the experiences of the families. Each family members' results were transferred to a Microsoft Excel (2013) spreadsheet for each standardized instrument, to calculate totals and average scores by parent or child group as a whole and also by gender. An assessment was made as to whether the standardized instrument findings were similar to the trends identified on the risk list. The scores across cases were then described by instrument and the comparison to the lists of risks identified by family members was described as well.

Again, this phase looked only at those themes or variables that emerged from the data elements, and from there the cross-case description of the phenomena was created. While the sample size is too small for significance testing, descriptive statistics of the variables was completed as a way to enhance the overall understanding. For example, in all five families, the parents reported they had been involved in the production of methamphetamine as a way to increase their family income. This information is valuable when considering interventions that address economic needs of the family.

Phase 3. The third phase involves analyzing both the within case risk themes and variables and across case risk themes and variables with frameworks that consider the degree to which children are at risk of maltreatment and if so, how to target interventions

most efficiently. The previously described SDM Risk Assessment Tools and Omaha System tools were used to suggest priority responses and interventions to the risks that were identified during the qualitative interviews and quantitative measures of social and behavioral functioning.

Data compilation. After completing all three phases, data was assembled describing each individual family and each element that was analyzed across cases.

Human Subjects Protection

Because this is secondary data that was collected under the same research aims as the original study, there is minimal concern for human subjects. All of the data elements studied was de-identified during the data analysis phase, participants were given new pseudonyms as opposed to participant numbers in order to maintain the humanness behind the data. In addition, some non-data elements that were inconsequential to the study were added, eliminated, or altered in order to further protect the anonymity of the participants.

Chapter 4 Case studies

Abbott Family

The Abbott family consists of April (39) and her children Alisha (12), Andrew Jr. (11), Alex (5), and Amber (3). The children's father, Andrew Sr., had passed away suddenly from undiagnosed diabetes complications approximately three years before the family participated in the study, shortly after Amber's birth. Both April and Alisha were interviewed and April provided responses to standardized instruments regarding herself as well as Alisha.

The Abbott family's involvement with CPS came as a result of a determination of neglect - injurious environment toward Alisha and Andrew Jr. This allegation stemmed from a report that the kids were physically fighting resulting in bruises, and that the children had serious mental health problems that April was not addressing. About six months later, there was another finding of physical abuse and neglect of Alisha by April, due to an incident in which April hit Alisha on the face with an object, leaving a bruise. The family also had been previously involved with CPS in another state due to April's methamphetamine use, which April reported increased significantly after the death of the children's father. April stated, *"Probably about six months after he was dead, then on I was on meth from that day until (over a year later) . . . they took my kids and I still couldn't stop. I was using it more (then) because I was alone. I didn't have nobody to keep pushing me."* During this child protective services involvement, all of the children

were placed in foster care, until April was able to complete treatment. The social worker noted that at least one other time in the past the children were placed in foster care due to a suicide attempt by April. The child protection social worker notes that *"the children have been neglected and exposed to violence for the majority of their lives" and* the *"family has extensive child protective services history in at least two states"* but no other specifics are given.

April described growing up the youngest child in a family in which her father was an alcoholic and used a variety of drugs, including methamphetamine. She reported her first time using methamphetamine was with her dad. She denied her mother used drugs or that there was any domestic abuse in her family of origin. She stated that all of her siblings have since grown up to become drug addicts and/or have their children removed by CPS. The family is currently residing in the town where April grew up, so she has many connections, both positive and negative in the area. April occasionally relies on her sisters and nieces for support but does not like to do so because they continue to abuse substances. April told to her social worker that the extended family members were verbally abusive to the children so she preferred to live with the children on her own. The researchers noted that "*it is believed that the grandmother, aunt, and uncle, who at times resided with the family, were involved in substances."* April's responses about family and personal relationships on the standardized instruments were similar to the other participants with the exception that she reported being widowed. Like most of the other parents in the study, she reported having few friends. April reported having close

personal relationships with all of her family members including her children, but reported a history of difficulties in her relationships with her extended family in the past and difficulties in her relationships with her children currently. She reported being extensively troubled by family problems for 2 of the last 30 days and that she had been emotionally and physically abused in the past, although the question did not specify the relationship status of the perpetrator of that abuse.

April stated that her first introduction to drug use was when her siblings gave her marijuana when she was about 19, and this continued to be a drug that she struggled with at the time of the interviews. She denied much other drug use until she was about 28 years old and then stated her alcohol use increased and she started dabbling in cocaine, speed, acid and ultimately methamphetamine. She said her husband got her involved in these other drugs, as he had been previously involved before they got together. April's history of alcohol use was less than most of the other parents in the study. In order to compare use histories with other parents, each parent's reported years of use on the Addiction Severity Index was compared to their age to create a percentage of lifetime use. When considering her age, April reported using alcohol for approximately 20% of her life while the average for all parents was 38%. April denied any intoxication over the 30 days prior to completing the interviews. April's reported use of cannabis was on the high end of the parent group however, at 51% of her life compared to 39% for the group as a whole, and 32% for the women. This was something that April admitted to in the interviews, that although she had just completed treatment for cannabis use, she still used

20 of the previous 30 days. It should be noted however that the child protection social worker stated that the treatment professionals were less concerned about her cannabis use and reported April's cognitive and mental health issues were of greater concern to them. April denied using hallucinogens or inhalants. She reported slightly longer cocaine use than other parents, reporting 8 years of use compared to the group average of 5 years. April reported using methamphetamine for approximately 15 years or 38% of her life, compared to the group average of 12 years use and 39% of life years. She listed methamphetamine as her most problematic substance. April reported having overdosed on drugs three times in her life compared to the group average of four times.

April reported that even as a baby, Alisha was closer to her father than to her mother, in that Alisha would get upset when her father left the room but was "indifferent" to her mother's presence. Alisha reporting being distraught about her father's death, and admitted that it was because she felt more connected to him as her parent than her mother. She stated he told her in the hospital as he was dying *"he was scared to leave me and my brothers and sister with my mom, because she's not that good of being a parent then dad was . . . he told me he was giving me my baby sister to take care of . . . but my mom don't let me."* In addition, when asked if she ever feels lonely, Alisha replied, "*a lot of times, because I miss my dad and I get mad at him for leaving me here. . . I miss him a lot and I just wish he was here, but sometimes I, like when I get scared, I feel like he's right there."*

While April, like the other parents in the study, did not use the term "risk of maltreatment" to describe how the children were impacted by her and her husband's methamphetamine use, she openly described her meth use as a negative influence in their lives in a number of ways.

Neglect: Substance use while parenting

Alisha and her siblings were exposed to methamphetamine use by their parents and others in the home. April said at first they would try to hide their substance use from the children, stating "*well, at least I thought I could."* When asked if the children were present while they used meth, April stated *"uh, yeah, they lived in the same house. . . towards the end they were very aware . . .I knew they knew, but they never said, oh, you're using drugs mom, but they also didn't ask (what we were doing)."* April also said that she regularly smoked in the house while the children were present. Alisha remembered seeing her parents use methamphetamine, stating *"my mom and dad used to use it, so they either snorted it or tasted it, or smoke it in their little ball thing. I saw when my dad used to make them out of lightbulbs and little glasses or bottles."* Alisha also reported being able to tell her mother was using by her behavior. She stated, *"she seemed paranoid, like she would bug out, say someone's watching you, and she would have a lot of people over."* April also told her social worker that her husband's brother, her sister, and her brother, who sometimes resided with the family also used methamphetamine. Alisha described how being in the presence of her parent's substance use was harmful to her physically. She said "*when they smoked around me, I either*

sneezed or my eyes watered." Alisha confirmed that she was aware her mother had periods of use and at other times tried to quit, stating "*with my mom, she would stop for months and then she would start again."*

A strength for April in this risk factor area is that at one point, she recognized that her meth use was harmful to her children and attempted to quit on her own several times. She got herself admitted into treatment, even after, she said, child protection social workers had discouraged her. April described the turning point as *"yeah, I quit on my own. . . one day I woke up. I kept praying and I woke up and decided I wanted my kids more than I wanted anything else. I got into rehab then went to a half house, and . . . I did it on my own."* Ultimately April *"completed 7 months of residential drug treatment while kids were in care; and recently completed a second outpatient treatment for marijuana and alcohol abuse"* according to her social worker. At the time of the interviews, April reported being "*clean*" for 18 months.

Neglect: Exposure to methamphetamine production

Alisha described the process her father used (she said her mother did not manufacture) to produce methamphetamine. She said *"when he did not have the rent money he would have to make drugs or sell drugs to get the money . . . he would make him some pills, and the most allergy medicines they can be used to make meth, so my mom wasn't allowed to use any Tylenol without asking. Not Benedryl, nothing like that."*

Neglect: Criminal activity of the parent

April admitted that there were often drug deals going on in the home while the children were present. The implication was that the dealers would hang out at the home and deal a variety of drugs as well as use with their customers. Alisha also remembered always needing to be aware of her father getting caught by the police, *"my dad would not be with us because there was a warrant for his arrest for drugs. The police were looking for him when he died. There was a warrant out for him for months and we had had to hide from the police."* April also reported that she had been convicted of obstructing justice when Alisha and Andrew Jr were younger and she had served time in jail for larceny. April reported other criminal activity as a result of her drug use, "*At the end, okay, yeah, I got caught with a syringe and some dope.* " She denied being on probation or parole, and reported 3 lifetime arrests for robbery, giving false information, and disorderly conduct. This is similar to the average of 3 lifetime arrests for the parent group as a whole. April stated 100% of her arrests resulted in convictions compared to 66% for the group as a whole. She reported spending less than 1 month in jail which was also similar to the other parent respondents.

Neglect: Children witnessing domestic violence

April said her husband was physically abusive toward her, often in front of the children, and recalled the most difficult thing about Alisha's first two years of life was *"she was always running from (Alisha's) dad for domestic violence."* April denied that Andrew Sr. was abusive toward the children, but "*he was extremely abusive and violent*

towards her, many times in the presence of the children." During her interview, Alisha confirmed that domestic abuse was a problem, up to and including the day before her father died saying, *"before he died and went to the hospital, my mom and dad got in this big old fight."* Unlike her mother, however, Alisha reported that her father physically abused her as well, stating *"he had a bad temper like me and he would hit us kids and my mom when he would get angry or when he was on drugs or alcohol."* April attributed the violence between the children to the violence they had witnessed by their father toward her. According to the social worker, at the time of the interviews, April had no current partner and the children were no longer witnessing domestic violence between adults.

Neglect: Failure to meet basic needs

April did not specifically discuss the physical environment during her interviews but the researchers conducting the interviews identified concerns about neglect due to safety and cleanliness, noting, "(there were) *broken windows, trash in the yard, lots of cats. The house was dirty, surfaces of furniture were grimy, windows were dirty, and the upholstery was dingy."* They also noted that, *"the house was in poor condition outside in contrast other homes in the neighborhood."* Similar to other families in the study, the Abbotts scored a four on the physical environment subscale of the HOME evaluation, compared to the population median level of seven. Alisha reported that the family was unable to eat meals together as there was not enough room nor chairs in the kitchen for them to all sit around a table.

Neglect: Lack of supervision

Alisha admitted to failing to supervise her children, saying that "*I just feel like, I put my kids in the corner, I just more or less ignored them. I shunned them, I was always on the run for meth. I'd come home, like I say crash,"* then after coming down from meth, *"I would be wore out, I would sleep, get up take a shower and do it all again."* April also reported leaving the children for long periods of time with her mother or sister who were also actively using substances.

Physical abuse

Although it is not clear that it is a direct result of methamphetamine use, the children were exposed to physical abuse, both by each other and by their mother, and possibly their father. April admitted hitting the kids on their bottoms, but denied leaving any marks. Alisha reported however that at some point in the past they had to go to foster care stating, "*we were getting abused. Because of me, I had a big bruise right here, I didn't get to go back right away."* Researchers also noted that April often *"hits and throws things at the children"* in their presence, and that "*the police have been called numerous times due to fights between mother and children or fights between the children."* The current child protection involvement was due to injuries that Alisha and Andrew Jr sustained while fighting with each other. Alisha told the researchers she *"had heard of families where there was no hitting and she wished she could live in a family where there was no hitting."* Alisha also said that she planned to have a family with no hitting when she grew up.

Emotional abuse

In addition to the physical abuse risk, there is also reported emotional abuse. The researchers noted that April *"was harsh, verbally abusive toward her children, had angry outbursts toward her children, almost barking at them in anger."* This seemed to be confirmed by the social worker's notes, "*April yells a lot, curses at her children*" and even after the CPS intervention, *"mother and children continue to yell, scream, curse, and physically attack one another."*

Other Risk Factors: Lack of parenting ability

April reported her daily routine started with "*fight(ing) with the kids to get ready for school."* When asked specifically how she felt meth involvement had affected her parenting, April replied, *"no discipline on the two older kids, I could never discipline them. . . I let them do what they want, you know as long as they were quiet."* When asked 'what do you think your parenting is like now?' April replied *"still shitty . . . they don't listen."* When asked what she thought could change that, she replied with *"I don't have a clue."* The researchers observed that *"the children were regularly verbally abusive toward each other and their mother,"* and that April responded only with similar behavior. She seemed not to know how to manage the children's behavior, instead responding in a way the researchers described as "*harsh toward children, but then would "give in" to demands . . . Mother yells a lot, curses at her children. . . And does not have a lot of patience for her children's behaviors"* Alisha's perception was also that her mother's parenting methods were ineffective stating, *"cause she's not that good of a*

parent" and "*not a 'good' mother"* further stating that her mother wasn't able to take care of them, especially her younger siblings. April's lack of parenting ability was also one of the risk levels that was of greatest concern to the child protection social worker who noted that while "*April recognizes the effects that some of her past decisions and behaviors have had on them"* and that she *"has insight into her lack of parenting skills but she is not motivated to enact change."* After the second report of abuse, the social worker stated, "*Parent insight into her own behavior and judgement is limited."* The social worker lamented the ineffectiveness of attempts to provide parenting interventions, stating "*after 9 mos. of services, April's parenting skills and abilities remain unchanged."* Problems in April's parenting ability were not limited to disciplining her children, but also planning for their general welfare, even when she was sober. The social worker noted, *"April moved children between states with no planning, no housing lined up, and no reliable means of income."*

Other Risk Factors: Chaotic household

A related risk factor involves living in a chaotic household, with a lack stable living environment. This was experienced by this family in part by the number moves the family experienced, often from state to state. April reported moving *"between at least four states,"* and within the year prior to the interviews the social worker noted, "*April and her children have lived with three different relatives since moving back to the state."* In fact, the researchers reported the family changed housing twice between the first and last interviews. The social worker also noted, "*due to continual crises, and lack*

of housing, it was difficult gathering information." Even when they were living in one setting, April reported regularly having other people take care of her children, saying she would "*push them off*" on anyone willing to care for them.

Other Risk Factor: Lack of resources

The lack of resources for April and her children also seems to contribute to a potential risk of harm. The researchers indicates the mother was assigned a counselor but was not attending due to lack of transportation, illness, etc. Andrew Jr. was also reported to be in need of therapy, and only sporadically able to attend.

Compared to the other parents studied, April was the least educated, having completed 8 years of school compared to the mean/median of 12 years, but she was one of only 4 parents who reported having been trained in a vocational skill, reporting certification as a personal care assistant. April reported her longest full time job lasted 2 years, just under the median of 3 years for the group. April received the majority of her family income from Social Security disability payments. Not surprisingly, April also reported the lowest level of financial income from all sources at about $200/household member. This compares to an average of $375 per household member across families. This is also consistent also with her report of being the most bothered by employment problems in the past 30 days. This made it difficult not only to meet current household needs but the social worker also noted "*mother is currently paying past delinquencies to get power and water turned on."* As a result, the social worker noted*, "Budgeting and housing will need to continue to be addressed to ensure that the children are provided*

with a safe and stable nurturing home." As stated earlier, while April had relatives that she relied on for support, they were often using or verbally abusive to the children, and she was not comfortable relying on them saying she did not find them "*to be a positive support."*

Other Risk Factors: Difficulty in parent/child relationships

April specifically attributed the difficulty in her relationships with her children to the experience of methamphetamine addiction. She replied to the question "Do you think that (meth addiction) is having an effect on the relationship now with your kids?" with "*Yeah . . . a deep impact.*" April explained further, "*Yeah, I just had them all messed up and confused. And they didn't know how to act, I mean they don't know how to act.* (I: And how do you think that is a result from using meth?) *From the ups and downs from that. . . You know, happy one minute and mean as hell the next . . . You know, and it got them confused and scared. . . I get irritated . . . I don't have no patience. Alisha, she'll try to go in depth with me about something, it's like I can't. . . It's like nerve racking. It just bothers me.* April seemed most bothered that she is "*unable to form a close relationship with Alisha*." The researchers also noted that April *"stated resentment for her daughter and believed her daughter is manipulative."* This may in part explain the negative interactions between April and the two older children that are described elsewhere. According to the researchers, April stated that Alisha *"has told her on several occasions that she wished her mother would have died and her father would have lived."* Alisha said "*I argue a lot with my mom, all the time"* and also suggested she was suspicious of

her mother, stating some of the tension was about whether April was still using drugs, "*I don't think that rehab was good for her, but I don't know any more so, I don't know if she's on drugs anymore but my mom says if she's does, it's none of my business. I think it kind of is, because it's concerning us too."* The social worker also noted, "*Mother's relationship with her children is very damaged, probably due to the years of her substance abuse and domestic violence in the home."* The social worker observed that while April and the other children hugged, there was no hugging or affection witnessed between Alisha and April.

The parent/child relationship between April and her younger children is considerably more positive than the relationship she has with Alisha in particular. The social worker noted "*there was holding, hugging of the youngest child by the mother . . . Mother expresses her love for her children and this worker has witnessed her hugging them and telling them she loves them."* The researchers noted the hugging of Amber by April and reported that Amber "*seems bonded to her mother*." Andrew Jr. seemed to have a mixed relationship with his mother, with some negative interactions but the researchers also noted he *"loves his mother and tells her so quite often . . . can be very caring toward his mother at times but at other times can be very disrespectful and belligerent."* The social worker suggested that April was *"trying to repair some of the damage in the relationship between her and her children"* as evidenced by April's attending the children's therapy sessions with them. Despite the positive relationship April seemed to have with her younger children, as a whole, the family scored a two out of eight on the

family companionship subscale of the HOME assessment. This compares to a population median score of five, and a study average score of four. The family also scored a three out of nine on the acceptance subscale, compared to a population median score of nine, and a study average score of seven.

Other Risk Factors: Difficulty in sibling relationships

The initial CPS report involved actual physical harm between Alisha and Andrew Jr. April also responded to the question of "*compared with others of his or her age, how well does your child get along with brothers and sisters?"* with *"worse."* The researchers observed that Andrew Jr.'s *"behavior typically turns outlandish, violent, and very loud whenever (Alisha) is in the home.* Alisha also said that there were struggles with the younger siblings fighting. "*When I get mad at my little brother and sister, I just yell at them.*" She went on to relate a story about trying to keep the little brother and sister separated because she said they were constantly fighting with each other.

Other Risk Factors: Child's behavior problems

The difficulty in relationships between Abbot family members is also likely related to the risk factor of child behavior problems. April attributed the behavior problems of her children to her addiction. In fact, her first response to how her meth addiction affected her children was *"Behavior mainly, they cuss, they tear up stuff."* Alisha's problematic behavior was described by the child protection social worker as "*she gets disrespectful and belligerent to her mother and other adults. She has gotten caught stealing things from other people and from stores recently. She is easily angered.*

It takes very little provocation by her mother or brother to be upset with her, which usually results in her screaming, cursing, and being physically violent towards her mother and siblings. . . She does not typically exhibit these same behaviors at school." April reported these behaviors were apparent as early as second grade, when Alisha would be found destroying property and throwing tantrums. Alisha's scores on the Child Behavior Checklist (CBCL), indicated clinical level concerns about anxiety and depression as well as somatic complaints. In addition, her rule breaking behavior score and aggressive behavior score were significantly above the group norm. Her total T score was in the 99th percentile, indicating significant clinical concern.

Alisha admitted to struggling with her behavior, stating *"sometimes when I'm mad at a person I think I bad thoughts about them and want to hurt them sometimes but, I don't do that . . . like my brother, I kept on punching him until he was bleeding because I am, I just get sick of them doing things."* Andrew Jr. also has a hard time managing his behavior. The social worker wrote, "*Andrew continues to have problems at school and in the home with cursing and threatening people. He doesn't listen, is aggressive toward peers, and is belligerent, disrespectful toward teachers."* As he gets older, Alex has also begun to demonstrate some concerning behaviors as well. The social worker noted, "*Alex does not listen to his mother or follow her directions. He is defiant and disobedient quite often . . . seems very active and does not follow direction, can be very disrespectful to adults, he cursed out the family support specialist when she drove by McDonald's*

without stopping to buy him a happy meal. . . he has had some problems at school with aggressive behavior."

Other Risk Factor: Cognitive/Mental health status of the parent

The behaviors of the children may also be related to the difficulties in April's cognitive abilities and mental health functioning. April scored the lowest on the Shipley Institute of Living Scale for the parent group, and particularly low on the vocabulary section of the test. She scored one standard deviation below normal for her overall cognitive functioning score.

April also reported the most significant levels of mental health concerns of all of the parents in the study. She stated she was hospitalized twice as often as the average parent and has been in outpatient treatment four times as often. She was one of three parents who reported having mental health concerns to the point of qualifying for disability payment. She denied ever having hallucinations or trouble controlling violent behavior, but reported having periods of depression, anxiety, and trouble concentrating and remembering. Like all but one parent in the study, she reported taking prescribed medications for her mental health. April reported being diagnosed with PTSD, depression, and bipolar disorder, as well as ongoing grief over her husband's death. April's responses on the SCL-90-R, a checklist of indicators of psychological distress (Derogatis & Cleary, 1977), were all well above the clinical cutoff and all were in the 90^{th} percentile or above, indicating significant psychological distress in multiple domains.

Interestingly, both April and her social worker reported concerns about April's level of depression, however that was one of the lowest of her high scores.

Some of this distress may be due to significant trauma history as reported by April on the Trauma Symptom Checklist (TSC-40). While the TSC-40 is not a diagnostic tool, it has been found to be valid and reliable as a research tool to identify a symptoms that indicate traumatic experiences in child or adulthood (Briere, 1996). April's total response score was more than double that of the average responses of the parents in this study and more than 4 standard deviations above the mean for participants in a recent study who had no abuse history (Neal & Nagle, 2013). In addition, in all but one of the subscales (sexual problems), April's responses indicated scores of more than 3 standard deviations above the mean for the participants who had no abuse history. April reported significant trauma at the hands of her husband and these response scores are indicative of this severe domestic abuse history.

Other Risk Factor: Mental health status of the child

Two of the children, Alisha and Andrew Jr. also were diagnosed with depression, and both have been hospitalized for suicide attempts. Alisha initially denied wanting to hurt herself and then said "*okay about the one about hurting myself. . . . I have, once in the hospital, like saying I wanted to kill myself."* Alisha did have some concerning scores on the CBCL as well as the Trauma Symptom Checklist for Children (TSCC). Alisha's CBCL scores indicated elevated levels of anxiety and depression although the TSCC only identified anxiety as a clinical level concern. While Alisha was able to describe a number

of traumatic experiences, especially when she was in foster care, most of her scores on the TSCC were within the normal range.

Other Risk Factor: Child's educational progress

One of the strengths that Alisha shows is that she seems to be doing well on her schoolwork. In particular she is reported to have above average scores in math and science. This is consistent with her reported performance on the intelligence test that was at slightly above average

Other Risk Factor: Physical health of family members

The researchers noted that April reported being diagnosed with serious health complications from the years of meth use, but continues to smoke cigarettes and not use her oxygen. April indicated she had been diagnosed with heart and lung problems as well as diabetes. Like all but two of the parents, she indicated she was taking medications to treat those physical health problems. At the same time, she was 1 of only 2 parents who were receiving disability benefits. April described experiencing physical problems on 30 of 30 days compared to the average for the group of 12.2 days of physical problems during the past 30. Like three-fourths of all parents in the study, April also reported significant dental problems as a direct result of her methamphetamine use. April reported about her health *"I have no brain left. My memory is shot. My health is shot. Life's hell."* Alisha also replied to the question 'are you afraid something bad might happen?' with "*yes, that my mom will die because she has diabetes herself and sleep apnea and*

asthma and emphysema and I worry about her all the time at school and I miss her at school and want to be there with her everyday so I'll know what happened."

April described her pregnancy with Alisha as normal, and that she did not use drugs, alcohol, or smoke. Despite her care however, Alisha was born via cesarean section due to the umbilical cord being wrapped around her neck. Alisha also is reported to have severe asthma, obesity, to take medication for other medical concerns, and has been referred for speech and language delays.

Other Risk Factors: Failure to participate in recommended services

Family members participated in many social services as recommended. The researchers noted that April made sure that *"Alisha attended her weekly therapy and every other week, mother attends this child's sessions."* The social worker also noted that *"April is very aware of the services in the community and the social services resources that are available to her."* The social worker also reported "*Mother is cooperative and appropriate with the worker at all times . . . she is motivated to make improvements to her and her children's lives."* April was less attentive to her own mental health needs however. Despite reporting feelings of depression, April *"enrolled in individual counseling services but is not attending."* When asked by the researchers about whether she could talk about her depression in counseling April replied, *"Yeah, not yet but I'm going to."*

Summary of child maltreatment risks

Risk Item	Risk Present?	Data Element Identifying Risk	Family Priority	SDM Priority	Omaha Priority
Neglect: Substance use while parenting	Yes	Parent interview, child interview, ASI, social worker report, researcher report		X	X
Neglect: Prenatal exposure	No	Parent interview			
Neglect: Parents involved in meth production	Yes	Parent interview, child interview			
Neglect: Criminal activity of the caregiver	Yes	Parent interview, child interview, ASI			
Neglect: Children witnessing domestic violence	Yes	Parent interview, child interview			
Neglect: Failure to meet basic needs	Yes	Parent interview, child interview, HOME assessment, researcher notes			
Neglect: Lack of supervision	Yes	Parent interview			
Physical abuse	Yes	Parent interview, child interview, social worker report			X
Emotional abuse	Yes	Researcher notes, social worker notes			
Sexual Abuse	No	Not addressed in any data element			
Other: Lack of parenting ability	Yes	Parent interview, child interview, researcher notes, social worker notes	X		X
Other: Chaotic household	Yes	Parent interview, child interview, researcher notes, social worker notes			
Other: Lack of resources	Yes	Researcher notes, Parent interview, child interview, ASI, Shipley, social worker notes	X	X	X
Other: Difficulty in parent/child relationship	Yes	Parent interview, child interview, researcher notes, social worker notes, HOME assessment,	X	X	X
Other: Difficulty in sibling relationship	Yes	Parent interview, child interview, social worker notes, CBCL			
Other: Child's behavior problem	Yes	Parent interview, ASI, TSC-40, Shipley, SCL-90-R	X	X	X
Other: Cognitive/mental health status of caregiver	Yes	Child interview, TSCC, CBCL	X		
Other: Mental health of the child	Yes	Parent interview, social worker notes, Child dev.	X		

		History quest., PPVT-III, CBCL, TSCC			
Other: Child's educational progress	No	Child dev. History quest., PPVT-III			
Other: Physical health of family members	Yes	Parent interview, child interview, ASI, Child dev. Quest.	X	X	
Other: Participation in recommended services	Yes	Parent interview, researcher notes, social worker notes			

Table 2: Abbott family maltreatment risks

Of all of the families reviewed in this study, the Abbotts seems to struggle the most with negative outcomes, reporting that the family experienced 18 of the 21 risks identified by all families in the study. The family members and professionals attribute the ongoing difficulties to the methamphetamine use of the parents. Among all of the parents in the study, April reported the second highest proportion of lifetime use of meth at 38%. The family also had to deal with the loss of the father, whose death was most likely hastened due to his methamphetamine addiction.

While the children lived in a chaotic household with substandard housing, experiencing neglect, physical abuse, and regularly witnessing domestic violence, the most problematic outcome of their parents' methamphetamine addiction according to both the family members and their child protection social worker, is the damaged relationships between family members and the subsequent problematic mental health issues and behavior of the children. Despite attempts to address these concerns with April and the children, the social worker reported that little progress was being made even though April was no longer involved with methamphetamine.

This lack of progress may be explained in part by April's lower cognitive functioning and heightened mental health needs compared to the other families in the

study, as well as her long use of methamphetamine. It is difficult to tell which came first, as there was no indication that April was attempting to use methamphetamine or other substances to address her mental health needs. Instead her substance use was yet another risk factor combined with the preexisting risk factors of physical, cognitive, and mental health problems. It seems plausible that the presence of another parent may have helped to mitigate these issues for some time, despite his involvement with substances as well. When her husband died, April was no longer able to keep things together enough to protect her children from maltreatment. Even though she reported she was no longer using substances, April was left with minimal internal and external resources to help her cope with the ongoing physical and mental health concerns.

At the same time, the significant trauma history that April's symptoms indicate may have been due to her husband's longstanding abuse toward her, both while using methamphetamine and while sober. April's physical and mental health statuses seem to represent the interactive complexity and compounding effects of substance use, domestic abuse, low cognition, and mental health on the risk of subsequent child maltreatment.

Child protective services response

The Abbott family scored in the high risk category of both the abuse and neglect scales on the SDM. The following chart shows the items on the SDM Risk Assessment Tool for which they received a point. Scores up to 2 indicate low risk, between 3 and 5 indicate moderate risk, and six or above indicate a high risk for future maltreatment (Children's Research Center, 2012).

Neglect	**Abuse**
Prior assigned reports Prior CPS history Number of children in the home Number of adults in the home Caregiver history of domestic violence Caregiver use of alcohol or drugs in last 12 months Primary caregiver has a mental health problem	Current report is for abuse Current report results in determination of physical abuse Prior investigation resulted in case opening, Number of children in the home Primary caregiver lacks parenting skills Caregiver employs harmful or developmentally inappropriate discipline Caregiver has a history of domestic violence Primary caregiver has a mental health problem
Score = 7 High Risk	**Score** = 8 High Risk

Table 3: Abbott family SDM Risks

Given the scores of high risk, in most states, the child protective services agency would be required to open a case and offer services. The Strength and Needs Assessment tool is utilized to determine where to target the required interventions. There is one section completed for the parent and one for each child. For the purposes of this study, only the child that participated in the study was assessed. The Strength and Needs tool assigns a numerical score for the presence or absence of each item as it relates to the risk of further maltreatment. Some items are more highly associated with future maltreatment risk and thus receive lower scores. Scores on each item above 0 are generally considered a strength, while scores below 0 are generally considered a risk (Children's Research Center, 2012). For the Abbott family, the strength and needs scores were as follows;

Caregiver Strengths
Physical Health (-1)
Social Support System (-2)
Parenting Skills (-2)

Caregiver Needs
Household Relationships (-5)
Resource Management/Basic Needs (-5)
Alcohol & Other Drug Use (-5)

Child Strengths
Alcohol & Drug Use (0)
Education (0)
Child Development (0)

Child Needs
Emotional/Behavioral (-3)
Physical Health/Disability (-3)
Family Relationships (-4)

According to the above measures, child protective services should focus on the top three priorities of the household and family relationships between the parent and the child (including physical abuse), the basic needs of the family, and the alcohol and drug use of the mother. As we can see, there seems to be a bit of a discrepancy between the outcomes of the parent strengths and needs and the reports of the parent regarding the issues she and her daughter found most problematic. The family identified the following risks as the primary areas they needed help;

- Difficulty of family relationships
- Lack of resources/basic needs
- Behavioral needs of the children
- Mental health needs of the child and mother
- Physical health needs of the mother

Part of this has to do with how the SDM Risk Assessment is scored. The three highest scores are identified as "strengths" and the bottom three are the prioritized "risks." Because the mother in this family is struggling with so many complex issues however, there was no positive score for any category, resulting in the lowest of the needs categories being included as strengths, despite the fact that there clearly are significant needs in those areas.

The Omaha system pathway works similarly to the SDM, although it takes a step further and also measures each problem area according to knowledge, behavior, and status of the client. While the SDM focuses on prioritizing which problems to target, the Omaha system identifies which interventions to prioritize based on the client functioning levels. By measuring the client's Knowledge, Behavior, and Status, (KBS) on Likert like scales, the child protective services social worker can evaluate whether progress is

actually being made, or if the intervention targets need to change. Using the SDM prioritized needs of Household relationships, Resource management, and Alcohol or other drug use, the Omaha system intervention plan is shown below.

Domain: Psychosocial		
Problem: Interpersonal Relationship (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Inadequate interpersonal communication skills • Difficulty problem solving without conflict • Minimal shared activities	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Anger management (strategies) • Communication (develop/improve skills) **Category: Case Management** **Targets and Client-specific Information:** • Counseling care (schedule/provide in-home family therapy services)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 1-minimal knowledge (cannot differentiate between positive and negative communication) **Behavior:** 2-rarely appropriate: (daily disagreements that dissolve into yelling and threats, physical altercations) **Status:** 1-extreme signs/symptoms: (tense, volatile atmosphere)
Domain: Health Related Behaviors		
Problem: Substance Use (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Uses street – recreational drugs • Buys/sells illegal substances	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Behavior modification (stop marijuana/methamphetamine use) • Coping skills (strategies to deal with behavior triggers, support lifestyle change) **Category: Case Management** **Targets and Client-specific Information:** • Support group (age and condition specific group) • Support system (spiritual/faith community) • Dental care (coordinate evaluation and services	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 3-basic knowledge (knows treatment options, beginning to relate physiological status to substance use) **Behavior:** 3-Inconsistently appropriate behavior (variable use of drugs) **Status:** 3-moderate signs and symptoms

	Category: Surveillance **Targets and Client-specific Information:** • Laboratory findings (urine screen) • Substance use cessation (ability to meet obligations (family, social)	(prepares to change behavior, receives treatment sporadically, meets some family obligations)
Domain: Psychosocial		
Problem: Abuse (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual Signs/Symptoms of Actual:** • Welts/bruises/other injuries • Attacked verbally • Violent environment	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Anger management (strategies) • Behavior modification (develop/improve skills) • Discipline (age-appropriate, limit setting, clear expectations) • Support system (active listening, emotional support, realistic expectations **Category: Case Management** **Targets and Client-specific Information:** • Counseling (schedule/provide in-home family therapy services)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 1-no knowledge (does not know the difference between usual interpersonal relationship and abusive behavior) **Behavior:** 2-rarely appropriate: (child is frequently disruptive or withdrawn) **Status:** 3-Moderate signs/symptoms: (no new injuries, old injuries evident)
Domain: Environmental		
Problem: Income (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual Signs/Symptoms of Actual:** • Low/no income • Difficulty with money management • Difficulty buying necessities	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Budgeting • Community Resources • Comprehensive analysis and action plan **Category: Case Management** **Targets and Client-specific Information:** • Community resources (coordination among providers, transportation services) • Spiritual/faith communities	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 2-minimal knowledge (identifies some sources/amounts of income and some expenses) **Behavior:** 3-inconsistently appropriate (is interested in idea of budget, uses some assistance programs) **Status:** 2-severe signs

	(referral to services within the church she belongs to)	and symptoms (in residence but utilities disconnected due to non-payment)

Table 4: Abbott family Omaha System application

While the Omaha system problem identifiers do not match exactly with the SDM needs, it is clear that there are options that are a close fit. For example, the Interpersonal relationships intervention pathway fits both the parent problem of household relationships as well as the child problem of family relationships. In this intervention plan, the family members would be given the opportunity to learn and implement skills that would be focused on improving their knowledge of effective communication; the social worker would look to observe behaviors that indicate they are using the non-violent communication skills; and the status would improve in that the family members would report decreased tension in the household.

While the mother in this family admits to occasionally using marijuana and her treatment providers were more concerned about her mental health, her substance use history is so compelling that it rises to priority level for intervention. The mother in this case seems to be precariously sober, and the impact of her previous use seems to have been detrimental to her family relationships. The Knowledge, Behavior, and Status (KBS) ratings reflect this positive progress but also show that still more intervention is needed. In particular, providing the mother with support options for maintaining her sobriety seems as though it would be most critical, and would impact the KBS scores for the other problem areas as well.

Because the reason for child protective services intervention with this family is specifically due to physical abuse, it is also important to include an intervention pathway that specifically addresses this problem, even though it is not a specific need category on the SDM Strengths and Needs Assessment tool. In this situation, the mother admitted to not knowing how to respond when her children refused to listen to her and that she resorted to physical discipline due to this inability. The KBS scores in this area show that there is the greatest need in knowledge and behavior, but that because there were no recent injuries observable, the status is improving. Without intervention on the knowledge and behavior concerns, it is likely that the status rating will drop due to more incidents of physical abuse.

Finally, the family resource needs are also targeted for intervention as this is another problem area prioritized by both the SDM and the parent. The mother reported that the family was without electricity at the time of the interviews due to previous bills not being paid. At one time, the mother tried to have a relative manage her finances, however that relative exploited her and did not pay the bills. At the same time, the parent did not report using all of the public assistance programs that were likely available to her. In addition, she reported that she had found a new church she liked attending, and it is likely that with some coordination, she would be able to access some assistance there. These areas were identified on the Omaha pathways, and again, the goal would be to improve her financial situation so that she had an effective level of income/assistance that

could follow a budget plan to ensure expenses were paid. Progress in this area would be measured by improved KBS scores.

The Brown Family

The Brown family consists of the mother Barbara (26), and Bill (29) the father, as well as three children, Billy Jr. 7; Bobby, 5; and Benny, 3. Bill and Barb were interviewed and completed the standardized instruments about themselves and their son Billy. Billy also participated in a child interview.

The family became involved in child protective services as a result of a raid on Bill's marijuana growing business. When asked about the family's involvement with child protective services, Bill replied "*I got in trouble for growing weed*." Barbara added, "*I was getting ready for work one day and the door got kicked down with a bunch of guns and then from there on CPS was involved.*" As a result of the raid, the children were briefly removed from the parent's care and placed with relatives. According to Barb, the children "*had to stay at my grandparents for two weeks I do believe, we were allowed to stay with them, but they just were not allowed to be alone with us, so we did that."* The family had been involved in child protective services approximately five years earlier when, according to Barbara, Bill contacted child protection to report concerns that she was taking the children and moving out, while she was actively using methamphetamine. According to the parents, CPS social workers did not recognize the level of Barb's meth addiction and ended up supporting Barb's care of the children to the exclusion of Bill. Bill reported, *"yeah, they didn't have a clue. Didn't have one clue and I walked back out*

and I told her, she said I believe you're lying just to try and get your kids, and that's what you believe. I said I'm speechless lady I said I don't know what to say. I was pleading my case to her and she wouldn't believe me." Barb also reported another involvement with CPS when Billy was born. She said, "*I got drug tested and actually I got involved with CPS then too, I forgot about that, when I had Billy he had tested positive for marijuana, so they came in and did an investigation."*

Barb shared that she grew up in a family that was heavily drug and alcohol dependent and as a result, she started to use at an early age. She stated, "*I kind of been into drugs a lot, I started drugs when I was 12. You know, I've been to rehab seven times, so this is been my life actually. My whole family has done it and everything."* Barbara elaborated further with, "*I started drinking really heavily at age 12. My mom was a bartender and worked nights, and I would babysit my little brother and sister. My payment was a six-pack of beer, I actually had eight illegal consumptions by the time I was 17."* She reported her most problematic drug was methamphetamine, even though she used many other types of drugs throughout her life. "*I've used meth, crystal, I've used cocaine, use marijuana, hash, alcohol, acid, mushrooms, and I've used everything."* Barb reported her most extreme drug use occurred when she was at the height of her methamphetamine addiction. She reported her use was fairly extensive, *"I used meth every day, any day that I could get my hands on it. I've used in all forms, I smoked it, I snorted it, I've shot it up, I've done it all."* Barb reported difficulties relating to her mother and siblings in the past due to their ongoing drug usage but indicated that in the

last 30 days there were no reported problems in those relationships. She reported her relationship with her father continues to be strained, and she no longer speaks to him.

Barb reported a total of 8 lifetime arrests for drug using related offenses, and stated they all occurred when she was a juvenile. This was the highest for all of the parents in the study. She reported that she spent no more than one day total in jail however, and suggested that she was regularly sent to treatment for her use rather than through the juvenile incarceration system.

Not surprisingly, Barb reported her total years of alcohol use was 14 which was similar to the average parent respondent. When her age was taken into consideration however, her reported use was 54% of her life compared to the average of 38% for the other parent respondents. Her total years of cannabis use was 14 years, also 54% of her life, the second highest of all of the parents. Barb reported using meth also for 14 years total, which at 54% of her life was the largest percentage of the parenting group. Barb's reported years of more than one substance used per day was 14 years as well, which was the highest of all the parents in the study. She reported going to treatment seven times over her lifespan, which was by far the highest of all the parents, who had an average of one treatment episode.

Bill described growing up the youngest of four children. He lived primarily with his mother and did not have the opportunity to get to know his father until he started college. He stated his father caught his mother cheating and left when Bill was a baby. Bill described his childhood as relatively normal other than the fact that his father was

not present in his life. He attributed his turn down the drug using path on an incident in which his father assaulted him, breaking his nose. Bill stated, "*he thought I'd been drinking and broke my nose but I, I actually hadn't been drinking, I had been to the party but didn't drink. That kind of put me on a rebellious path."* Bill denied any current or past relationship issues with his mother and siblings but reported that he has no contact with his father, even though his father is a fairly wealthy doctor and is connected to Bill's older sisters.

Bill stated his introduction to methamphetamine was as a drug runner rather than as a user. He said he met two friends at school who suggested that he could go out of state and help run the drugs back to the Midwest. Initially, Bill stated the focus was exclusively on methamphetamine distribution rather than use, *"the type of people they were looking for, they weren't looking for users or people that could get them into trouble, they wanted somebody that could have a clear head and make them some money and that's where I fell in. I stayed out there three weeks, it was just like going to school, and I had to learn all about the drug. Just about anything you can think about the drug I had to learn about it and when I finished they sent me on my first trip."* Despite his success on the business side of methamphetamine sales, Bill admitted over time he began using as well, "*well, at the later ends of the trips, I started to use more even though I really wasn't into the using when I was making money."*

Bill also described using methamphetamine multiple times a day when his use was at its peak, *"right when I got up and had breakfast, depending on what Barb was*

doing or whatever, I would say I had to go to the garage or something. Then I would pull out a big old piece of foil and fill it up. I'd keep it there and in between I'd go up in and smoke some more." Bill also seemed to boast about coming up with a method of taking meth in a manner that delivered effects throughout the day, "*I came up with a capsule, like those time release capsules, and then throughout the day it would just keep kicking in and kicking in, I was a firm believer in the capsule."*

Despite his active involvement in methamphetamine and cannabis trafficking and distribution, Bill reported only one drug related criminal conviction, when he answered "1" to the question how many times in your life have you been charged with a major driving violation (not including driving under the influence). This is compared to the average parent report of 3 arrests. He did report however, being busted at one point in Mexico, but it appears as though he was never charged. It is unclear whether or not charges were pending at the time of the interviews due to the raid on his marijuana growing business. It seemed as though he may have escaped charges by becoming an informant for the police as he reported that his German shepherd had recently been killed seemingly by someone upset with his law enforcement involvement.

Bill reported the lowest lifetime history of alcohol use of all of the fathers, at only 9 years or 31% of his lifetime. This percentage was just under than the average reported lifetime percentage of all parents at 38%. For the males, the average percentage was 52%. Bill reported slightly longer cannabis use history at 10 years or 34% of his life. This was again the lowest of the fathers and just under the parent group percentage of

39%. There was no response noted on Bill's methamphetamine total years used, but from the content of his interview, it can be inferred that his use was somewhere around 8 years and 27% of his life, which is close to the parent average of 29%. Bill reported going to treatment twice in his lifetime, compared to once for the average parent in the group. It should be noted that the researcher who was completing the Addiction Severity Index with Bill responded "yes" to the questions of whether the information was significantly distorted by patient misrepresentation.

Like other parents in the study, Barb and Bill described many circumstances in which methamphetamine use had a negative impact on their parenting. Their interview comments were grouped by risk factors as previously identified by the Child Welfare Information Gateway (2013). All of the risk factors that parents spoke of are listed, and discussion is included about the similar presence or absence of risk as identified by the Browns.

Neglect: Substance use while parenting

Both Bill and Barb reported using methamphetamine on a regular basis while parenting their children. Barb initially indicated she thought the children did not know of her involvement with methamphetamine, and discussed how she attempted to keep the children from being aware of her use, *"I thought it was a bit okay because I would go to the bathroom and it had a ventilator, so the kids wouldn't be getting the effects off of it though, but I did smoke it in the same house as them."* She explained further however, that although she did not smoke or use meth in front of the children, they were likely

aware, "*I know they noticed a difference, they had to have. Especially when I took off for those weeks because like Bobby didn't want anyone else to hold him, or you know it was such a struggle with him because he was so in touch with me and everything and it really affected him."* Barb also reported being high when shopping for methamphetamine ingredients with her children, *"I dragged them from store to store . . . you knew that I was preparing to get the drug, and of course I was high."* When discussing the developmental milestones of her son Billy, Barb described the most difficult part of his first two years as, *"mother and father did meth."*

Both of the parents denied any involvement with illegal drugs of any type, at the time of the interviews. Barb specifically stated, *"We're clean now that's all that matters. I don't even smoke cigarettes anymore. I'm kind of an extremist now."*

Neglect: Prenatal exposure to substances

Barbara indicated an awareness of the dangers of using drugs while pregnant. She commented "*I didn't do meth whenever I was pregnant with them, I just smoked pot when I was pregnant with Billy and I did smoke pot at the beginning when I was pregnant with Bobby."* Barb stated that because of her previous experience of Billy testing positive for marijuana at birth, she "*knew they were going to test me again, so at about like four or five months I quit smoking pot with Bobby."* She stated that at the time she used marijuana while pregnant to address her severe morning sickness. Although Barb initially denied using meth while she was pregnant, she also commented that she inadvertently

used before she was aware she was pregnant, *"I found out I was pregnant and had done meth for two months and I didn't know."*

Neglect: Exposure to methamphetamine production

Barb admitted that part of her and Bill's meth use included production. Barb denied being responsible for the manufacturing directly, however, suggested that it was Bill's role, "*I bought pills for him. I've always been the shopper. I've never really was the manufacturer*." Bill seem to be somewhat proud of his ability to manufacture methamphetamine in broad daylight, *"I came up with a way that I could do it outside, I could be talking to outside, and it could be 10 feet from you and you wouldn't even know it."* Bill also said proud of the quality of the meth that he was able to manufacture, *"it was about how good it was and I mean I was all about the purity and the buzz."*

Neglect: Criminal activity of the parent

Barb reported that the manufacturing of meth contributed to criminal activity on her part, "*I had a retail theft for stealing pills and batteries at Walmart, luckily I just got out of that with a retail theft rather than attempting to manufacture, but that was like right in the beginning of manufacturing."* Barb stated she included the children in her shopping runs. She said, "*My kids hate Walmart to this day. I dragged them around from store to store to store, we would go to every store there was that sold pills, and all day long we would shop."* Barb reported that her criminal shopping activity was not limited to obtaining methamphetamine production precursors. She stated she also learned to run

scams on the stores getting money for returns etc. She said, *"I really ran a lot of scams at stores, took a lot of stuff back, I made more money off of that than I did the drugs."*

Barb reported limited drug dealing conducted by her and her husband. She stated, "*I didn't really sell the drugs, even his dealings were low dealings, it wasn't like you know everybody came and got it from us or that everybody came and got messed up from us for that matter, this was not a trafficking place."*

Barb also talked about how her methamphetamine use and the drug using lifestyle contributed to her acting violently in the community on more than one occasion, "*I was kind of the habitual offender, I've had disorderly conduct, and aggravated battery, anyone who looked at me wrong, I would just beat the shit out of them, that's just kind of the way it was."*

Even when Bill and Barb stopped using methamphetamine, Bill continued to grow marijuana and deal it in the community. According to Barb, this was out of economic necessity, and Bill seem to concur, "*I got into marijuana, like I told you, I've had a bum leg for a long time and when I found out that I wasn't able to work, and you know not having much money, so I got into growing my own."*

Barb was particularly concerned about the impact of the drug bust on the children. She said, *"it was very traumatizing, I didn't know what to do, they told me to get on the ground, I ended up getting on my knees. All I could do was scream my kids, my kids."* Billy, however, did not identify any memories of this instance during his interview.

Neglect: Children witnessing domestic violence

Both Barb and Bill denied any current use of physical or psychological violence toward each other either at the time of the interviews. They reported that their relationship was solid and they "cared for each other even though we disagree" and "showed respect for my partner's feelings about an issue." Barb reported that in the past she had thrown items at Bill when she was angry, kicked him, and insulted or swore at him. She also stated he had done these things to her. Bill, however, denied that either of them had used these tactics in the past and only reported positive interactions between the parents. There was no indication that the children witnessed any violence between the parents.

Neglect: Failure to meet basic needs

Barb described the conditions of their home as problematic but suggested it was their only option, "*we moved into this crappy place, and we had to, it was hell. Boards were falling in and you would have to make sure to go and press the button so you can have hot water, and hauling water from the kitchen to the bathroom whatever, I mean it was horrible.*" The researchers noted the current home was "*very dirty, the kitchen area table were cluttered so it was hard to tell if the surfaces areas were very clean, there were visible food spills that were not cleaned up trash lying around, dishes and open food containers in the kitchen and living area."* The family scored a six out of eight on the physical environment subscale of the HOME assessment which is slightly higher than the study group average of four but just under the population median of seven.

Neglect: Lack of supervision

Barb described how methamphetamine changed her mood which ultimately influenced her ability to supervise her children, "*and me being so moody and everything with the kids, you know I was not giving them undivided attention."* Bill was also concerned about Barb's ability to supervise the children when she was high and he was not around and reported that this concern was why he made the report to CPS when she attempted to leave with the boys.

Other Risk Factors: Lack of parenting ability

Barb reported that initially she felt as though the meth helped her get things done around the house and be a better parent, *"I'm thinking I am doing the trick because I can get everything done. You know everything's going to be spic and span, and everything's going to be great, but then you come down and everything's a wreck, and you're like oh crap, now I've got to go get some more dope so I can quick get this cleaned up you know."* Barb also reported that when she crashed from meth she would often sleep for days, *"for two days you know, I'd get up, eat and go back to sleep, you know that type of deal."* Barb reported that while she and Bill made sure the children's basic needs were met, they'd didn't provide other necessary parenting responses, *"but other than that you know, as for like loving, caring, nurturing, attention, they didn't really get a whole lot of that."* Barb reported that her greatest regret about using methamphetamine was its effect on her parenting. She cried while stating, "*I would just sleep and eat... I tried snapping at them, tried to keep popping in movies after movies, you know so that they would get to sleep, or you know they got to do what they wanted on those days. . . I really hate the fact*

that I missed out on a lot of the kids' stuff. I mean like when they were little and stuff there was a lot of stuff that I should have done, you know I mean I neglected them, and I hate that, that's the worst part."

Barb stated that at one point she left the home and left Bill with the kids in order to use drugs full time, "*I took off and it was all about the drugs. They kept me high the whole time and I occasionally went and seen the kids."* During this time it appears as though Bill was trying to be protective of the kids and keep them from the impact of their mother's drug use (even though he was using himself). According to Barb*, "I stopped in and he didn't really let that let me take them too much. I think I took them once or twice and I took them only where he allowed me."* Bill stated that was a turning point for him, "*what woke my eyes up was when she took off and left the kids with me. I had no problem with it, it was just that I told myself if I don't clean up, their lives are doomed."* He said it made him realize that, "*you know I can do something to myself, but there's no need to do this to my kids. Why should they have to suffer for my sicknesses and my diseases, I mean that's I wouldn't want it done to me if I was a little kid."* The ability to put children's welfare before his own seemed to be a strength for Bill that became even more solid after sobriety.

Both Barb and Bill reported that their primary focus at the time of the interviews was on being good parents. Barb specifically stated, "*My kids are my life now, I mean everything I do revolves around them, I'm trying to do everything."*

Other Risk Factors: Chaotic household

Barb reported that the family moved to six different states over the course of Billy's first three years of life. In addition to these multiple moves, Billy also changed caregivers as he was often left with relatives and was in foster care during this time.

Despite the disarray of living arrangements, as well as the lack of supervision of the children while the parents were high and/or crashing from methamphetamine use, both parents indicated a strength in this area in that they have always tried to maintain a daily structure in their family life. Barb reported that, "*he and I did the essentials you know, they got their diapers changed, and their bath, and they got their food and everything."* The researchers also noted that, "*the family has fairly regular and predictable daily schedules including meals bed time TV and homework time."*

Other Risk Factor: Lack of resources

Both parents spoke about their concerns regarding the family's lack of economic resources due to Bill's inability to work. Both Barb and Bill reported the longest full-time job they had ever held was four years, which was the average for the parent group. They also both described their usual employment pattern for the last three years as "part-time." Both parents made several comments about their difficult financial situation contributing to the marijuana growing operation. The lack of financial resources also contributed to unstable living conditions, as Barb noted, "*we get kicked out of our places because, of course, we aren't paying our rent."*

Bill reported that much of their income came from Barb's part time work as a server in a restaurant, and from food assistance programs. Barb reported working at least

some time during 20 of the last 30 days, which was the second highest of the parents in the survey. Not surprisingly, the family was just under the average of the per family member income level, reporting monthly resources of $362 per family member. Barb reported that her grandparents were often a source of support for them when they had financial difficulties.

Other Risk Factor: Cognitive/Mental health status of the parent

Although there were no comments to indicate that there was a negative impact on the children, Barb responded to the question 'do you have chronic medical problems that continue to interfere with your life' with, *"yes – bipolar."* The researchers also noted that Barb reported to them that she suffered from ongoing depression. Barb reported that she has had at least one episode of serious anxiety, and in the past had at least one period that she had trouble remembering things. Barb scored almost 1 standard deviation above normed responses on the anxiety subscale of the Trauma Symptom Checklist-40 but near the population mean on all of the other scales. Her scores on the SCL-90-R were all also below clinical concern levels. Barb reported having trouble controlling her violent behavior in the past but not in the last 30 days, and reported using tactics such as kicking or hitting with partners in the past. Barb reported a history of suicidal ideation as well as an attempted suicidal event. She states she continues to struggle with these mental health concerns and takes medication to treat them. Of the last 30 days, she shared that 15 had been problematic for her psychologically. Bill denied any history of mental health problems, but again the researcher interviewing him about these issues answered "yes" to

the question of 'is the above information significantly distorted by patient misrepresentation.' He did however score close to the population mean on all of the subscales identified on the TSC-40. There were no further comments however to indicate the exact area of concern. Bill's scores were similar on the SCL-90-R with no areas scoring above the clinical concern cutoff, but it should be noted that several scores were just under the clinical concern cutoff.

Both Barb and Bill reported educational attainment of 12 years which was the average for the parent group. They denied having any other technical skills, with Bill describing his usual occupation as a laborer and Barb as a server. Cognitively, they both scored in the average range, as did most parents in the study. There was no information that indicated that cognitive issues were a concern either in understanding the interview questions nor their parenting or other life skills.

Other Risk Factor: Child's educational progress

Barb reported that Billy Jr. developed as expected and achieved the early developmental milestones at similar ages as his peers. Intellectually, Billy scored within the normal range on the PPVT-II achieving the 61st percentile rank and a stanine score of 6, in the upper range of average.

Barb reported that initially she homeschooled Billy because the family was constantly moving around, and it was too hard to keep him in school. In addition, because the parents were manufacturing meth, Barb stated it was more convenient to home school the kids. After the parents stopped using methamphetamine, they decided it was more

appropriate to send the children to school. Barb reported that Billy has taken some speech classes at school, and that he struggles in reading class. When asked what concerns her most about Billy, Barb responded with "*I want him to get up to speed with the rest of his class."* This was despite other records in the file that indicated Billy was on par with his expected developmental level. Barb reported that Billy has a lot of friends at school and seems to enjoy spending time with his peers in a variety of activities.

Other Risk Factor: Physical health of family members

Bill reports chronic knee problems which at times has impacted the economic conditions of the family. Both parents reported that Bill's physical health problems prevented him from working and was in part the reason for his involvement in growing marijuana for sale. Despite these debilitating knee issues, Bill reported only one hospitalization in his lifetime and Barb reported none. Both Barb and Bill reported taking medications for pain however, and Bill reported that 30 of the last 30 days he experienced medical problems. Like the majority of parents interviewed, both Barb and Bill also reported substantial dental concerns, likely as a result of their chronic meth use.

Other Risk Factors: Failure to participate in recommended services

Barb reported going to rehab numerous times since she began using alcohol and drugs at age 12, *"I've been to rehab seven times, so this has been my life actually."* She also reported actively participating in the social services that were offered, "*I do go to*

counseling and I go to family education once a week… I had parenting classes, I've had relapse prevention classes, and I've had early recovery skills classes."

Ultimately Bill seemed to recognize the benefits of being involved with child protective services, "*one positive thing is we wouldn't be where we are today as a family, if we wouldn't have went through what we went through."* Bill was particularly appreciative of his involvement in Narcotics Anonymous and Alcoholics Anonymous, suggesting that connection to other people in similar circumstances helps to maintain recovery.

Summary of child maltreatment risks

Risk Item	**Risk Present?**	**Data Element Identifying Risk**	**Family Priority**	**SDM Priority**	**Omaha Priority**
Neglect: Substance use while parenting	Yes	Parent interview, child interview, ASI,	X	X	X
Neglect: Prenatal exposure	Yes	Parent interview			
Neglect: Parents involved in meth production	Yes	Parent interview			
Neglect: Criminal activity of the caregiver	Yes	Parent interview, ASI			
Neglect: Children witnessing domestic violence	No	Parent interview, researcher notes			
Neglect: Failure to meet basic needs	Yes	Parent interview, researcher notes, HOME assessment			
Neglect: Lack of supervision	Yes	Parent interview			
Physical abuse	No	Researcher notes			
Emotional abuse	No	Researcher notes			
Sexual Abuse	No	No statements were made supporting or dismissing			
Other: Lack of parenting ability	Yes	Parent interview			
Other: Chaotic household	Yes	Parent interview, Child dev. history quest., researcher notes			
Other: Lack of resources	Yes	Parent interview, ASI	X	X	X
Other: Difficulty in parent/child relationship	No	Parent interview, child interview			
Other: Difficulty in sibling	No	CBCL			

relationship					
Other: Child's behavior problem	No	CBCL, Child dev. history quest.			
Other: Cognitive/mental health status of caregiver	Yes	Parent interview, ASI, TSC-40, Shipley, SCL-90-R	X	X	X
Other: Mental health of the child	No	Parent interview, child interview, CBCL			
Other: Child's educational progress	No	Parent interview, PPVT-III, child dev. history quest.			
Other: Physical health of family members	Yes	Parent interview, ASI			
Other: Failure to participate in recommended services	No	Parent interview			

Table 5: Brown family maltreatment risks

Despite reporting heavy methamphetamine involvement by the parents, including active involvement in methamphetamine production and sales, the Brown family seems to be on a fairly positive family trajectory. They reported experiencing only 11 of the 21 risk factors identified by all the parents in the study, the least of any family reviewed. As Bill stated, "*for our kids, it was fortunate that we never took it too far, they've never been in harm. Anybody can come to our house and see that."* He in particular, seemed to provide a protective influence, especially when Barb was not in the picture. Both parents talked about having a minimum standard of parenting while they were using methamphetamine in which they made sure that their children's basic food clothing and shelter needs were met, even while admitting they lapsed in the provision of providing nurturance and parental supervision. When there methamphetamine use stopped the parents made a concerted effort to improve their nurturing and involvement with their children. At the time of the interviews, the family scored an eight out of 10 on the emotional climate subscale which was higher than even the population median of seven. Indeed, one of the researchers noted, "*There was a distinctive feeling of togetherness*

within the home as is witnessed in their joking around with one another in the parents' positive regard of their children."

It seems as though this family camaraderie and the relatively small portion of the children's lives may also have contributed to positive outcomes. At the same time, given Barb's significant drug use history and mental health concerns, as well as the family's precarious economic situation, it seems as though the family will have to be very vigilant in guarding against relapses that may have a more significant negative impact on their ability to effectively parent their children.

Child protective services response

The Brown family scored in the high risk category on the neglect scale and low on the abuse scale on the SDM. The following chart shows the items on the SDM Risk Assessment Tool for which they received a point. Scores up to 2 indicate low risk, between 3 and 5 indicate moderate risk, and six or above indicate a high risk for future maltreatment (Children's Research Center, 2012).

Neglect	**Abuse**
Current report is for neglect Number of prior assigned reports Number of children in the home Age of primary caregiver Either caregiver has/had an alcohol or drug problem during the last 12 months. Primary caregiver has/had a mental health problem	Primary caregiver lacks parenting skills Primary caregiver has/had a mental health problem
Score = 6 High Risk	**Score** = 2 Low Risk

Table 6: Brown family SDM risks

Given the score of high risk on the neglect scale, the child protective service agencies would usually be required to open a case and offer services. It should be noted however that at least 4 of the 6 items on the neglect scale are issues that the family will

not able to change, which might be considered a concern about the SDM tool. The Strength and Needs Assessment tool would then be utilized to determine where to target the required interventions. There is one section completed for the parent and one for each child. For the purposes of this study, only the child that participated in the study was assessed. The Strength and Needs tool assigns a numerical score for the presence or absence of each item as it relates to the risk of further maltreatment. Some items are more highly associated with future maltreatment risk and thus receive lower scores. Scores on each item above 0 are generally considered a strength, while scores below 0 are generally considered a risk (Children's Research Center, 2012). For the Brown family the scores were as follows:

Caregiver Strengths
Household Relationships (+3)
Social Support System (0)
Physical Health (-2)

Caregiver Needs
Alcohol and Other Drug Use (-5)
Resource Management/Basic Needs (-5)
Mental Health/Coping Skills (-3)

Child Strengths
Physical Health (0)
Education (0)
Family Relationships (+3)

Child Needs
No needs were identified

According to the above measures, child protective services should focus on the Alcohol & other drug use problem of the parents, the basic needs of the family, and the mental health/coping skills of the mother. This seems to be in line with the issues the family identified. As with the Abbott family however, some of the strength categories were actually need categories that simply had the highest scores. For this family, the Omaha system intervention plan would put less emphasis on the substance use of the parents (their KBS scores did not indicate a need for a priority response). Instead, the

mental health of the parents and the Income needs of the family were identified as the top priorities for intervention.

Domain: Health Related Behaviors		
Problem: Substance Use (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Uses street – recreational drugs • Buys/sells illegal substances	**<u>Intervention Scheme</u>** **Category: Case Management** **Targets and Client-specific Information:** • Support group (age and condition specific group) • Legal system (referral to legal assistance organizations) • Dental care (coordinate evaluation and refer for services) **Category: Surveillance** **Targets and Client-specific Information:** • Laboratory findings (urine screen) • Signs/symptoms (mental and physical)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 5 - Adequate knowledge (knows treatment options, understands the danger of substance use to self and others) **Behavior:** 5 – Consistently appropriate behavior (reports no use of substances) **Status:** 4-Minimal signs and symptoms (Uses treatment options, meets most family obligations)
Domain: Psychosocial		
Problem: Mental health (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Somatic complaints/fatigue • Loss of interest in activities • Mood swings • difficulty managing stress • difficulty managing anger	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • coping skills (adjustment to illness, crisis intervention) • support group (emotional support) **Category: Case Management** **Targets and Client-specific Information:** • psychiatric care (schedule appointment, coordination among providers,	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 3-basic knowledge (aware that symptoms are a sign of a disorder and impact about illness on life) **Behavior:** 2-Inconsistently appropriate (attends therapy

	transportation services)) **Category: Surveillance** **Targets and Client-specific Information:** • Continuity of care (coordination among providers)	inconsistently) **Status:** 3-Moderate signs and symptoms (occasionally depressed, increased awareness of self and others' needs)
Domain: Environmental		
Problem: Income (high priority) **Problem Classification Scheme** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Low/no income • Difficulty buying necessities	**Intervention Scheme** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Community Resources • Comprehensive analysis and action plan **Category: Case Management** **Targets and Client-specific Information:** • Community resources (coordination among providers, transportation services) • Charitable organizations	**Problem Rating Scale for Outcomes** **Knowledge:** 3-Basic knowledge (identifies some sources of assistance) **Behavior:** 3-inconsistently appropriate (is interested in idea of budget, uses only one assistance programs) **Status:** 3-Moderate signs and symptoms (has utilities but no consistent source of income)

Table 7: Brown family Omaha System application

The first problem area prioritized by the SDM was the mental health needs of the mother. Barb described feeling *"like a mess"* due to her bipolar diagnosis as well as other mental health concerns. In evaluating her progress however, she seemed to be doing fairly well, with the exception that she reported only attending therapy sporadically. It seems that some initial monitoring of maintenance efforts and providing support options would be most effective in improving her situation.

The family resource needs are also targeted for intervention as this is another problem area prioritized by both the SDM and the parent. While the family is currently minimally paying their bills, the mother reported they are unable to move to safe housing due to lack of income, and the father was growing marijuana as a way to make ends meet.. The mother is working part time and has some income, but the father is not currently employed. Given the low income level of the family, it seems they should be eligible for more public assistance or charitable program than they reported using. These areas were identified on the Omaha pathways, the goal would be to connect the family with resources that improves their financial situation so they are able to move into safer housing.

The Carter Family

The Carter family consists of Carol (31) and Charlie (40) and their 3 children, Carrie (11), Caleb (8), and Cody (4). The family became involved in child protective services after Charlie got frustrated with his wife's drug use and lack of parenting ability, and he contacted CPS asking for help. Carol said, "*He took it upon himself to call CPS because I went in a car and I almost killed myself . . . I cross addicted from meth to pain killers."* Charlie reported the reason for his call was, "*she was staying with a friend and she had all the drugs she ever wanted so all she'd have to do is go over there and get whatever she needed. I got a little tired of that so I told her that I was taking Cody and we were going. Well, at the time we weren't married, so I could not legally take Cody. I was staying with my mother and then I found out that she had a friend of hers who was a*

crack addict too, and I found out she'd been hanging out there and smoking crack with Cody with her at the time so I called CPS and filled them in on the situation and they opened the case and made it to where she couldn't be alone with Cody." Carol reported that as a result of the current CPS involvement, the children have been placed out of the home and into the care of her mother although there is no current court order requiring the children to stay in care. Charlie confirmed that they have voluntarily agreed to let the children stay with her mother, "*voluntarily let the kids go and stay there because there's still a little bit of a problem with the painkillers."* In addition to the current involvement, Carol reported previous CPS involvement when Carrie was a baby. She said she became homeless and contacted CPS in order to get help finding a place to live. While Carol reported, *"we've cleaned up on everything"* it should be noted that the researchers commented that *"the mother in this interview sounded as if she were under the influence of drugs most likely painkillers."* This seemed to be corroborated with Charlie's previous statement that he believes Carol still occasionally is using painkillers.

Like many of the parents in the study, Carol reported that her dad and her stepmother were heavily involved in drug use. She stated, "*They were involved with the cooking as well as using.*" Carol said her father was a trucker and so he took speeders and other amphetamines. She denied that her mother used substances. Carol reported that her mother abandoned her by leaving her with her father while taking her sister and moving out of state. Carol's mother then showed up six months later to pick up Carol and take her out of state. Carol stated that as a result, she acted out and ended up in foster care. She

said, "*we didn't hear from her, see her or nothing for six months and then I'm made to move with her and I ran away. I had a lot of resentment toward my mother for a lot of years actually, I don't think I ever forgave her for what she did until I was in treatment and learned a lot more about forgiveness and you know how what you're holding inside can cause, you to relapse."* Carol said it was these experiences, as well as her father and stepmother's drug use that contributed to her initiation into the drug culture.

Carol also reported that her mother, father and sister were especially supportive of her when she went to treatment and when she got out and needed to restart her life. She stated that she no longer talks much to her sister, despite reporting that she monitors visitation between the children and their father and also seems to check up on how Carol is parenting her children. Carol explained the tension and her relationship with her sister, "*she's nosy, and she don't know how to mind her own business, stay in her own family and instead is poking around in mine."* Carol answered 'no' to the question of whether she feels she has had a long lasting personal relationship with her mother, and yes to the same question about her father and siblings.

Carol stated her first drug use was at age 14 when she started using marijuana. She said she also used alcohol and tried other drugs such as acid during that time. She reported being about 20 when she used methamphetamine for the first time. When asked about her first experience with methamphetamine, Carol responded, *"I was introduced to it years ago, I had been clean for a couple years and then Charlie and I got together and he was using meth, so then I started using too."* Carol reported one of the main reasons

for using methamphetamine was that it was better than any other drug in giving her energy, "*with meth, it is like one of the best highs ever because you either snort a line or smoke a bowl or smoke a foil, it just gives you 50 times more energy."* During the interview when Carol was asked to talk about the positives or negatives during her experience with meth she replied, "*oh my goodness, most of it was good, except while the kids were gone, I stayed up for seven days. I hallucinated, I thought somebody raped me, and they had to call the ambulance on me and everything and get the cops out there."* She further explained, "*There really isn't any part of methamphetamine use that affected me negatively. Ever since we quit using it's like we don't have any energy or any umph to get us going."* Carol reported that she used meth for approximately 10 years or 32% of her life which was slightly more than the parent average of 29% but similar to the average for the women only at 31%. Carol reported that in addition to methamphetamine, she was also "*highly addicted to narcotic pain relievers*." Carol reported that she was still struggling with this addiction at the time of the interviews, "*right now, you know I've been to rehab, but I can't honestly say that if they were put in front of my face I could say no."* She stated further, *"I don't go a lot of places because if I don't run into the narcotics, I don't take them."* Carol reported only 2 years of her life using alcohol or 6% of her lifetime compared to 38% for the parent group as a whole and 30% for all of the women. Carol also denied being addicted to marijuana stating, "*I tried weed but we just made me want to eat and does put me to sleep, it wasn't something I*

enjoyed." She reported that her lifetime marijuana use was about 1 year, or 3% of her life compared to the parent group average of 39% and 32% for only the women.

Charlie reported growing up relatively poor and being primarily raised by his mother. He reported that she used prescription amphetamines and drank sometimes. He said he has been told by others that his father drank fairly heavily and also occasionally used acid. Charlie attributed both his parents' substance use to the drug culture of the 60s and 70s, and denied it had any negative impact on him. Charlie answered 'yes' to the questions of whether he has had a close personal relationship with his mother and siblings and not applicable to the question about his father. Charlie reported that the first time he used crystal meth was during his senior year of high school at his graduation party. When asked to describe this experience further he reported, "*I was a big drinker too, so I really don't remember much about that part but I know it was Hells Angel stuff from out west that was made with jet fuel and all that stuff."* He reported that it was another couple years before he used again stating, "*my friend had an uncle that was dealing so he had access to it all the time and that's actually when I fell in love with it."* When asked why he liked it he said, "*I've always been a rather large person and it started taking the weight off me and I got down to where I wanted to be and I guess by that time I just like it so much I just using it and actually the attention that I got with the girls and stuff, it's an awesome aphrodisiac."* When asked if there was anything negative about using methamphetamine, Charlie replied, "*I really didn't see anything about it then, like I told you I was a drinker and a partier, I'm an alcoholic too, so I have the whole spectrum*

there.“ Charlie stated that he eventually got involved in manufacturing meth, *“I hooked up with another guy and that’s when I started cooking this stuff, me and him because he lived just across the street and we cooked in the house in the projects you know. . . And well I was doing meth and I didn’t have any other ambition but finding that next high.”* Charlie reported that even after he left that situation he continued to use meth regularly even when he was employed as a cabinetmaker, “*I build cabinets and I was doing meth at work. We would take our 10 o’clock break and smoke a pipe, go to lunch and go out to smoke a pipe, 2 o’clock break go out and smoke up pipe then from the time you get off from the time you go to work the next day you get up and I’m smoking meth.”* Despite reportedly not using meth for over three years, Charlie reported, “*I still taste it, I dream about it, still wake up with the taste in my mouth and that’s a big part of it too, it tasted so good when you smoked it.”* Charlie reported using methamphetamine for 10 years total or 25% of his lifetime, compared to the average parent in the study at 29% and the average for the men in the study at 24%.

Carol reported and Charlie confirmed to the researchers that he continues to smoke pot and has been open about this fact with the CPS social worker. Carol said that “*the pot has never interfered with his ability to care for the children and so . . .he will continue to use.”* Charlie reported using marijuana for 21 years of his life or 52% which was essentially the same as the average for the men in the study, but higher than the all parent average of 39%.

Charlie denied using much alcohol once he got involved with methamphetamine, suggesting, "*methamphetamine actually weaned me off of alcohol to be honest I don't know how or why but I just preferred it over alcohol."* At the same time he also reported significant negative effects of his years drinking. Charlie reported that he had two DUIs and three driving on a revoked license arrests. He said that although he has occasionally had a drink since then for the most part he avoids alcohol stating, "*I decided that I didn't like the hangovers anymore, and then I got together with her and it was about the meth just getting high and then my favorite part of meth with the sex."* Charlie reported drinking for 21 years or 53% of his life. This was higher than the parent average of 38% but in line with the average of 52% for the men in the study.

Unlike many other parents in the study, Carol and Charlie described feeling as though their use had a primarily positive impact on their parenting ability. At the same time, they also described situations in which their methamphetamine use contributed to situations that are recognized as risk factors according to the Child Welfare Information Gateway (2013) descriptions.

Neglect: Substance Use by Caregivers or Other Household Members

Carol reported at the peak of the parents' methamphetamine addiction they were using every single day. She said, "*It was crazy because everyday life revolved around the drug. You know you could be cleaning your house and doing laundry and go to your bedroom and smoke a little more and go back to cleaning or doing laundry and go to your bedroom and do a little more and that was our daily life."* Carol denied that the

children ever seem to be specifically aware of their methamphetamine use however she stated that Carrie in particular was attune to changes in the schedule when she was using most heavily, as Carol often stayed up all night and Carrie would ask her about it, "*the one thing that bothered me the most was if I stayed up all night, she could always tell and she would ask me, mom did you go to bed last night? And I told her a lie and I'd say no, I slept, well she knew better, she wasn't stupid."* Carrie confirmed that she knew her mom was using methamphetamine during her interview. When asked if methamphetamine use was something she experienced or knew anything about, Carrie replied, "*I don't know anything about it but I know that my mom has used it because they use to use it to stay up late."* She said she also knew because her parents acted, "*grouchy, like they would tell us to clean the house, and then they wouldn't help."* Carrie indicated she would try to avoid her parents when they were using, she would "*go outside or if they were awake I would just go back in the back bedroom and go to sleep."*

Carol reported that since she has been sober, Caleb has indicated a concern about her return to drug use, "*Caleb, he was so scared that I was going to use pills again that when I got out of treatment, he started acting crazy and really funny when I take my regular prescription medicine, and you know Charlie had to reassure him that that was my medicine, and I wasn't taking anybody else's. I had to do a lot of assuring to both Carrie and Caleb but Caleb more than anybody."* Carol admitted that when they were using, *"you know we didn't spend a whole lot of time with our kids at all."* She said, *"I didn't really think anything about it because at that time it was just routine (to use)."*

Charlie also denied that they smoked methamphetamine in front of any of the children. He said usually he would smoke in the bedroom, *"I have a picture one time of me sitting on my bed, Carol took a picture of me smoking a foil and I had three other ones sitting right in front of me ready to go."* He did however try to keep his use away from the children saying, "*I was always hiding from, from the kids or whoever."*

Carol reported that Charlie continues to smoke pot however she does not allow him to do so at home or in the presence of children. Instead, he uses at a friend's house. Charlie admitted to the researchers that he continues to use marijuana, but does not see himself having the same issues with it as he had with methamphetamine.

Neglect: Prenatal Exposure to Substances

Carol reported that she had been using meth for approximately five years when she got pregnant with Carrie, and continued to use even though she was pregnant. She said, "*I mean I didn't use the whole time I was pregnant, but I did use, no more than five times probably, but I did use."* Carol reported that she stop using methamphetamine when she found out she was pregnant with Cody and then primarily took up using pain pills after his birth.

Neglect: Exposure to Methamphetamine Production

Carol reported that although the children were never directly exposed to methamphetamine production, they did have some exposure to the environmental hazards in their home and vehicle, "*Charlie and I had quite a bit of meth because we never had to pay for it because we would either store it in an anhydrous tank in the closet in our*

apartment or let them (the manufacturers) use our car to go out into the country and make it whatever." Charlie also admitted to storing the anhydrous tank in the bedroom, saying that whenever they ran out of meth, "*you start chasing the next buzz, or in my case, I would get the anhydrous tank out of the closet, go and take it across the street and hook it up again, and we get the materials to (make some more)."* He also reported that while he didn't produce any methamphetamine in his own home with the children present, there were children around his production, "*the people that I would make it with had two kids and we would do it late at night when they were in bed, but it was in the same house with them you know. I never really felt right about it, but it wasn't enough to make me stop."* It seemed as though he was aware of the risk to the children but was unable to put their needs before his own.

Neglect: Criminal Activity of the Parent

Both parents denied currently being on probation or parole. Carol reported that she had a total of 4 lifetime arrests, for shoplifting, burglary, and forgery; which is just slightly more than the parent group average of 3. Carol reported that one of the reasons the children ended up in her mother's care was that at the same time Charlie reported her to child protective services, "*I went to jail for nine forgeries and I spent 52 days in jail."*

Charlie reported having been arrested a total of 7 times, with 5 of those for alcohol related offenses. The other two were for robbery and a probation violation. This was the highest number of arrests for all of the men, and more than twice the parent

average of 3 arrests. There was no report however that any of Charlie's arrests or criminal activity had any impact on the children.

Neglect: Children Witnessing Domestic Violence

While there is no information to indicate that domestic abuse occurred between the parents, Carol reports that their relationship was particularly strained during the period in which her husband had stopped using methamphetamine and she continued to use meth and other drugs such as cocaine and pain pills. She said, "*we would argue about my pills and my friend, because I would bend over backwards to do what I needed for her because there were always free pills and free-market narcotics available."* It was this continued drug use by Carol in fact that concerned Charlie so much he contacted child protective services for help intervening. Carol also admitted that when she was coming down from her methamphetamine highs, "*I was hell when it came to Charlie, because I had a big time crash. It was always, it wasn't always, but I was grouchy a lot."*

Charlie also reports struggling with fits of rage that were often directed at Carol however he denies any domestic abuse saying, "*I've always, I always controlled it, I never touched Carol. . . It was always more verbal."* The scores on the Conflict Tactics Scale 2 for both parents were lower than the group average for negotiation, but near the group average for psychological aggression. They both scored 0 for physical assault. This seems to confirm Charlie's report that they often get into verbal altercations but that it does not rise to the level of physical abuse toward each other.

Neglect: Failure to meet basic needs

Carol reported that during the height of her methamphetamine use, "*we had meth every day, so we were up cleaning, going through things, just, our house was immaculate at all times, I mean it was spotlessly clean, laundry was always done in."* Since stopping her meth use, Carol admitted she had trouble finding the energy to clean things up around the home. This lack of cleanliness was reflected in the scores on the HOME assessment. The family scored a 4 on the physical environment subscale, which was the average score for the study group but under the population median of 7. The home was described by the researchers as "*substandard and in a very poor neighborhood. It was very small, with no pictures on the wall and having minimal furniture."* They answered 'no' to the question of whether the child's outside play environment appeared safe and free of hazards. They said the home was "*very unclean and extremely cluttered with things lying on the dining room table as well as throughout the home. The dining room table and chairs were not in good condition and instead of a living room sofa, there was a mattress taking up most of the floor."* In addition, the researchers noted that there were almost no learning resources such as reading materials in the home. In fact, the learning materials subscale score on the HOME was only 2 out of 8, the lowest score the family received.

Neglect: Lack of Supervision

Carol reported that when she was high on narcotic pain pills, she would "*get so spun out on pills, I would sleep a lot, stay up all night, and then sleep a lot during the day, Carrie knows all about it, I mean she watched Cody while I was asleep and Charlie was at work, that was pretty much it, every day for a long time."*

Emotional Abuse

While there were no reports of emotional abuse of the children by the parents, the researchers did note the lack of emotional interaction between the parents and children. The interactions were described as very flat and cold.

Other Risk Factors: Lack of Parenting Ability

Carol reported that she felt as though her parenting was much better during her meth addiction then during her sobriety, "*when I was using, I was an excellent mother, my children, I don't know why but they came first, I would make sure they had food morning noon and night, they had clean clothes, I would do her hair before school, they were bathed every night, it was weird because I had all the energy to do that, but now it's like it's just a chore and it has been since we stopped using."* Carol also reported that the methamphetamine side effect of paranoia also contributed positively to her ability to parent, "*a lot of it has to do with paranoia too, about getting paranoid that somebody sees your kids like that and what are they going to think about what kind of parent you are."* Carol did admit however that when she was crashing from her methamphetamine use that Charlie was the one who had to get the kids up and ready for school. She said, *"I slept from, I would crash and sleep all night and probably half the day."* She also said she thinks her pill addiction was a greater problem and may have contributed to poor parenting. She said, *"I think it took a toll on her (Carrie) because like I said she was changing his diapers, feeding him, and taking care of him while I was passed out."*

Charlie described being more conscientious of his methamphetamine use when he was parenting, "*I always knew when it was time to go to bed, I would sleep it off at night and get up the next day after doing that, I get something to eat and make sure the kids go off to school and actually for a while my son was waking me to go up to work too."* Charlie also reported feeling that his marijuana use contributed to improved parenting ability on his part. He responded to a question of whether marijuana negatively impacted his parenting with, *"*no*, not at all, I'm sure there are people who would disagree, it makes me more nurturing."* Finally, Charlie reported that if he really needed help, rather than putting the kids in danger, he could count on his mother for help, "*I guess I've always gone someplace where I knew somehow I always had somebody to . . . help take care of the kids."*

The researchers observed a few concerns in the area of parenting ability, indicating that perhaps the parents may not be aware of some of their shortcomings, or as the parents suggested, their parenting ability was worse when they were no longer using. The researchers answered 'no' to the question of whether the parents set limits for the child and generally enforce them. Similarly, they answered 'no' to the question of whether the parents were consistent in establishing or applying family rules. They also noted that there did not appear to be an adequate supply of healthy food for the children, observing that the only visible food items were sugary cereals and other types of junk food.

Other Risk Factors: Chaotic Household

Carol reported that Carrie moved between 6 different states during her first 3 years of life. In addition, Charlie reported that he and Carol split up regularly, usually because they would get into fights over her drug use, "*there was always cops involved and this and that, I don't know how many times I put her stuff out on the back steps and told her to leave."* He reported and Carol confirmed that the parents would regularly move in and out of the home, staying with friends or family members.

Other Risk Factor: Lack of Resources

Carol reported having achieved a GED and a driver's license that she could use to obtain employment. She reported her longest tenure at a full time job was 1.5 years, which is the second lowest of all the parents in the study and less than half of the average of all parents. She reported being currently unemployed and receiving public assistance for support.

Charlie reported having graduated from high school and being a skilled cabinetmaker. He admitted that he no longer has a vehicle nor a driver's license due to his numerous drinking and driving related offenses. Of all the parents, Charlie reported the second longest tenure at a full time job at 10 years. He said his most recent employment was as a fence builder but was currently unemployed, and was receiving unemployment compensation.

As a household, the parents reported income from unemployment compensation that Charlie receives and public assistance that Carol receives. The monthly income per family member is $233 which is almost $150 per month less than the average household

in the study. As a result, Charlie reported that financially the family often struggles to get by, and it sometimes gets to the point where they may not have money to pick up the kids for a visit, "*We'd like to get them every weekend if we could get the gas money to go get them, her mom's pretty good about it if we don't have the money she will bring them down."*

Carol reported getting significant emotional and caregiving support from her family when child protective services became involved. She said, "*when I was in treatment and I got out my whole family supported me so that helps my mom all my are at the time, would call me every day, and ask doing you know are you doing okay, do you need anything and things like that. My family didn't do that before so it made me actually feel really good."*

Charlie also reported that his mother was particularly helpful when he separated from Carol and when he was taking care of his older sons from a previous relationship. He stated that even when he was unable to parent effectively, his mother was able to step in and compensate.

Other Risk Factors: Difficulty in Parent/Child Relationships

Carol responded to the question of 'what concerns you most about your child?' with *'there is no communication about what is on her mind."* There was no specific difficulty in relationships identified, however the researchers noted that while the parents seemed to be accepting of the children, there did not seem to be a particularly nurturing relationship. The researchers answered "no" to the question of whether they observed the

parent conveying positive feelings when speaking to the child. They also noted that the emotional climate of the home was disconnected, there were no observations of warm or loving contact between the family members. The researchers noted, "*The family was extremely poor economically and emotionally."*

Other Risk Factor: Cognitive/Mental Health Status of the Parent

Both Carol and Charlie scored within the normal range of intelligence, with T-scores of 50 for both of them on the Shipley Assessment. They both also had higher scores on the abstraction part of the test than on the vocabulary portion.

Carol reported suffering from depression and taking medication, however she questioned the medication effectiveness, "*since I've been diagnosed with MS it just seems not to be, I go back to see my psychologist because I'm just a mess."* She also reported having disturbing dreams on a regular basis but did not know if it was due to the methamphetamine use or the multiple sclerosis. She denied ever having been hospitalized for a psychological concern, and having been treated on an outpatient basis twice in her life. Carol also denied any current anxiety, but answered yes to having experienced anxiety in the past. She also denied any significant periods of experiencing hallucinations, having trouble understanding, or controlling violent behavior. Carol also denied having thoughts of, or attempting suicide. Carol scored near the population mean on the dissociation, depression, sexual abuse trauma, sleep disturbances, and sexual problems subscales on the Trauma Symptom Checklist, but similar to other parents in the study, scored more than one standard deviation above the population mean on the anxiety

subscale. Carol's scores on the SCL-90R indicate levels of clinical concern for the subscales of somatization, depression, anxiety, psychoticism, and global functioning, with somatization concerns being the most significantly elevated score.

Charlie reported taking medication for depression and to help him sleep. He also said the medication is also intended to help him with feelings of rage that he has struggled with even when he was using methamphetamine. Charlie reported that he has never been hospitalized for a psychological problem but has been treated on an outpatient basis three times in his life. He reported having previous problems with depression and current and previous problems with anxiety. He said he also has current and previous problems with remembering and concentrating, but denied having any trouble controlling violent behavior. He said he has had previous thoughts of suicide but not current thoughts and has never attempted suicide. Charlie scored near the population mean for the subscales of sexual abuse trauma, sleep disturbances, and sexual problems on the Trauma Symptom Checklist-40, but more than one standard deviation above the population mean for Dissociation, Anxiety and Depression. Of the men in the study, Charlie's scores were the most elevated. Charlie's similar scores on the SCL-90R indicate levels of clinical concern for the subscales of obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, phobic anxiety, paranoid ideation, and global functioning, with depression and phobic anxiety concerns being the most significantly elevated scores. It should be noted that the researchers observed and

documented a concern for his current mental health status and recommended during the interview that he consider returning to his treating physician for a checkup.

Other Risk Factor: Physical Health of Family Members

Carol reports that she has been diagnosed with multiple sclerosis which she identified as one of the few negatives about her methamphetamine use, "*Now that I have multiple sclerosis it is a real, it's a chore to take care of my children and it doesn't make me happy for sure."* When asked if her doctors have attributed her multiple sclerosis to her methamphetamine use Carol replied, "*they don't know about me using, but what my mother has told me is that there are cases of people that have a MS and I guess they pointed to their addiction with meth."* Carol further identified a consistent lack of energy that she felt was related to stopping the use of methamphetamine, "*I would like to know the reason why we just are, just dead, no energy and no umph."* Carol reported having headaches often as well. She reported being hospitalized twice in her life which was the same as the median for the parent group. She also reported that she takes medication daily to address her physical ailments, but denied being considered disabled. Like many of the parents in the study, Carol also reported having significant dental concerns as a result of her chronic methamphetamine use.

Charlie reported having a similar lack of energy even though he has not been diagnosed with multiple sclerosis. He said, "*I have a problem with our motivation, I can get my motivation up at all since I stopped and stop using it's like I don't have any energy,"*

Charlie also conveyed that since he stopped using methamphetamine he has gained over 140 pounds which contributes to some health issues for him. He stated he has been hospitalized for physical ailments 4 times is twice as high as the median for the parent group. He reports taking medication on a regular basis for a physical health problem, but denied being disabled. Unlike most of the parents in the study, Charlie was only one of two parents who reported having no dental concerns.

Other Risk Factors: Participation in Recommended Services

Carol reported trying to see her psychiatrist on a regular basis but at this time is only able to see him infrequently. In between these visits, she often asks for additional time, "*I know if I call his nurse and tell her exactly how I'm feeling that day, she will work me in and so I know that I don't have to worry about waiting if I need to go that day."* Carol also reported having completed treatment for drug abuse once in her life, but during other parts of the interview indicated she still occasionally uses pain pills.

Charlie reported that he quit using methamphetamine on his own as opposed to going to treatment. He did however report talking with his doctor about his use. He said that he attended treatment for alcohol abuse twice, but ultimately made the decision to quit using on his own and not as a result of treatment. He admits to occasionally drinking but reported it happens rarely.

Summary of child maltreatment risks

Risk Item	**Risk Present?**	**Data Element Identifying Risk**	**Family Priority**	**SDM Priority**	**Omaha Priority**
Neglect: Substance use while parenting	Yes	Parent report, child report, ASI		X	X
Neglect: Prenatal exposure	Yes	Parent interview			

Neglect: Parents involved in meth production	Yes	Parent interview			
Neglect: Criminal activity of the caregiver	Yes	Parent interview, ASI			
Neglect: Children witnessing domestic violence	No	Parent interview, Conflict Tactics Scale 2			
Neglect: Failure to meet basic needs	Yes	Parent interview, HOME assessment, researcher notes			
Neglect: Lack of supervision	Yes	Parent interview			
Physical abuse	No	No mentions			
Emotional abuse	No	Researchers notes indicated only that parents were "cold"			
Sexual Abuse	No	No mentions			
Other: Lack of parenting ability	Yes	Parent interview, researcher notes,	X		
Other: Chaotic household	Yes	Parent interview			
Other: Lack of resources	Yes	Parent interview, ASI, Shipley	X	X	X
Other: Difficulty in parent/child relationship	Yes	Parent interview, researcher notes, Child dev. history quest.			X
Other: Difficulty in sibling relationship	No	CBCL			
Other: Child's behavior problem	No	CBCL			
Other: Cognitive/mental health status of caregiver	Yes	Parent interview, ASI, Shipley, TSC-40, SCL-90-R		X	X
Other: Mental health of the child	No	Parent interview, TSCC			
Other: Child's educational progress	No	Parent interview, PPVT-III, Child dev. history quest.			
Other: Physical health of family members	Yes	Parent interview, ASI, SCL90-R			
Other: Failure to participate in recommended services	Yes	Parent interview, researcher notes			

Table 8: Carter family maltreatment risks

Of the families reviewed in depth, the Carters seem to be on the most precarious footing for returning to drug use. First, they are already continuing to occasionally use substances–Charlie with marijuana and Carol with pain pills. Second, they are the only parents in the study that described feeling as though ultimately their lives were better when they were using meth vs. not using meth. Both of the parents are struggling with

major mental health concerns, and Carol in particular is struggling with the physical problems associated with multiple sclerosis. The Carters reported having elements of 14 out of the 21 risk factors identified by all the families, which was close to the average and median of 15 for the families in the study, yet they seem to be at the greatest risk.

The parental dysfunction does not appear to have a significantly detrimental impact on the children. None of the children were reported to have severe behavioral or mental health concerns and in fact, Carrie seems to be doing better than most behaviorally. While Carrie seems to be struggling in school, she is within the normal range of functioning. This is despite the fact that Carol reports having used while pregnant with Carrie.

Child protective services response

The Carter family scored in the moderate risk category on the neglect scale and moderate on the abuse scale on the SDM. The following chart shows the items on the SDM Risk Assessment Tool for which they received a point. Scores up to 2 indicate low risk, between 3 and 5 indicate moderate risk, and six or above indicate a high risk for future maltreatment (Children's Research Center, 2012).

Neglect	**Abuse**
Current report is for neglect Number of children in the home Either caregiver has/had an alcohol or drug problem during the last 12 months. Primary caregiver has/had a mental health problem	Primary caregiver lacks parenting skills Primary caregiver has/had a mental health problem Number of children in the home
Score = 4 Moderate Risk	**Score** = 3 Moderate Risk

Table 9: Carter family SDM risks

Given the score of moderate on the both scales, this family case would be optional for opening. Because the father in the family actually contacted CPS due to his belief that the children were being neglected due to the mother's continued drug use, it seems likely that most child protective services agencies would open a case, or at least refer the family to other community agencies for voluntary services. It is interesting to consider the family's lower risk scales because in reading the interviews, this researcher considered this family to be one of the two families at greatest risk for further neglect, in part because of the parents continued moderate drug use as well as their descriptions of having more energy for parenting when they were using methamphetamine. The Strength and Needs Assessment tool would then be utilized to determine where to target the required interventions. There is one section completed for the parent and one for each child. For the purposes of this study, only the child that participated in the study was assessed. The Strength and Needs tool assigns a numerical score for the presence or absence of each item as it relates to the risk of further maltreatment. Some items are more highly associated with future maltreatment risk and thus receive lower scores. Scores on each item above 0 are generally considered a strength, while scores below 0 are generally considered a risk (Children's Research Center, 2012). For the Carter family the scores were as follows:

Caregiver Strengths
Social Support Systems (-2)
Parenting skills (-1)
Physical Health (-2)

Caregiver Needs
Alcohol and Other Drug Use (-5)
Resource Management/Basic Needs (-5)
Mental Health/Coping Skills (-4)

Child Strengths
Physical Health (0)
Education (0)

Child Needs
Family relationships (-2)

Family Relationships (+3)

According to the above measures, child protective services should focus on the Alcohol & other drug use problem of the parents, the basic needs of the family, and the mental health/coping skills of the parents. It should be noted that like the Abbott family, the caregivers scored below 0 in all categories and yet the "highest" scores are considered "strengths." This again provides a misleading perception of how the family is functioning. In particular, the mother reported being diagnosed with multiple sclerosis, and yet physical health was an area that was scored as a strength.

Using the SDM prioritized needs of Alcohol and drug use, Resource management, and Mental Health, the Omaha system intervention plan is shown below.

Domain: Health Related Behaviors		
Problem: Substance Use (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Uses street – recreational drugs • Abuses prescription drugs • Buys/sells illegal substances	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Behavior modification (motivate change, decrease/stop street drug use and prescription drug use) • Coping skills (strategies to deal with behavior triggers, strategies to support behavior/lifestyle change) • Medication action/side effects (important to take as prescribed, purpose/benefits) **Category: Case Management** **Targets and Client-specific Information:** • Support group (age and condition specific group)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 2 – minimal knowledge – knows some dangers of substance use and some treatment options **Behavior:** 3 – Inconsistently appropriate behavior (variable use of drugs) **Status:** 3 – Moderate signs and symptoms (Uses treatment options sporadically, meets some family obligations)

	• Nursing care (evaluation, schedule services) • Dental care (coordinate evaluation and refer for services) **Category: Surveillance** **Targets and Client-specific Information:** • Laboratory findings (urine screen) • Signs/symptoms (mental and physical)	
Domain: Psychosocial		
Problem: Mental health (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Somatic complaints/fatigue • Mood swings • difficulty managing stress • difficulty managing anger	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • coping skills (adjustment to illness, crisis intervention) • support group (emotional support) • Medication action/side effects (purpose/benefits, important to take as prescribed) **Category: Case Management** **Targets and Client-specific Information:** • psychiatric care • medical/dental care • individual therapy (schedule appointments, coordination among providers, transportation services) **Category: Surveillance** **Targets and Client-specific Information:** • Continuity of care (coordination among providers)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 2-Minimal knowledge (aware that symptoms are a sign of a disorder but does not understand the impact of the symptoms) **Behavior:** 2-Inconsistently appropriate (attends therapy and medical appointments inconsistently) **Status:** 2-Severe signs and symptoms (talks about depression and other fears, does not express current suicidal thoughts)
Domain: Environmental		
Problem: Income (high priority)	**<u>Intervention Scheme</u>**	**<u>Problem Rating Scale</u>**

<u>Problem Classification Scheme</u> **Modifiers: Individual and Actual Signs/Symptoms of Actual:** • Low/no income • Difficulty buying necessities	**Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Community Resources • Comprehensive analysis and action plan **Category: Case Management** **Targets and Client-specific Information:** • Community resources (coordination among providers, transportation services) • Disability assistance (referral for eligibility determination) • Charitable organizations	**<u>for Outcomes</u>** **Knowledge:** 3-Basic knowledge (identifies some sources of assistance) **Behavior:** 3-inconsistently appropriate (does not use all available assistance programs) **Status:** 3-Moderate signs and symptoms (has utilities but no consistent source of income)
Domain: Psychological		
Problem: Interpersonal Relationships (high priority) **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual Signs/Symptoms of Actual:** • Minimal shared activities • Inadequate interpersonal relationship skills •	**<u>Intervention Scheme</u>** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Communication (improve skills) • Exercises (family activities) • Counseling (therapy to strengthen family support systems) **Category: Case Management** **Targets and Client-specific Information:** • Community resources (coordination among providers, transportation services) • Support group (age/condition appropriate support groups)	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 2-Minimal knowledge (expresses interest in learning better communication skills) **Behavior:** 3-inconsistently appropriate (family relationships seem to be precarious, primarily avoid each other) **Status:** 2-Severe signs and symptoms (limited, brief communication and interaction)

Table 10: Carter family Omaha System application

For the Carter family, the Omaha system seemed to fit well and prioritized problems identified on the SDM. While the parents report they are no longer using methamphetamine, the father admits to continuing to use marijuana, and is quite adamant that it is something he is not interested in ceasing. The mother reports that she recently completed treatment for prescription pain medication use, and stated that she rarely uses, but both the father and the researchers interviewing her observed that she appeared under the influence at that time. Both parents were able to describe some negative impacts of drug use but especially given their physical and mental health concerns do not seem very knowledgeable about the impact of these drugs on their physical and mental well-being.

The second problem area prioritized by the SDM was the mental health needs of both parents, especially the father. He reported concerns in the areas of depression, phobia, paranoia, and obsessive compulsiveness, to the degree that warrants clinical interventions. The mother also scored within the recommended clinical intervention range for somatization. It is likely that these issues are exacerbated by the ongoing drug use of the parents, which increases the importance that the substance abuse interventions take place. As the Omaha pathways suggest, the parents in particular seem to be in dire need of ongoing support from both peers and community resources, in order to address the difficulties they are having managing their substance abuse and psychiatric needs.

The family resource needs are also targeted for intervention as this is another problem area prioritized by both the SDM and the parent. While the family is currently minimally paying their bills, the father reported they are unable to meet their basic needs

due to lack of income. Neither parent reported being employed, although the father was receiving some unemployment benefits. Given the mother's multiple sclerosis diagnosis and increasing inability to manage, as well as the father's significant mental health needs, it is likely they are eligible for disability assistance. In addition, the only public assistance they reported receiving was food stamps but given their income level they are likely eligible for more programs such as housing assistance and TANF or Temporary Assistance to Needy Families.

Despite the struggles of the parents, the children seem to be managing quite well with the exception of some improvement needed in the family relationship area. The researchers specifically noted that the interactions between family members were cold and minimal. Interventions for the children that engage them with their other family members and focus on improving communication patterns seem to be warranted and were addressed as a priority on the Omaha system but not on the SDM.

The Duncan Family

The Duncan family consists of Debbie (33) and Dave (55) and their two children Deanna (12) and Danny (11). The case record contained interviews of Debbie and Dave and both of the children, as well as standardized instruments measuring psychosocial functioning of family members. The family became involved in child protective services as a result of David and Debbie contacting them when they became aware of inappropriate sexual activity between David's grandson and Deanna. The parents were not willing to provide any more information about that particular incident. They did

report however that they are currently working with a child protective services worker on other issues in their family. Debbie in particular seems to be appreciative of the services, stating, *"I love my caseworker, I'm able to sit down and talk to her about just about anything. I'm very open with them and I'm just really grateful."* The parents denied that the children had ever been placed out of their care as a result of CPS involvement. Debbie stated this was surprising to her given her level of methamphetamine involvement, "*I'm so surprised my kids weren't taken away and I'm surprised that CPS was not involved when I was using."*

Debbie reported that her first introduction to drugs and alcohol was at the age of eight when she started drinking. She said she was encouraged to do so by her mother, who also, "*took me to bars when I was 16 years old. I was getting drunk and stuff when I was 18 with my mom, and she said, 'here you need to try this (meth)' and so I did."* Debbie stated that methamphetamine is her drug of choice, although before it was as readily available she regularly drank alcohol. She said, "*Basically it was whatever I could get my hands on."* When she finally decided to stop using methamphetamine she said she was very motivated to change her life. She said, "*I was tired of hurting so much, my pattern was I'd get high and everything would be gone, I would never work, so I'd rely on the other person to fulfill that for us and that didn't work out and we'd end up with absolutely nothing and have to pack what we could and move and start all over again, it was hurting me, there was no benefit from getting high anymore. I felt dead."* Debbie said that after quitting her methamphetamine use, she realized how destructive it had

been in her life, *"I think meth is the devil. It kills, it does nothing but destroy. I don't think anything good can come out of methamphetamine. It destroys anything it touches."* Debbie described using alcohol for about 20 years or 60% of her lifespan, which was the second highest of the parent group as a whole, (only Dave's was higher) and double the length for the women in the study. She reported the same situation for her marijuana use, and was again second only to Dave at 60% of her lifespan. Debbie was more similar to the parent group with her methamphetamine use, reporting 10 years or 30% of her lifespan which was the average for the parent group as well.

Dave also described being introduced to drugs by his mother who he described as "*overweight and addicted to diet pills*." He said, "*She gave me my first drug, one of her diet pills, when I was sick and didn't want to go to kindergarten. After that I would sneak her diet pills."* Dave reported that during his teenage years he drank alcohol and used marijuana. He also reported that while in the military he used LSD and other drugs as well as drinking. Dave reported using alcohol for approximately 40 years of his life of 72% of his lifespan. This was the highest of anyone in the parent group, and almost twice as long as the average of 38% of the lifespan. Dave also reported 40 years for marijuana use which was again the highest of all the parents in the study. Dave reported a much shorter number of years using methamphetamine, reporting a total of 12 years or 22% of his life which was similar to the men's average of 24% and the parent group as a whole of 30%.

Neglect: Substance Use by Caregivers or Other Household Members

Prior to using methamphetamine, Debbie reported that she drank heavily in front of the children. She said Danny in particular, still talks about her drinking, "*he remembers more of the alcohol being around, than a lot of other stuff. . . There have been instances, where Danny has come up, and said, 'do you remember when you were drunk?' And I don't ever recall being you know drunk in front of my kids, but their idea of me being drunk is, you know and mine, are completely different."* Debbie also indicated that although she initially believed she was able to hide her use from her kids, she realized her children were aware of their methamphetamine use, and ultimately she and her husband started using in front of them. She gave the example of *"Danny came up one time, and he rolled a pipe and he said here, daddy. It was how David would make tinfoil pipes, they were exposed to a lot. . . They knew what was going on, and they knew that it wasn't a good lifestyle."*

Deanna confirmed that she was aware of her parent's drug use, "*I've seen them do it. And mom was like always in bed all the time. She was always asleep."* Danny also confirmed that he was aware of their drug use, *"I remember when they were doing drugs. I think about it almost every day, all the time. . . I was so aggravated, saying stop it, stop it, you're hurting yourself. They didn't want to stop. I would start crying all the time stop it, stop it, don't do it, you're killing yourself."* He further stated, "*they eventually listened, I was so happy."* When asked to tell a story about a time in his family that was sad or scary, Danny replied, "*Well, probably when my mom was doing drugs. I was really, really mad and sad all the time."* Danny described feeling like, "*a sharp knife was*

stabbing my stomach, and my heart. . . I could just lay around in bed, there was not much to do except that."

Debbie reported that at the height of her methamphetamine use, she used as much as she could, "*When I was using I didn't want to come down so I did everything and anything I could so that I could possibly stay high . . . One time, I did stay up for 28 days straight. I could have been classified as a paranoid schizophrenic."* She said that in addition to her and Dave using in the house, they often had other friends who would use at their home as well. She stated, "*We always had company, or we were always at someone else's house. And the kids would be, in their room or outside, and we would be somewhere else using."* Debbie also reported that in their early years, the children were exposed to their biological father using crack cocaine, "*that was his drug of choice."*

The researchers seem to confirm that the parents were no longer using chemicals when they answered "*Yes"* to the question, 'none of the adults in the home displays obvious signs of reason alcohol or non-prescriptive drug consumption.'

Neglect: Exposure to Methamphetamine Production

Debbie reported that the children were exposed to meth production by their biological father. When they lived with him, she said she tried to keep the kids from being around the production, "*usually, when he would manufacture we would leave, then one time he started to manufacture while we were sleeping upstairs in the house, out in the country. We woke up because the house was just filled with ammonia. I snatched the kids out of the house and ran outside and we went back to sleep in the garage."* Dave

also reported that he allowed friends of his to cook meth at home. By doing so, he was able to get meth for free. Both Debbie and Dave admitted that toward the end of their use, Dave was also actively producing meth, although it was not clear whether the children had access to the meth production at that time.

Neglect: Criminal Activity of the Parent

Debbie reported that when Dave was cooking meth, she would go around and collect the supplies for him, usually by theft. She said, "*I was very fortunate and to not be arrested for shoplifting or anything else like that."* Debbie reported having been arrested or charged 4 times in her life, once for assault, once for deceptive practices, once for contempt of court and once for homicide or manslaughter. There was no other information about this last charge in any other part of the record, although she did report serving a total of 2 months in jail during her lifetime, which was the highest of the all of the parents in the study. Her total of 4 times arrested or charged was just over the average of 3 for the parents in the study.

Debbie indicated that during periods of unemployment, she and Dave relied on selling methamphetamine as a source of income. She said one of the instances that contributed to Dave's decision to become clean was when he had an accident with meth precursors in the vehicle, *"he was driving a truck that wasn't licensed to us, and he had a bunch of pills in the vehicle and lots of paraphernalia and then he crashed it and he wrecked it."* She further commented, "*Part of his motivation (to quit) was to keep his ass out of jail, and then another part was that I was going to leave him, I told him he was*

going to have to, and I have to change, I have to quit. I can't live like this." Dave reported that he was not on probation at the time of the interviews and that he had a total of 2 lifetime arrests, once for a drug charge and once for a delinquency. This was just under the average of 3 arrests for the parents in the study.

Neglect: Children Witnessing Domestic Violence

According to Debbie, Deanna and Danny's biological dad was very abusive toward her. She said, *"I just got done giving birth to Danny and then abuse got to where I wasn't able to shield them from it anymore. My pregnancy with Danny was very bad."* She further stated, "*He was very stingy and very abusive. I feared for my life, and that was my excuse to use and stay awake so much . . . because I felt I had to be there for the kids. Keep them safe, to keep myself safe. And, you know, know where he was at all times."* She said his abusiveness impacted her ability to stay employed, which perpetuated the problem.

Deanna confirmed that she observed her father being abusive toward her mother, *"I remember my mom, and my real dad, he was an abuser you know, and a drug addict, and he abused my mom and my brother a lot, but never me. I always remember him grabbing my mom by the throat and leaving hand bruises, picking her up, and slamming her on the floor.*" Danny also suggested that he continued to worry about his mother safety, "*I worry about my dad and getting hurt again. Or mom, and somebody walking in and hurting mom, that's what I worry about."*

Debbie stated that her current relationship with Dave was very supportive, particularly after they got clean together, "*I wouldn't have been able to get clean if I wasn't around somebody else that was getting clean."* She further reported, "*Dave and I have a very good strong and supportive relationship."* Deanna also described the relationship positively, "*he loves to tell jokes, and he'll do funny things that make my mom laugh so much, that's what I love about him."*

Neglect: Failure to meet basic needs

Debbie reported that when she and Dave were using methamphetamine, they were barely attentive to the children's basic needs. She mentioned that when she was crashing, all she did was sleep, "*they come into the bedroom now and then and say mom, I need you, I'm hungry. And I would just tell them to go make some toast or something."* She said basically, *"they had to find a meal here, and a meal there, they fended for themselves."*

Deanna reported that she felt as though she had physical effects from the lack of nutritious meals, "*My nails were so thin, and they fall off every once in a while and I'd hate it."* She further stated, "*I guess we were unhealthy at the time, we really didn't have a shower, because he took up the bathroom."*

Debbie also spoke numerous times about how the family had to regularly live in substandard housing because of their methamphetamine use. During the home visits for the interviews the researchers noted a continued concern for the housing environment. On the HOME assessment scale, the researchers answered *"No"* to the questions, 'house or

apartment has no potentially dangerous structural or health hazards,' 'the house or apartment is clean,' and 'the immediate external environment contains no obvious health or safety hazards.' They further noted, "*The carpet was threadbare and filthy. The kitchen floor lean to one side and a large sunken area revealed the subfloor had disintegrated. The kitchen table was sticky, the dishes in the sink and on the countertops that were dirty."* On the physical environment subscale of the HOME assessment, the family scored three out of seven. It was the only subscale score on the assessment in which the family scored below the upper quarter of the population norm.

Despite the difficulty in the housing environment, Debbie reported that since getting clean they are much more able to meet the children's basic needs. She said, "*Today, you know, they sleep at night, every night. They have clean beds to sleep in. There clean clothes. They have food, I cook supper regularly. And everyone sits down at the table to eat together."*

Neglect: Lack of Supervision

Despite her regular use, Debbie said she did try to always know where her children were, "*I did really try to keep the focus on Deanna and Danny, and make sure that I knew where they were constantly through that part of our lives even though they were exposed to a lot of drug use."* When questioned further however, Debbie admitted there were numerous instances where the children were unsupervised, "*I guess there were times when nobody cared for them when I was down, and then when there was, whoever*

was in the house, they would supervise them. . . When I did come down I was out for two days sometimes and so the kids pretty much fended for themselves when I was out."

Danny described an incident that happened when he and Deanna were left alone, he said, "*I remember falling out of a window . . . I actually got pushed by Deanna."* He relayed another incident when he was left alone outside, "*I usually would play, dig in the yard and once found a BB gun. . . I didn't do much, I would pretend I was a world-famous hunter and I was chasing things. . . (I would do that) when they were using meth."*

Physical abuse

Debbie reported and Deanna confirmed that Danny was physically abused by the children's biological father when he and Debbie were using methamphetamine. Danny also reported that he is no longer allowed to be around his biological father and said, "*I don't want to be near him, because he abused us"*

Emotional Abuse

Deanna described an incident of emotional abuse toward Danny by their biological father, "*always yelling at him . . . I remember him keeping my brother in the closet for a couple of days."*

Sexual Abuse

Debbie indicated that both of the children had had incidents of sexual abuse perpetrated on them, "*there was a sexual abuse issue, there was a sexual abuse issue with Deanna a year before actually two years now, and then an incident with Danny came up,*

but I'm not going to go into specifics about that." Deanna described an incident of sexual abuse but it is unclear if it the same incident that Debbie was referring to. Deanna said, "*I woke up with my pants undone. And then unzipped and him lying next to me and when I woke up I could see him hurry up grabbing my feet and I'm like oh no! I grabbed my clothes, at least the ones I could see, and I just went home. He didn't stop me, I just went home."*

Other Risk Factors: Lack of Parenting Ability

Debbie reported that there was definitely a negative impact on her parenting ability when she was using methamphetamine. She said, "*I'm surprised my kids were not taken away and I'm surprised that CPS was not involved in our lives when I was using. I'm very fortunate for that. I was in a very bad, I was very badly addicted to meth and that was my way of life. How they survived is by the grace of God. . . and then when I did come down I was out for two days sometimes, the kids had to pretty much fend for themselves when I was out. "*Debbie also discussed the differences in her behavior when she was drinking versus when she was using meth, "*when I was drinking, I was probably more laid-back than anything else. But you know when I was strung out on meth, I'm very agitated very nervous, and very stressed. When I was drinking, I was very mellow and very calm . . . and you know I think they probably got away with anything."* She said, "*when I was trying to get high, they would be in some other part of the house while I was locked into one room getting my fix. You know, that's where my focus was on, again the kids were pushed off to the side."*

Debbie also described using physical punishment as her main form of discipline. She said she, *"gave them spankings, and I don't allow cussing. So I used dish soap for when they said bad words."* Deanna related that things are better now, that when she gets in trouble, "*I tell them what happened, I tell them everything. I understand and sometimes I get grounded or sometimes I get the lecture talk, but talking helps."*

Other Risk Factors: Chaotic Household

Debbie reported being unable to maintain stable housing while she was using methamphetamine. She stated, "*Before we got clean we would, there were times when the kids and I would just live anywhere we could."* As a result the family moved around a lot, in order to follow work opportunities. She said, "*when he first got off meth we moved out of state and we worked on a crew and when we finished that job we go to another job and to another state, and then we went to another state."*

Debbie reported that in addition to unstable housing, their general lifestyle when using meth was fairly chaotic. When asked what her family routine was like when they were using, she replied, "*very chaotic, when we had meth, we were always up, always busy, but nothing ever got done, and the kids usually got pushed off to the side it was just very chaotic, very crazy, but when I didn't have meth, all we did was sleep."* She further described, "*the kids would probably be on more or less my schedule when I was using. You know so they would stay up, try to step as long as I did because they wanted to spend time with me, even as I kept pushing them away. You know they didn't have a set bedtime, there was no set time to eat, and it was just chaos."* Debbie also described living with

her children in a hotel room when Dave went to treatment as she tried to quit using on her own. She said, "*the kids and I just stayed in that room. The only time we went out is when we needed to get more groceries. It was winter time and I turned the window into a fridge, because it was very cold in there. That's where I kept the milk and stuff so we just lived off of Ramen noodles and cereal."* Debbie reported that since the parents stopped using methamphetamine, their lives have become far more stable. Debbie described their schedule as, "*we do homework. We do chores. And then supper. We go to a meeting together and then we come home and we go to bed."* The researchers seem to agree, observing, "*The family has a regular and predictable daily schedule."*

Other Risk Factor: Lack of Resources

Dave reported that he had completed four years of college and was trained as an Electrician. Debbie reported having graduated from high school and working as a clerical worker. As a couple, they were the most educated of the parent group, and not surprisingly, they also had the highest monthly income at close to $500 per family member per month. At the time of the interviews, the family income was solely derived from Dave's disability payments.

Debbie described numerous instances both when the parents were using meth and after they became clean when they struggled financially. She said ultimately Dave started producing meth and they would sell it in order to make ends meet. She said currently Dave receives disability payments for numerous "on-the-job" injuries to his back and shoulder's. While stating that the injuries are real, Dave admitted that, "*I was skillful at*

using the system. I would have an "accident" at work to get benefits and even go through operations in order to maintain my disability status and then I would also have access to pain pills. Now I have to live with the consequences."

Other Risk Factors: Difficulty in Parent/Child Relationships

Debbie stated that when the family continued to move around for Dave's work after they got clean, it actually had a positive impact on the relationships between the parents and kids. She reported, "*Since we've been clean they spent almost every day with us. As we got clean and started to work on ourselves, the more the kids started to recover too... I don't know, we've gotten very close."* Debbie clarified that everything was not perfect however. She said Deanna in particular struggles because, "*she has abandonment issues, she is very angry with me, she's very, very angry with me."* Debbie says she tries to deal with that anger by being very open and honest with the kids about her experiences. She said, "*You know, they went through the trenches with me. I try not to sugarcoat anything for them. I don't hide anything from them, and I asked them not to hide anything from me. You know if we can keep the honesty good and upfront, things work out."* She said she tries to share the sobriety milestone achievements with her children as well, "*whenever I get key tags, in the beginning they asked me, mom do I get one too? And I give them a key tag to because you know they have gone through this with me."*

Deanna also confirmed that the relationship was getting better. She said, "*You know as long as they're clean now, I really don't care. Because you know, they are my*

parents. I'm going to love them anyway. I would be disappointed if they started doing it again, I wouldn't you know love them in the same way as I do now." Danny also said the relationship is better in particular because they spend time talking, "*my mom is a good listener, and she is the one I really, really know and love."*

This positive relationship seemed to be confirmed by the researchers. They noted, *"When speaking of or to the child, the parents voice conveyed positive feeling and parent shows emotional responses to praise of the adolescent by visitor."* They also noted, "*Parent does not ridicule or express hostility or referred to the adolescent in a derogatory manner."*

Other Risk Factors: Child's Behavior Problems

While the parents were using methamphetamine, Debbie reported the kids had a hard time developing their social skills, "*they were starved for attention, I kept them very sheltered and they didn't have social skills."* She also indicated that the children struggle with their behavior and other ways, saying, "*They have trouble with their coping skills, and how they deal with their emotions, and their anger, and stuff like that."* Deanna agreed commenting, "*I get in fights with girls they get up in my face a lot... This other kid came up and pushed me and I didn't like it and I picked him up and slammed him on the ground and hit him on the cabinets of the school."*

Debbie said since they've cleaned up however, "*They just blossomed so much."* Deanna in particular, seems to be doing well, "*she's my social butterfly, and the boys are an interest now to, so now I'm getting scared (laughs)"* On the child behavior checklist

however, Deanna scored in the clinical range of concern for subscales of Thought problems, Rule-breaking behavior, Aggressive behavior, and overall externalizing behavior scores. Danny scored near the median for all subscales.

Other Risk Factor: Cognitive/Mental Health Status of the Parent

Both Debbie and Dave scored above average on the Shipley Assessment of Intellect, with stanine scores of 7 each and estimated IQs of close to 120. Debbie reported graduating from high school, and Dave reported attending four years of college.

Debbie relayed that she had mental health problems of her own, stating, "*I have depression, and other stuff, and I'm a mess."* On the measures of psychological distress on the SCL-90-R and the Trauma Symptom Checklist-40 however, Debbie scored well within the normal range on all subscales with the exception of sleep disturbances, where she scored just over 1 standard deviation above the population norm. Debbie denied ever having been hospitalized for psychological problems, but she had been treated twice on an outpatient basis for depression, anxiety and trouble concentrating or remembering. She reported previously having thoughts of suicide but never having attempted. She also reported that she was taking prescription medications for mental health problems.

Dave scored near the norm or slightly above but below 1 standard deviation on all of the subscales on the TSC-40 and near the norm for all of the measures of distress on the SCL-90R. He did however report that he had been hospitalized twice in his life for psychological problems. He reported having had suicidal thoughts, suicidal attempts depression, and trouble controlling violent behavior in his lifetime but not in the past 30

days. He also reported that at the time of the interviews, he was taking prescribed medications for psychological problems.

Other Risk Factor: Mental Health Status of the Child

Both of the children have reportedly attended counseling to address the sexual abuse issues that neither Debbie nor Dave were willing to discuss. In addition, Debbie described other mental health concerns for both of the children, "*Deanna and Danny have anger issues and some depression. Danny has been diagnosed with ADHD and I believe that Deanna has probably got the same thing. Danny suffers from low self-esteem as well."*

Deanna talked about her own mental health concerns as well saying, "*It swings a lot, sometimes I get to the stage where I'm feeling joyous, then so lonely. . . I get so angry I want to scream so badly and I want to grab something and just break it or I just want to hurt someone to make them feel the pain I'm feeling right now you know to make them go through what I'm going through."*

On the Trauma Symptom Checklist for Children (TSCC), Deanna answered questions in a manner that indicated a clinical concern for the subscales of Anger and Depression. She answered "almost all the time" to the questions of whether she argued too much, and whether she felt as if no one liked her. Danny scored in the clinical concern level for the subscales of Anxiety and Post Traumatic Stress, indicating he was still harboring some effects of previous experiences. He answered, "almost all of the time" To questions of whether he remembered scary things, remembering things that

happened that he didn't like, can't stop thinking about something bad that happened to me, wishing bad things never happened, and whether he cried often.

Other Risk Factor: Child's Educational Progress

Debbie stated that she homeschooled the children when the family was staying at the hotels because Dave was working. She reported, *"I was working with them on their reading and I was working on them with their phonics and I was kind of trying to get them into that stuff because I didn't have them in school."*

At the time of the interviews, Debbie reported the children were enrolled in school, and Danny is doing particularly well. She said, "*Danny is very talkative, he's my little scientist, and my little mathematician. He is very, very creative he has some ideas that I think are just awesome he is so creative..."* She also reported that Deanna was performing worse than the average of her peers in all of her school subjects while reporting that Danny was performing above average compared to his peers. Interestingly, however, Danny scored a 4, which is just below the mean stanine for the intelligence testing scale PPVT-III, while Deanna scored a 6 or just above the mean.

Other Risk Factor: Physical Health of Family Members

Debbie reported that both she and Dave have experienced physical health problems. She said, "*I have a high sensitivity to chemicals now. I have asthma. I have arthritis. I have ulcers. My intestines, my digestion is, you know, terrible. . . . Dave has back and shoulder injuries."* Dave also indicated during the Addiction Severity Index interview that he suffered from chronic pain and nerve damage in his back and shoulder.

Like the majority of parents in the study, both Debbie and Dave reported significant dental problems due to their years of methamphetamine use. Dave in fact recently had to have his teeth removed and he now wears dentures. There is no indication that the children had any physical health concerns.

Other Risk Factors: Participation in Recommended Services

Debbie stated that when Dave decided to go to treatment for his chemical use she wanted to become sober as well. Because someone needed to stay with the children, she decided to quit cold turkey all by herself, but when Dave got out they made a point to attend NA meetings together and as a family. Debbie said she was sure that her attendance at the meetings is what has made it possible for her and Dave to stay clean. She said, "*It is the best therapy. Talking to somebody that is, who is in the trenches and has you know lived that lifestyle and then crawled out of it and is living and surviving now. I can go to a meeting and sit there and say I've had the most horrendous day today, and my emotions are going in every direction. It's just like being in a family. It's like coming home. It's not always fun, and it's not always easy but it's the only thing that I found that works for me."* Dave also reported on the usefulness of participating in Narcotics Anonymous meetings, stating that he believed that in helping others, he is healing himself.

Debbie also talked about being involved with CPS as a useful experience. She said, "*I would tell someone if you're involved with CPS or social services, take advantage*

of the services that are available. You know use them, help use them you know don't limit your options. . . Counseling too, it's a very good treatment and very helpful. "

Danny reported however that he found the counseling less useful. When asked if he had a counselor that he sees he commented, "*yeah but I usually talk to myself, its better. I can trust myself. I trust my counselor, but I trust myself even more."*

Summary of child maltreatment risks

Risk Item	**Risk Present?**	**Data Element Identifying Risk**	**Family Priority**	**SDM Priority**	**Omaha Priority**
Neglect: Substance use while parenting	Yes	Parent interview, child interview, ASI, researcher reports			
Neglect: Prenatal exposure	No	Parent interview			
Neglect: Parents involved in meth production	Yes	Parent interview			
Neglect: Criminal activity of the caregiver	Yes	Parent interview, ASI			
Neglect: Children witnessing domestic violence	Yes	Parent interview, child interview			
Neglect: Failure to meet basic needs	Yes	Parent interview, child interview, HOME			
Neglect: Lack of supervision	Yes	Parent interview, child interview			
Physical abuse	Yes	Parent interview, child interview			
Emotional abuse	Yes	Parent interview, child interview			
Sexual Abuse	Yes	Parent interview, child interview			
Other: Lack of parenting ability	Yes	Parent interview, child interview			
Other: Chaotic household	Yes	Parent interview, researcher notes			
Other: Lack of resources	Yes	Parent interview, ASI, Shipley	X	X	X
Other: Difficulty in parent/child relationship	Yes	Parent interview, child interview, researchers report			
Other: Difficulty in sibling relationship	No	Child interview			
Other: Child's behavior problem	Yes	Parent interview, child interview, CBCL	X	X	
Other: Cognitive/mental	Yes	Parent interview, Shipley,	X	X	X

health status of caregiver		ASI, SCL-90-R, TSC-40			
Other: Mental health of the child	Yes	Parent interview, child interview, TSCC, CBCL, researcher notes		X	X
Other: Child's educational progress	No	Parent interview, PPVT-III, Child dev. history quest.			
Other: Physical health of family members	Yes	Parent interview, ASI, SCL-90-R		X	
Other: Failure to participate in recommended services	Yes	Parent interview			

Table 11: Duncan family maltreatment risks

The Duncan family seems to be well on their way to moving past many of the child maltreatment risk experiences they reported. As a family, they reported experiencing 19 of the 21 risks that were identified by any family, the highest number in the study group. The most significant risks the family was facing at the time of the interviews were the mental health problems of both parents and Deanna, and Deanna's aggressive acting out behavior. It should be noted that Danny seemed to talk about being more severely troubled by his parent's drug use past, as was demonstrated by his elevated trauma symptom checklist scores, but his scores on other measures did not show elevation. It seems possible that as Deanna is outwardly displaying the effects of the trauma, Danny is feeling the trauma more inwardly and Debbie, who answered the other standardized instruments, is less aware of his struggles. The parents seem to be actively participating in all of the intervention services being offered and are ensuring that their children get any services they need as well. The parents also demonstrated that they are willing to ask for help when need as indicated by their seeking out of child protective services rather than waiting for it to come to them.

<u>The child protective services response</u>

The Duncan family scored in the moderate risk category on the neglect scale and low on the abuse scale on the SDM. In some states child protective services would not be required to offer services to the family. The following chart shows the items on the SDM Risk Assessment Tool for which they received a point. Scores up to 2 indicate low risk, between 3 and 5 indicate moderate risk, and six or above indicate a high risk for future maltreatment (Children's Research Center, 2012).

Neglect	**Abuse**
Number of children in the home Either caregiver has a history of domestic violence Primary caregiver has/had a mental health problem	Primary caregiver has/had a mental health problem Either caregiver has a history of domestic violence
Score = 3 Moderate Risk	**Score** = 2 Low Risk

Table 12 Duncan family SDM risks

Given the score of moderate on the neglect scale, and low on the risk scale, this family's case would be optional for opening. The parents in the family actually contacted CPS due to an allegation of sexual abuse toward the children by the father's grandson, so it is likely they would be opened for services. Despite reporting the highest number of risks during the time they were using methamphetamine, the parents have actively sought and utilized services to address those problems, which is likely the reason for the low scores on the SDM Risk Assessment Tool. The Strength and Needs Assessment tool would then be utilized to determine where to target the required interventions. There is one section completed for the parent and one for each child. For the purposes of this study, only the child that participated in the study was assessed. The Strength and Needs tool assigns a numerical score for the presence or absence of each item as it relates to the risk of further maltreatment. Some items are more highly associated with future

maltreatment risk and thus receive lower scores. Scores on each item above 0 are generally considered a strength, while scores below 0 are generally considered a risk (Children's Research Center, 2012). For the Duncan family, the Strengths and Needs Scores were as follows:

Caregiver Strengths
Household Relationships (+3)
Alcohol and other Drug Use (+3)
Social Support System (+2)

Caregiver Needs
Resource Management/Basic Needs (0)
Physical Health - Pain (0)
Mental Health/Coping Skills (0)

Child Strengths
Physical health (+3)
Child Development (0)
Family Relationships (+2)

Child Needs
Emotional/Behavioral (-3)

According to the above measures, child protective services should focus on the emotional/behavioral needs of the children, the basic needs of the family, the physical health of the parents, and the mental health/coping skills of the parents. The Omaha system did not indicate a concern for David's pain management, but did identify needs in the problem areas of mental health concerns for all family members, and family resource support.

Domain: Physiological		
Problem: Pain **<u>Problem Classification Scheme</u>** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Expresses discomfort/pain	**<u>Intervention Scheme</u>** **Category: Case Management** **Targets and Client-specific Information:** • Medical care (evaluation, schedule services) • Other community resources (pain clinic) • Dental care (coordinate evaluation and refer for services) **Category: Surveillance** **Targets and Client-specific**	**<u>Problem Rating Scale for Outcomes</u>** **Knowledge:** 4 – Adequate knowledge – knows which medications relieve pain and how to take them **Behavior:** 4 – Inconsistently appropriate behavior

	Information: • Medication/Action side effects	(uses appropriate medications most of the time) **Status:** 3 – Moderate signs and symptoms (regularly exhibits signs of pain)
Domain: Psychosocial		
Problem: Mental health (high priority) **Problem Classification Scheme** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Somatic complaints/fatigue • Mood swings • difficulty managing stress • difficulty managing anger	**Intervention Scheme** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • coping skills (adjustment to illness, crisis intervention) • support group (emotional support) **Category: Case Management** **Targets and Client-specific Information:** • psychiatric care (schedule appointment, coordination among providers, transportation services)) **Category: Surveillance** **Targets and Client-specific Information:** • Continuity of care (coordination among providers)	**Problem Rating Scale for Outcomes** **Knowledge:** 3-basic knowledge (aware of symptoms and impact about illness on life) **Behavior:** 2-Inconsistently appropriate (attends therapy, does not always use coping skills) **Status:** 3-Moderate signs and symptoms (occasionally depressed, increased awareness of self and others' needs)
Domain: Environmental		
Problem: Income (high priority) **Problem Classification Scheme** **Modifiers: Individual and Actual** **Signs/Symptoms of Actual:** • Low/no income • Difficulty buying necessities	**Intervention Scheme** **Category: Teaching, Guidance, and Counseling** **Targets and Client-specific Information:** • Community Resources • Comprehensive analysis and action plan **Category: Case Management** **Targets and Client-specific Information:** • Community resources (coordination among	**Problem Rating Scale for Outcomes** **Knowledge:** 3-Basic knowledge (identifies some sources of assistance) **Behavior:** 3-inconsistently appropriate (is interested in idea of budget, uses only one

	providers, transportation services) • Charitable organizations	assistance programs) **Status:** 3-Moderate signs and symptoms (has utilities but no consistent source of income)

Table 13: Duncan family Omaha System application

For the Duncan family, the Omaha system seemed appropriate for addressing the prioritized problems identified on the SDM, although there is no specific category that addresses the unique emotional/behavioral needs of a child. The best fit for this problem area was in the problem classification for mental health, which actually seemed to fit both the needs of the parent and the child. Another area prioritized by the SDM was the physical health needs of the father, particularly in the area of pain management. The father in this family is currently on medication for pain management and also is receiving disability payments as it impacts his ability to work. Because he is utilizing his medical and financial resources, the Omaha Knowledge, Behavior, and Status (KBS) scores in this area indicate he is actually functioning at fairly high levels and intervention should focus on maintenance. Like most of the families in the study, resource needs are also targeted for intervention as this is another problem area prioritized by both the SDM and the parents. Although the father is receiving disability payments, the family's total income puts them just below the poverty threshold. They seem to be making ends meet and paying bills, but especially given the high physical and mental health needs of the family members, it is important that this area be assessed and a plan put in place to make sure they are maximizing use of all available assistance programs.

The Edwards Family

The Edwards family consists of Ellie (28) and Earl (36) and their six children ranging in age from 1 to 10 years old. The Edwards family documents included interviews of Ellie and Ethan, and the HOME assessment. Although there are no other standardized instruments to contribute information about the Edwards family members, Ellie's interview in particular seems to confirm a similar experience of methamphetamine use while parenting.

Ellie reported that her family became involved in child protective services about three years earlier, when she *"had just gotten away from my ex-husband, just got away from all the drugs . . .I was just trying to take care of everything on my own, stay away from everything, trying to calm myself down, and I couldn't do it."* She said she realized she needed help and so she contacted CPS herself. She said she *"called them and asked them to come in and help me take care of my kids because my anger was getting out of control."* She said she had only been off of meth for about two weeks before she called for help.

Ellie stated that she grew up with her mother who was very controlling. Ellie reported that her mother eventually became aware of her methamphetamine use and while she considered calling the police, she held back. Ellie said her mother didn't want to be around when they were using meth, but regrets not coming in for the baby's sake. Ellie reported that her mother did at one point try to confront her, but she responded, "*I told her it was my life and I was going to do what the hell I wanted to do."* Ellie stated

now that she is in recovery, she appreciates the structure her mother gave her stating, "*I still find myself doing things that my mom told me when I was younger that well when you get older you'll thank me one of these days."* Ellie reported that when she finally decided to leave her ex-husband and stop using meth cold turkey, her mother let her move in with her. Ellie said, "*She told me as long as I promise that I was going to straighten up that she was willing to help me."*

Ellie reported using meth for about five years, starting when she was about 20 years old. She said her husband at the time introduced her to meth, "*he was in prison when I met him, he got out of prison and then he had the bad boy lifestyle, so when I got with him, everything was like, I'm going to do what I want to do now and he introduced me to all of it."* Ellie described her first experience of using meth as, "*it was intense, like a rush, it made you feel good, a rush of an energy was the biggest thing because I, used to be tired all the time and I got tired of being tired and I'm like hey here's an energy boost."* When asked what the positive of her methamphetamine use were, Ellie reported, "*just energy. And the fact that you don't really give a care in the world when you're on it. You don't eat, you lose weight, I mean when you're on meth you can drink like a damn fish, you could drink probably enough that would give a normal person alcohol poisoning."* When asked 'what were the negatives of her use?' she reported *"your family life goes to hell, you don't have the connection. The bond like in my situation with my husband was gone all the time. He didn't care about his family at all, he didn't care, and your family life goes to hell."* Like other parents in the study, Ellie described

circumstances in which methamphetamine use had a negative impact on her parenting. Their interview comments were grouped by risk factors as identified by the Child Welfare Information Gateway (2013).

Neglect: Substance Use by Caregivers or Other Household Members

Ellie reported that Ethan was about one year old when she started using meth. She said that she tried to balance using methamphetamine and taking care of him at the same time. Ellie said initially she felt as though the methamphetamine was actually a benefit, "*I seemed calmer when I was on meth, I was calm, and I could talk to my kids. You couldn't remember anything when you're sober, but you talked, but it affects your memory so bad, your memory is awful when you get off of it."* Ellie described a typical day when she was using methamphetamine as, "*I'd wake up, and I'd feed the babies, make sure they had their breakfast and stuff. While they were eating, I go to the bedroom and we'd smoke a foil or a lightbulb, and would probably smoke two or three. Then I'd go out, make sure the kids had something to play with. We also had company over all day long all night long, all day all night, and they had kids so we all just let the kids play."*

Neglect: Prenatal Exposure to Substance

Ellie reported continuing to use meth when she became pregnant with her second son Eric. She said, "*I didn't know I was pregnant, so for the first three months I was on meth, I was using meth pretty heavy then, and I know that's when your brain develops."* Ellie also indicated a concern about the effect of methamphetamine use on the child via the father sperm. She said, "*My husband, he didn't help me when I got pregnant because*

he was using too, and most of the stuff comes from the dad's sperm. Everybody blames things on just the mother, but when you get pregnant, whatever the dad is on, it's in their sperm. And I can't help but get so mad because I think more research needs to be done about what goes on with the father as compared to blaming everything on the mother."

Neglect: Exposure to Methamphetamine Production

Ellie reported that she primarily obtained her meth from her husband who was cooking it. Ellie said that generally she was the buyer of the supplies and he was the cooker. She said, "*I would go get everything, and I'd give it to him, because for 50 bucks we could make quite a bit."*

Neglect: Criminal Activity of the Parent

In addition to manufacturing the methamphetamine for their personal use, Ellie reported that they also sold methamphetamine. She said, "*We were actually a supplier for quite a few counties for a long time. We never got caught. We were one of the luckier ones, because we never got caught."*

Neglect: Children Witnessing Domestic Violence

Ellie reported the kids witnessed a lot of fighting between her and her husband, she said, "*there was a lot of fighting, a lot of screaming . . . in front of my kid."* She attributed much of the fighting to the paranoia that comes as a side effect of using meth. She said, "*After a while, you start seeing things and you think somebody is doing something they're not doing. For him, he was so insecure that he thought I was cheating on him all the time. But emotionally, I just wasn't feeling connected to him."* Ellie

reported that the fighting did progress to physical violence. *"So there would be a big fight, he would come in and smack me upside the head or he would call me nasty names, anything he could think of. There was a lot of violence in front of the children. Once he was in a rage for four days because he thought I was cheating on him."* She described another violent incident, "*we were fighting heavily, almost every night, and he would drag me out of bed by my hair. He would choke me, kick me in the back, the stomach, leave bruises on me, drag me down the hallway by my throat it didn't matter. And Ethan witnessed this, I didn't realize he witnessed it until I actually left."* Ellie said she ultimately left because the violence was getting so severe, "*I walked out the door, and he came after me and was pushing me, hitting me upside the head, punching me with the baby in my arms, and I said enough is enough. There was something in his eyes that I was more afraid than that but I'd ever been. And I thought he's going to kill you. So I called my uncle that night who lives in another state, and I asked him to come and get me because I'm done."*

Neglect: Failure to meet basic needs

When talking about parenting while using methamphetamine, Ellie said she always tried to meet her son's basic needs. She said, "*He was always clothed, always fed, and if I knew I was going to do it, I would always cook more meals prior to that and have it in the refrigerator so all I had to do was warm it up for him."* She further stated, "*Most people think that the kids are always neglected, in my case, with me, it wasn't like that, with my husband it was like that, he neglected Ethan but I didn't."*

On the physical environment subscale of the HOME assessment, the family scored a five out of eight or slightly under the median for the population scores, but above the average score of 4 for the families in the study. The researchers answered "*yes"* to the question 'is the child outside play environment safe and free of hazards?' and "*yes*" to 'are all visible rooms of the house are reasonably clean and minimally cluttered?'

Neglect: Lack of Supervision

While Ellie described meeting Ethan's basic needs even though she was using meth, she admitted that he did not get a lot of attention or supervision. She said, "*as far as attention, like one-on-one attention I didn't do very good on that. There was not a lot of teaching attention. I mean he pretty much had to play by himself, watch TV. We were always in the bedroom doing our thing which was not right. I know that now."* Ellie said that when their use was pretty heavy, she and her husband would take turns crashing so that one of them would be awake with the kids. She reported, "*if I was up for two days obviously he was up for two days, on the third day I'd crash, he'd stay awake, and then once I got done sleeping, pretty much all day long and all night, then he'd crash and I'd be up with the kids. We alternated. And then we'd get back up by smoking again."*

Physical abuse

Ellie reported that before the family became involved with child protective services that she "*had an anger problem, big time."* She said, *"I was smacking my kids in their mouth, pretty hard, um, I would knock them on their butt."* Ellie denied having hit

her kids hard enough to require medical attention, but said, "*It was bad enough that I knew if I did not get the help I was going to end up hurting one of them."* Ellie also reported a situation in which Ethan could have been physically harmed when she was using meth. She said, "*One time as I was taking a hit and I went to blow it out he walked right into it, so he was up all night long, off of that, off of me just blowing out of my mouth he was up all night long. I didn't even know he was there. He would have been pretty close to two at that time."*

Emotional Abuse

Ellie also admitted to emotionally abusing her children before she got help for her anger issues, she said, "*um, I would yell at the top of my lungs, I mean I was yelling LOUD, I was always yelling at them."*

Other Risk Factors: Lack of Parenting Ability

When Ellie was using meth, she reported her parenting ability suffered. She said that although she met her son's basic needs, "as *far as his attention, like the one on one attention, I didn't do very well on that."* She said it "*took a while"* for her to realize that it was not right to not be paying attention to her children.

Other Risk Factors: Chaotic Household

Ellie reported that her current household was very chaotic, no longer because of her meth use but because there were so many people in the household. She said, "*It's very hectic, from the time they get up until the time they go to bed its nonstop chaos, but sometimes it's controlled chaos. I mean you've got screaming and yelling and crying and*

I want this, I want that, somebody wants something. You're trying to do one thing, and somebody else's behind her but screaming that they want something else."

Other Risk Factor: Lack of Resources

Ellie report that she worked about four days a week she goes in at 4:30 and gets off at 10 PM. She said that sometimes it's easier for her to go to work and get relaxation than it is for her to stay at home. She also reports that her mother has been a great help to her now that she is no longer using meth. Her mother provided her with a place to live and helped take care of her children when she initially left her husband.

Other Risk Factors: Difficulty in Parent/Child Relationships

Despite difficulties in the parent/child relationship that Ellie reported when she was using meth, during the interviews the researchers observed the relationship to be a strength of the family. On the HOME Assessment subscale of family companionship the family scored a five out of six, on emotional climate a seven out of eight, and family integration of four out of four. Ellie reported that since she quit using, her primary focus has been on reestablishing her relationship with her children.

Other Risk Factors: Child's Behavior Problems

Ellie alluded to but did not expand on the fact that she has problems with Ethan and Eric's behavior which she attributes to both her prenatal use of methamphetamine in the early stages of her pregnancy as well as the fact that her husband was also using heavily at the time. She believes his sperm was also damaged. She reported receiving in

home assistance from a behavior specialist who was helping her to manage her children's behavior.

Other Risk Factor: Cognitive/Mental Health Status of the Parent

Ellie reports, *"I still have pretty bad nerves, I'm on Paxil, which takes care of some of the problems I have."* She also reported having anger issues that she has needed assistance to control.

Other Risk Factor: Mental Health Status of the Child

Ellie did not provide specific information about this risk area, but indicated there were some problems. During Ethan's interview, the interview had to end early because he was not able to sit still and listen to the questions, despite being almost 10 years old.

Other Risk Factor: Child's Educational Progress

Again, there was no specific statement made about the educational progress of the children, but Ellie did state that Ethan has problems understanding basic statement sometimes.

Other Risk Factor: Physical Health of Family Members

Ellie reported that she was particularly conscientious of her dental care when she was using methamphetamine so at the time of the interviews she did not have any dental issues. She said, "*I knew that the number one thing that meth does is it screws your teeth up. So I tried to always keep my teeth brushed on a regular basis 2 to 3 times a day. You know I'd also take a bath twice a day sometimes once every day. But I tried to keep that part of me up. I was kind of a clean meth head."*

Other Risk Factors: Participation in Recommended Services

Ellie said that at the time of the interviews, she was working with a child protection social worker, and a homemaker to help her organize and create a routine in the house, and a behavior specialist to help her manage the kids. She said *"six kids is a lot to deal with and trying to keep everyone on a routine, it's kind of hard to do."*

Summary of child maltreatment risks

Risk Item	**Risk Present?**	**Data Element Identifying Risk**	**Family Priority**	**SDM Priority**	**Omaha Priority**
Neglect: Substance use while parenting	Yes	Parent interview			
Neglect: Prenatal exposure	No				
Neglect: Parents involved in meth production	Yes				
Neglect: Criminal activity of the caregiver	Yes				
Neglect: Children witnessing domestic violence	Yes				
Neglect: Failure to meet basic needs	Yes				
Neglect: Lack of supervision	Yes				
Physical abuse	Yes				
Emotional abuse	Yes				
Sexual Abuse	No				
Other: Lack of parenting ability	Yes				
Other: Chaotic household	Yes				
Other: Lack of resources	Yes				
Other: Difficulty in parent/child relationship	Yes				
Other: Difficulty in sibling relationship	Yes				
Other: Child's behavior problem	Yes				
Other: Cognitive/mental health status of caregiver	Yes				
Other: Mental health of the child	Yes				
Other: Child's educational progress	No				

Other: Physical health of family members	Yes				
Other: Failure to participate in recommended services	Yes				

Table 14: Edwards family maltreatment risks

Even though there were not as many documents to review about the Edwards family, Ellie's described 14 of the 21 risk areas identified by the family members in the study, which was the average for the families. Ellie had been receiving child protective services for about two years at the time of the interview, and was actively utilizing the services she was offered. While Ellie described having some mental health concerns, she actively sought out assistance and is taking medication, which has allowed to function adequately as a parent and maintain employment. Ellie identified some behavioral and mental health problems in her sons as a result of being exposed to their parents' methamphetamine use, but did not indicate there were any areas of significant dysfunction. The family was observed by the researchers to be close and engaged in warm interactions with each other, indicating some positive outcomes.

Child protective services response

The Edwards family scored in the high risk category on the neglect scale and moderate on the abuse scale on the SDM. The following chart shows the items on the SDM Risk Assessment Tool for which they received a point. Scores up to 2 indicate low risk, between 3 and 5 indicate moderate risk, and six or above indicate a high risk for future maltreatment (Children's Research Center, 2012).

Neglect	**Abuse**
Number of children in the home	Primary caregiver has/had a mental health problem
Age of the youngest child	Either caregiver has a history of domestic violence
Child in home has a developmental disability	Number of children in the home

Age of primary caregiver Either caregiver has/had a history of domestic abuse Primary caregiver has/had a mental health problem	Child in home has a developmental disability
Score = 6 High Risk	**Score** = 3 Moderate Risk

Table 15: Edwards family SDM risks

This is another family in which the parent contacted child protective services for help. At that time, three years earlier, the mother was leaving the extremely abusive father of the oldest two children and trying to get herself off of methamphetamine and other drug use. Despite making great progress, after three years and a new relationship, there are enough risk factors still present that the likelihood of neglect occurring are considered high. At the same time, at least four of the risk factors are things that the mother cannot change. The same is true for the risk element's identified in the abuse category. The Strength and Needs Assessment tool would then be utilized to determine where to target the required interventions. There is one section completed for the parent and one for each child. For the purposes of this study, only the child that participated in the study was assessed. The Strength and Needs tool assigns a numerical score for the presence or absence of each item as it relates to the risk of further maltreatment. Some items are more highly associated with future maltreatment risk and thus receive lower scores. Scores on each item above 0 are generally considered a strength, while scores below 0 are generally considered a risk (Children's Research Center, 2012). For the Edwards family the strengths and Needs scores were as follows:

Caregiver Strengths	**Caregiver Needs**
Household Relationships (+3)	Social Support Systems (0)
Alcohol and other Drug Use (+3)	Resource Management/Basic Needs (0)
Physical Health (+1)	Mental Health/Coping Skills (0)
Child Strengths	**Child Needs**
Family Relationships (+2)	Emotional/Behavioral (-3)
Education (0)	Physical Health/Disability (-3)
	Child Development (-1)

According to the above measures, child protective services should focus on the mental and physical disability needs of the child. It should be noted that because there were no standardized instruments and the mother's interview was quite brief, there is really not enough information available on this case to move on to utilizing the Omaha system to discuss interventions. There are simply too many unknown variables about the child's functioning level to make a useful attempt.

Chapter 5 – Cross Case Analysis

Risks of child maltreatment

The qualitative interviews of family members and quantitative data from standardized instruments were coded according to risks that were suggested by the Child Welfare Information Gateway (2013) report of indicators of child maltreatment. There were no risks that were identified that were not included in the list of indicators, and risks that no family member discussed were not considered. The chart below shows that of the five families included in the in depth case studies, how many reported experiencing the event in a manner that could be considered an indicator that the child was at risk of being maltreated.

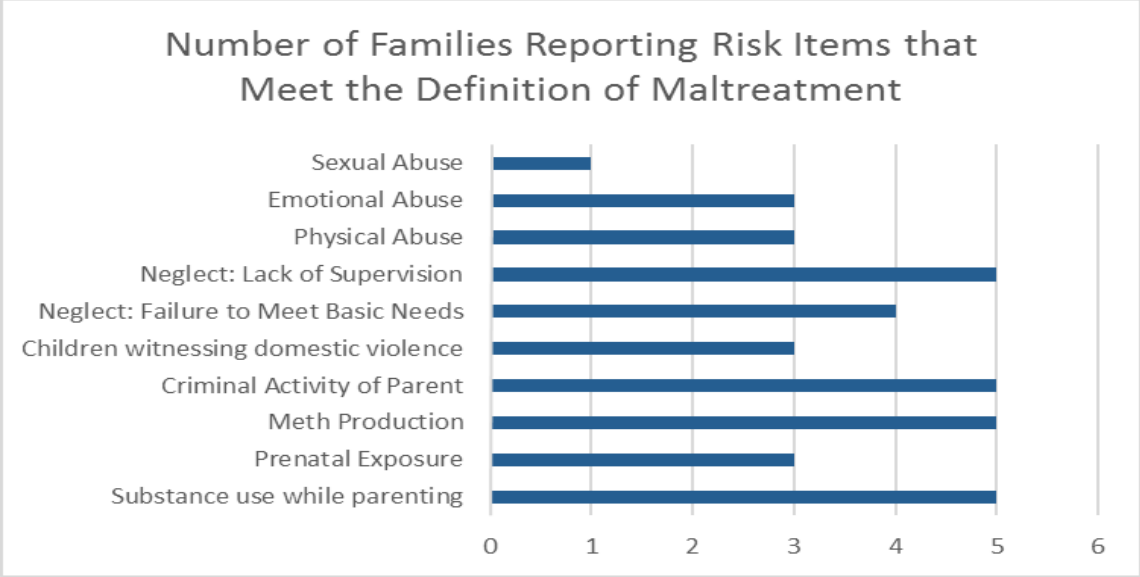

Figure 1: Number of families reporting risk items meeting definition of maltreatment

As can be seen above, not surprisingly, all of the families experienced substance use while parenting. Since the sample was specifically drawn from families that had an

open child protection case and had reported to their social worker that they had used methamphetamine, 100% of the families experienced and described this risk.

A more unexpected revelation is that 100% of the families also reported participating in exposure to methamphetamine production, and criminal activity of the parent. This was usually associated with obtaining ingredients, or distributing meth to others in their community. Even though most of the parents denied producing meth in the immediate presence of their children, several of the children indicated they were aware of the production and that their parent was involved. The mothers suggested that they were responsible for obtaining the ingredients for manufacturing meth, while the fathers were the "cooks" or managed the actual production. The mothers admitted to taking their children with them when they obtained the ingredients, often by shoplifting or theft. All of the parents reported turning to the manufacture of methamphetamine as a way to save money on their own use as well as to make ends meet when they could not get or maintain employment. This is compared to only one family that reported producing marijuana to sell, even though all of the parents also reported using marijuana in addition to methamphetamine. This significant level of movement into the production of the drug seems to be unique to methamphetamine abuse and may explain why law enforcement agencies often scrutinize those reports of parents using methamphetamine more frequently than other substances (Halkitis, 2009).

Related to substance use while parenting, three of the mothers reported using methamphetamine while they were pregnant, contributing to neglect: prenatal exposure to

methamphetamine. All five mothers indicated that they tried to stop using meth once they found out they were pregnant, but three of the mothers admitted that they used for most of the first trimester, while one mother, used sporadically throughout the pregnancy.

The most significant risk factor described was neglect: lack of supervision. While100% of the parents discussed knowing that their meth use was not a positive experience for their children to observe, they also reported at various times they left the children unattended, sometimes for hours on end, while they went to another room to get their "fix." Lack of supervision also came up when parents described "crashing" or coming down from a period of extended methamphetamine use. 100% of the parents reported incidents in which their children were at risk due to being left without adequate supervision while the parents crashed.

Mothers especially seemed more likely to report needing multiple days to sleep after a period of several days of constant use. At the same time, they often tried to plan ahead for ensuring their children's basic needs were met while they were crashing. Three of the five mothers reported using the time they were high to cook meals ahead, get housecleaning done, and get the children bathed, knowing they would not be able to complete those tasks over the days they were crashing. In contrast, while all of the fathers reported the same cycle of use and crash, they seemed to be focus their attention on being more planful in managing the crash intensity and duration. All of the fathers talked about "controlling" the effects of their use, (and sometimes their partner's use) by making sure they continued to eat and sleep during the periods of being high, thus

minimizing the amount of time their bodies spent recovering from the methamphetamine effects. Interestingly, the fathers did not seem to actually increase the amount of time they cared for their children, but rather were more attentive to monitoring and controlling the amount of time the mothers spent on meeting the children's needs.

Although the parents did at times describe creative methods to ensure their children's basic needs of food and clothing were met, four of the five families were continuing to experience the risk of failure to meet basic needs due to inadequate housing at the time of the interviews. The researchers noted on all of the four families' HOME assessments that the housing environment was extremely dirty, and/or there were actual structural deficiencies that posed a danger to the children. Two of the mothers reported that they were often evicted from living environments either for the criminal behavior or for failure to pay the rent. This lack of resources then resulted in having only substandard housing options available to them. The parents were not specifically asked to explain the lack of cleanliness in their home, but parents from at least two families talked about the lack of energy they now feel as a result of their previous meth use. They reported that when they were high, they were able to keep up the cleanliness to a greater standard.

These risks seem also to be related to how families reported experiencing the risk of having a chaotic household. All five of the families reported moving among several (between 3 and 7) states over the course of less than three years. As the parents discussed this risk, they reported that they were often trying to flee the negative consequences of

their methamphetamine use in one state, to start a new life (without meth use) in the new state. Unfortunately, they also reported very quickly becoming even more meth involved in the new state. Then they continued to move from state to state until finally returning to their home state in order to utilize family and community resources.

Besides moving from state to state and home to home within the same community, it was reported in at least four families that numerous people, usually drug dealers and drug using friends were often coming and going from their homes, which also contributed to the chaotic household environment many parents discussed. While research suggests that this movement of people in and out of the family home is common and often results in increased sexual abuse to the children (Walsh, MacMillan, Jamieson, 2003), the children in this particular study did not seem to be at greater risk of sexual abuse than the general population. Only one family reported incidents of sexual abuse. They were not willing to give much detail about the situation, but indicated that it was not related to the previous methamphetamine use.

Within reports of a chaotic household also came discussions of the children witnessing domestic violence. None of the families reported that there was any domestic violence present at the time of the interviews, but the mothers from three of the families reported that their children witnessed domestic violence toward them by previous partners, and the children in two of the families confirmed this exposure. All of the violence reported was substantial and long standing and mothers feared for their lives. In at least two families, it was reported that an assault occurred to the mother while they

were holding a child. The mothers, in trying to protect their children, also moved out numerous times and took the children with them. The mothers reported that these men were the biological fathers of the children, and in two of the families, the mothers were ultimately successful at leaving their husbands, and in one situation the husband died for other reasons. None of the fathers reported being victims or perpetrators of domestic physical abuse, and their current partners denied any physical abuse as well. In three of the families however, the parents did report that substantial verbal abuse occurred when they were using methamphetamine and that it was one of the primary things they were grateful about changing after becoming sober.

These three families were the same families that reported physical and emotional abuse of a child occurred. In addition to the perpetrating domestic abuse, the biological fathers (not involved in the study) perpetrated physical and emotional abuse on the children. Interestingly however, two of the mothers also reported having physically and emotionally abused their children, even after the biological father was out of the picture. Both of them reported that they felt that it was a side effect of "being so messed up" from the methamphetamine. One of the mothers was described as being physically and emotionally abusive still at the time of the interviews.

In addition to the risk factors that are directly related to child maltreatment, there are a number of risk factors, under the category of other risks, which the parents discussed. These other risks, tend to relate to care for the child's well-being, one of the three primary target areas of child welfare services.

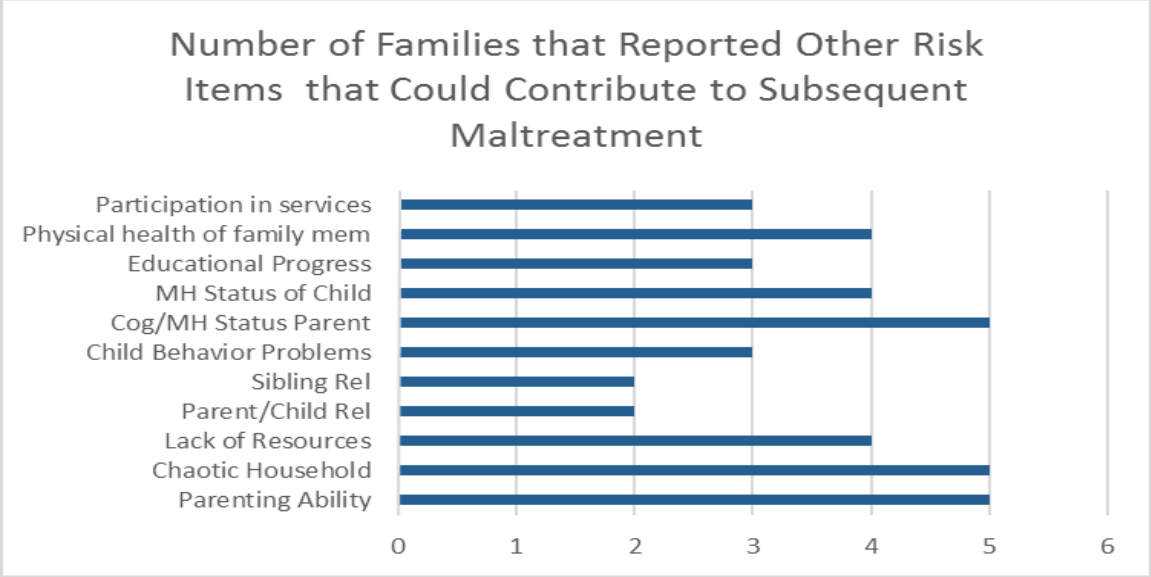

Figure 2: Number of families reporting other risk items that contribute to maltreatment

As discussed earlier, 100% of the parents reported that their meth use had a negative impact on the parenting ability. Although they reported trying to ensure the children's basic needs were met, all of the parents reported that during the height of the methamphetamine use, they were less than attentive to their children's emotional needs. All of the parents reported that caring for their children became secondary to their meth use and that the children were often pushed off onto other friends or relatives or simply ignored and left to fend for themselves. One of the parents echoed the sentiment of all of the parents saying, "*I was always hiding from the kids, trying to not let them know what I was doing"* and another said *"I let them do what they wanted, as long as they were quiet."* A third parent lamented that she missed out on much of that time of her children's lives, "*there was a lot of stuff I should have done . . .I really, really hate the fact that I missed out on a lot of the kid's stuff when they were little."* All of the parents

talked about how they have worked on improving their parenting abilities once they stopped using, with some reporting more success than others.

Another risk that was described by 100% of the parents and confirmed by at least some of the psychosocial measures, is the mental health or cognitive problems of the parents. It is hard to know from the interviews however if the problems came as a result of the methamphetamine and other drug use, or if their cognitive and mental health issues made them more vulnerable to addiction. It seems as though the parents believe that that it is the former, that their life circumstances took a turn that led them to drug use, and now as a result, they have long term mental health concerns. The women in particular described their mental health difficulties, saying things like, *"I have no brain left, my memory is shot,"* and "*I still have pretty bad nerves,"* and "*I have depression and other stuff, I'm a mess!"* While the men did not identify mental health problems as readily in their interviews, they did report some problems on the standardized measures. Only one of the parents tested with low cognitive ability, scoring more than one standard deviation below the norm.

In addition to mental health problems, a surprising number of the parents reported ongoing physical health problems, with two of the eight parents actually receiving disability for their health issues. Again, it is not clear if the health issues are the result or the contributor (or likely both) to the drug use, but it seems to be practically significant that 7 of the 8 parents (88%) reported significant physical health problems. As is expected given the popular knowledge of the impact of meth use on teeth, 6 of the 8

parents reported significant dental problems. Again, while this is not a risk factor that in and of itself contributes to child maltreatment, the level of physical health problems and the parents' descriptions of how debilitated they feel as a result, suggests that there is an impact on the parents' abilities to meet their caregiving responsibilities, at least, and possibly contributes to higher stress levels and mental health instability at worst.

These physical and mental health problems also were reported to contribute to a lack of resources for at least four of the five families. While all families reported at least some emotional and some financial support from an occasional family member, some of their extended family members were also involved in substance abuse. At the time of the interviews, all of parents reported living on their own and having to rely on their own ability to meet their family needs. Four of the five families reported having only minimal financial support, with no family reporting an annual income above the poverty threshold for their household size (US Census Bureau, 2008). Two of the families in fact had incomes that would put them in extreme poverty, or less than half of the poverty level. As discussed earlier, this lack of resources was also evident in the housing that was available to them. It also likely had an impact on the availability of learning and other nurturing opportunities as measured on the HOME assessment. Only one of the families scored near the median on this subscale.

Four of the five families reported a cognitive or mental health problem for at least one child. The degree of difficulties ranged from some post-traumatic stress indicators reported by one child to clinically significant scores on almost every measure of

psychosocial functioning for another child. The two oldest girls, who were young teens at the time of the interview, seem to be struggling the most, possible because of their extended exposure times to their parents' meth use. Both of the girls were also witnesses to severe domestic abuse against their mothers. As a group, however, the children seem to be doing quite well in their psychosocial development. This seems surprising given the levels of addiction, however it should be noted that many of the children have received intervention services which may have contributed to the positive scores. These findings will be discussed more in depth with each of the standardized scales discussions.

The mental health problems of the children seem to be related to the risk factor of child's behavior problems, as the three of the families reporting having a child with behavior problems were also included in the four families with a child with a mental health or cognitive problem. Two of the three girls in the study were reported to have clinically significant problematic behaviors related to controlling anger and physical aggression, while one of the boys had similar behavior problems to the girls, and a second boy was reported to have problems following direction and sitting still.

Educationally, the children all seemed to be making adequate educational progress, although three of the families indicated a concern about at least one of their children. None of the children was reported to be performing below grade level, and the reported concerns may have been skewed by the parent's concerns about their child's cooperation with completing schoolwork vs. their actual ability to perform.

Two of the families reported significant problems in the parent/child relationships and the sibling relationships. These were the same two families, and were also the same two families that had the three children who were struggling behaviorally in all settings. It is possible that these items are all related. This particular study does not adequately examine this interrelationship, but it is certainly an area for recommended further study. The families that did not report problems in this area, in fact reported their family relationships to be a strength, and the researchers confirmed the strength with their observations. It seems that for the families doing well in this area, the parents reported a stronger commitment to staying sober and improving family life.

Not surprisingly, two of the families that are struggling in their relationships are also struggling to follow through on recommended services such as treatment program requirements and mental health services for family members. These families also are the families in which the parents are also still using marijuana, and as a result also seem to be under extended scrutiny from child protective services. While sobriety alone does not guarantee a reduction in risks, it seems for the families in this study, those that were not actively using, regardless of previous use history were displaying less concerning risks.

In summary, there were a total of 21 risks identified by family members during the study. Of the five families, the highest number of risks reported was 20 out of 21, and the lowest number of risks reported was 11 out of 21, which was just under the average of 15. The families that were furthest along in their recovery were the Brown and Duncan and Edwards families, while the Carter and Abbott families seem to be

struggling quite a bit with the shortest time in recovery and the greatest number of individual psychosocial and family problems reported. This would seem to indicate that number of risks is less important than type of risk.

The areas of risks that were identified by all of the families included the risks of substance use while parenting, exposure to meth production, criminal activity of the parent, and lack of supervision, lack of parenting ability, chaotic household, and mental health or cognitive problems of the parent. The first four risks are associated with direct child maltreatment findings, while the last three are considered other risk factors that contribute to an increased likelihood child maltreatment could occur. According to the parents' reports, the most concerning for them were the substance use, the lack of supervision, and the lack of parenting ability, as these were the areas they were most likely to report negative concerns. Even parents who reported risk due to parenting ability however, also described situations in which they made sure to meet their children's needs despite the distraction of their meth use. The lowest level of reports of risks for the families in this study were related to the relationships of family members, which many parents and children reported actively working to improve.

Standardized psychosocial measures of the parents

A number of standardized psychosocial tests were given to the parents and the children in the study, in order to gather more information on potential mental health problems and/or trauma experiences among the family members in the methamphetamine involved families. Each test will be discussed individually regarding the findings for the

parent group or the children group as a whole. Any unique outcomes for individual participants was discussed in the individual family experiences in Part I of this chapter. When possible, the T score is given, which indicates the family members score as compared to the population with 50 being the population mean and 10 points in either direction the equivalent of 1 standard deviation above or below the mean (Brock, 2015).

Parents –Shipley. The Shipley Institute of Living Scale is intended to measure the cognitive functioning levels of the parents. This is an important measure as it can identify any problems a parent may have in interacting on a verbal or abstract basis with their environment.

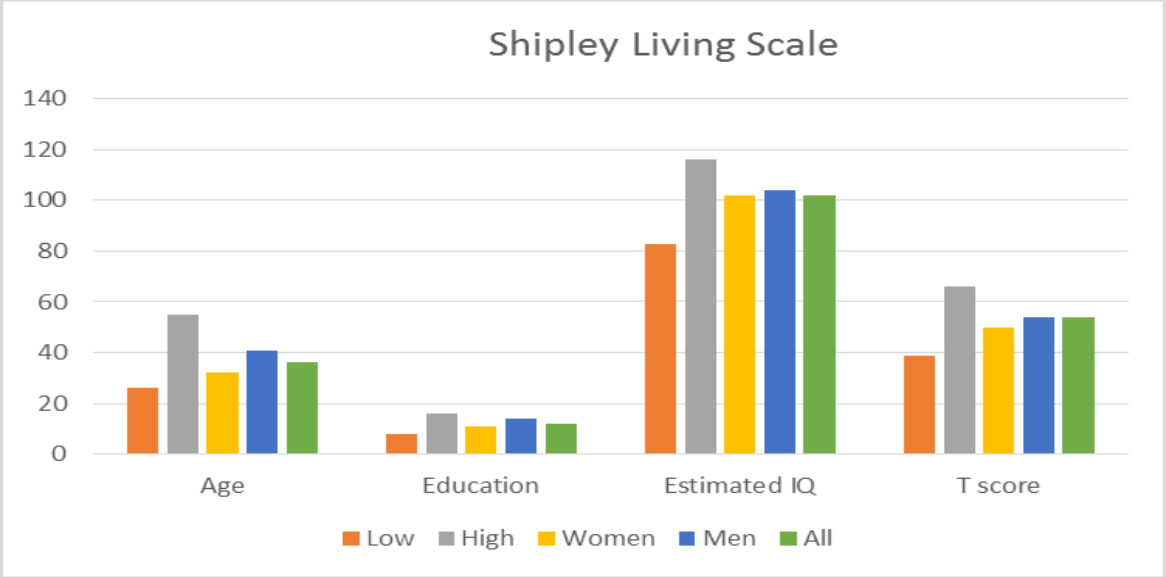

Figure 3: Shipley Living Scale scores for parents

As a group, the 7 parents tested range in age from 26 to 35 years of age for an average age of 36. Their educational level is from a low of 8th grade to a high of four years of college. These ends could be considered outliers however, as the other five parents all reported 12 years of education or high school diploma equivalent. The

estimated IQ ranged from 83 to 116. This correlates to Total T score ranges from 39 to 66. Not surprisingly, the person with the lowest educational attainment also scored the lowest in the estimated IQ. The person with the highest estimated IQ had an average level of educational attainment. As a group, the parents' mean T score of 54 was within the normal range, or just slightly above the mean score of 50. The parent with the lowest score scored just under 2 standard deviations from the population norm, indicating some serious cognitive concerns, and that would be recommended for further assessment. The woman with the highest score was the spouse of the man with the highest score. Interestingly, the parents with the highest scores were from the family reporting the highest number of maltreatment risks in part I, 20/21; while the person with the lowest score was from the second highest scoring family at 18/21. While the sample size is too small to draw any conclusions, for this group cognitive ability does not seem to be directly related to levels of risk.

Parents – Addiction Severity Index (ASI). The Addiction Severity Index is an interview guide used to understand a person's addiction history and quantify it in relation to health status, legal status, employment status, family status, and psychiatric status (McClellan, Luborsky, O'Brien, & Woody, 1980).

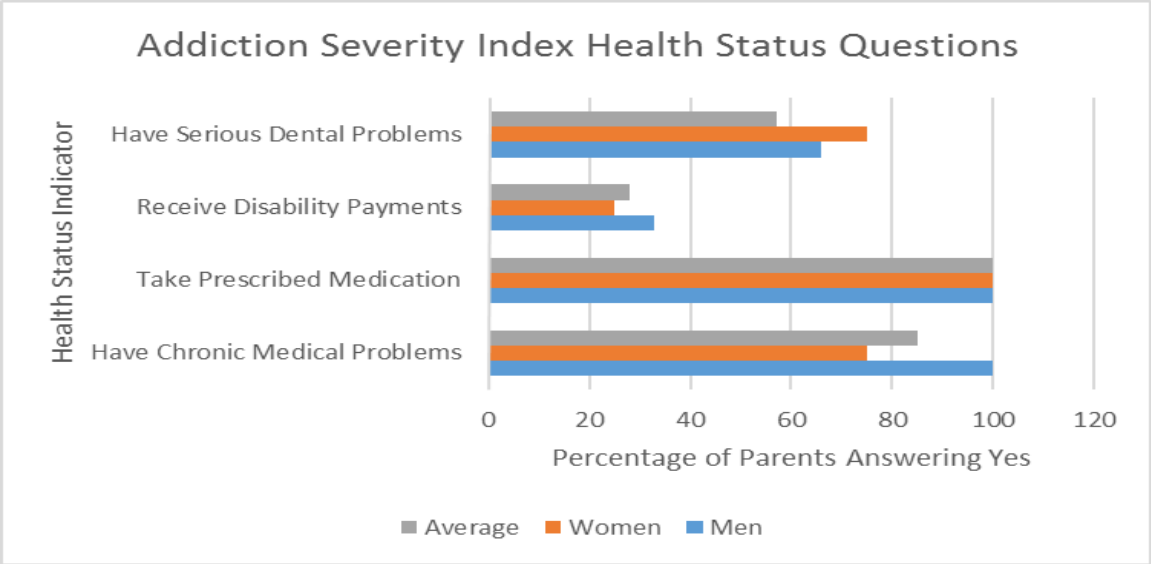

Figure 4: Addiction Severity Index Health Status Questions

As the chart shows, 75% of the women and 100% of the men report chronic medical problems, although it cannot be assumed that the problems are the result of methamphetamine use as that is not the way the question was asked. Interestingly, 100% of the parents interviewed indicated they were taking prescribed medications for a medical problem, which indicates at least one of the parents taking medication did not see her problem as chronic. Only 1 man and 1 woman, not from the same family, indicated that they were receiving a disability pension, meaning that their medical problem is long term and likely to keep them from being fully employed. The men reported a higher number of days of struggling with their medical problems than the women. All but 1 woman and 1 man reported serious dental issues, most of which they did attribute to their meth use. The parents from the families reporting the highest number of risk factors were also the two families that had the most problems in the health status area. The lowest health status did not seem connected to the lowest number of risk factors however.

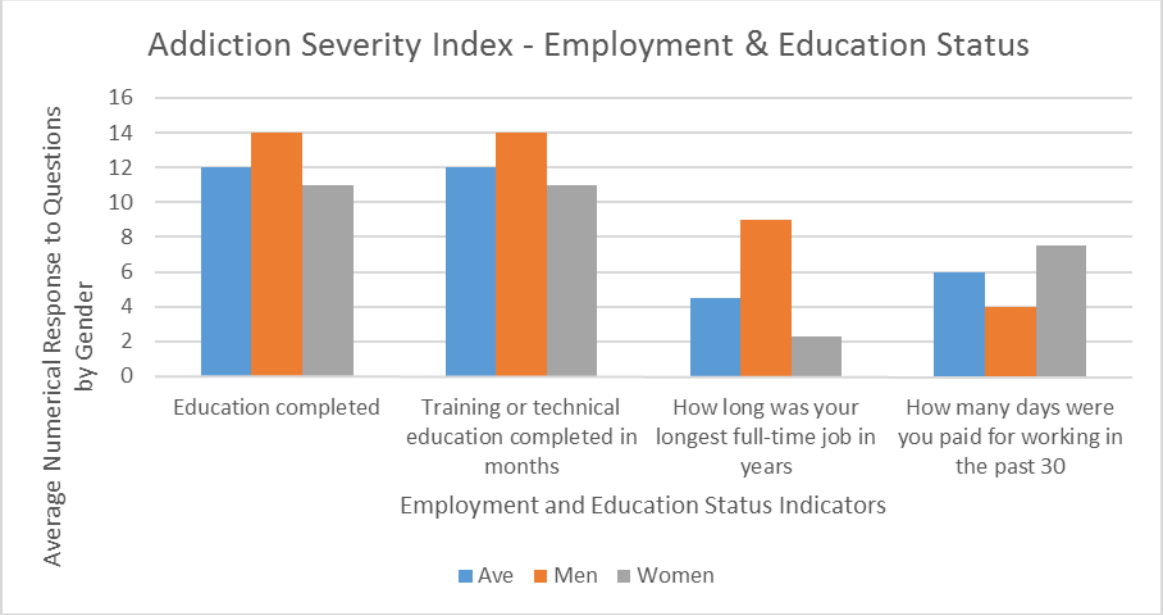

Figure 5: Addiction Severity Index Employment and Education Status

As was stated earlier, all of the families struggle in the area of employment. The men have the longest employment histories but that is likely a factor of age. In the 30 days prior to the interview, the women actually worked more days, but one of the men was receiving unemployment because he had been laid off. Of greatest significance is that none of the families are earning enough to raise them above the poverty threshold. Given that two of the families consist of parents are receiving at least partial disability payments, it is unlikely that these amounts will change significantly. This is a concern especially given that all of the parents spoke about selling drugs as a way to make ends meet. The amount of income the family received does not follow the trend line of the number of child maltreatment risks each family identified.

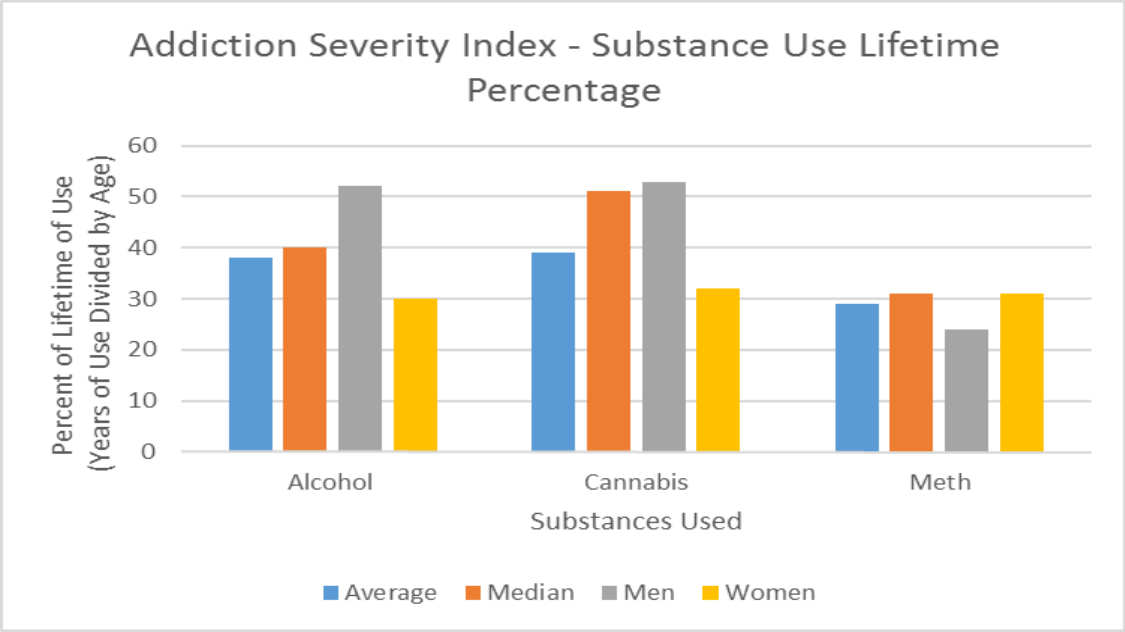

Figure 6: Addiction Severity Index Substance Use Lifetime Percentage

The above chart shows the average by group of the percentage of lifetime that the members were involved with drug use. Given the different ages of the parents in the study and the different lengths of time they all used each substance, the number of years the parents reported they used was divided by the age of the parent to calculate the lifetime percentage. For all parent groups, cannabis use was a tiny bit higher percentage of their lives than alcohol and men had longer lifetime histories with both alcohol and cannabis. Interestingly, methamphetamine use was reported to be a larger part of the lifespan of the women than the men. This may be due to the fact that men as a group are older, and meth has only recently been more commonly used. Also, it seems as though the women transitioned into meth use more quickly during their overall drug using tenure. There does not seem to be a connection between the percentage of lifetime of

drug use and the number or type of risk factors that the families reported, as the family with the longest reported meth use is the family that reported the fewest number of risks.

Not surprisingly, as a group, 100% of the parents reported having been arrested at least once. The two parents with the highest number of arrests however, Barbara Brown at 8 and Charlie Carter with 7, report that the majority of their arrests had to do with their alcohol use and not with their meth use. Barbara specifically reported that all of her arrests occurred as a juvenile, when she was regularly charged with underage consumption. The lack of arrests related to methamphetamine involvement is particularly interesting given that 100% of the parents reported committing crimes in the course of their meth use, either in obtaining precursors or in manufacturing and selling the drug. Many parents reported feeling lucky they had not been arrested. This finding may have something to do with the sample selection however, as it is likely that if a parent had been arrested and convicted for meth related criminal activity, they would not have been available to participate in the interviews.

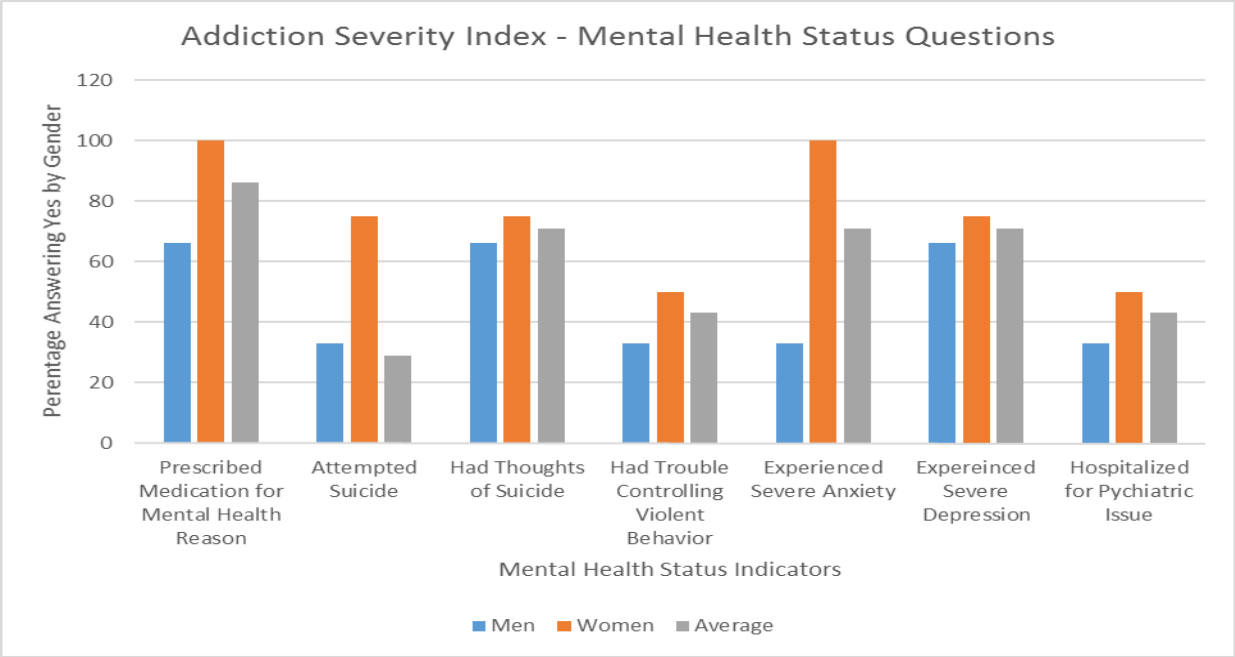

Figure 7: Addiction Severity Index Mental Health Status Questions

Similar to the reports of physical health problems, the majority of the parents reported having significant mental health problems. Only one parent replied no to all questions related to mental health concerns. His spouse however answered yes to all the mental health questions, indicating that 100% of the families had a parent that had significant mental health problems. The most common problem experienced by both men and women appears to be anxiety. It is also important to note that the parent who had a finding of child maltreatment for physical abuse answered 'no' to the question of whether they had trouble controlling their violent behavior, suggesting there may have been some minimizing of responses. It is also remarkable to note that the family with the parent who denied all questions related to mental health problems, also had the lowest number of risk factors identified of all of the families, in the study. At the same time, the families that had the two highest number of risk factors, also answered yes to the highest

numbers of mental health risk factors. This would indicate that perhaps there should be a larger study that looks specifically at the correlation of mental health problems on the part of the parent and subsequent child maltreatment.

Overall, the ASI standardized measures confirmed the presence of many of the risk factors the parents identified in their interviews. Most notably, all of the families reported having a parent with a significant physical health problem and a significant mental health problem, and the level of mental health concerns seemed to follow a similar trend as the number of risk factors identified by family members, with more mental health problems reported in families reporting more risk factors. There did not seem to be a trend among families with the subscales related to employment, criminal history, or addiction longevity.

Parents – SCL-90-R. The Symptom Checklist 90 (SCL-90-R) is a standardized instrument intended to measure psychological distress in adults. Given the high rates of mental health concerns reported by the parents during the Addiction Severity Index, it seems important to explore further the extent of those concerns. On the SCL-90-R, parents answered various questions about their thoughts and emotions and their responses to those questions are then grouped according to psychological problem subscales. In this way, the response to a single question may not indicate a clinical level of concern, but similar answers to similar subscale questions does indicate whether a particular subscale should be explored further. The subscales include; Somatization (SOM), Obsessive-Compulsive (OC), Interpersonal Sensitivity (IS), Depression (DEP), Anxiety

(ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR), Psychoticism (PSY), Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST). The responses are converted to T scores, which indicates that scores between 40 and 60 are within 1 standard deviation of the norm, while scores above 60 or 1 standard deviation are considered concern for further exploration and scores over 70 or 2 standard deviations are considered to be of clinical concern.

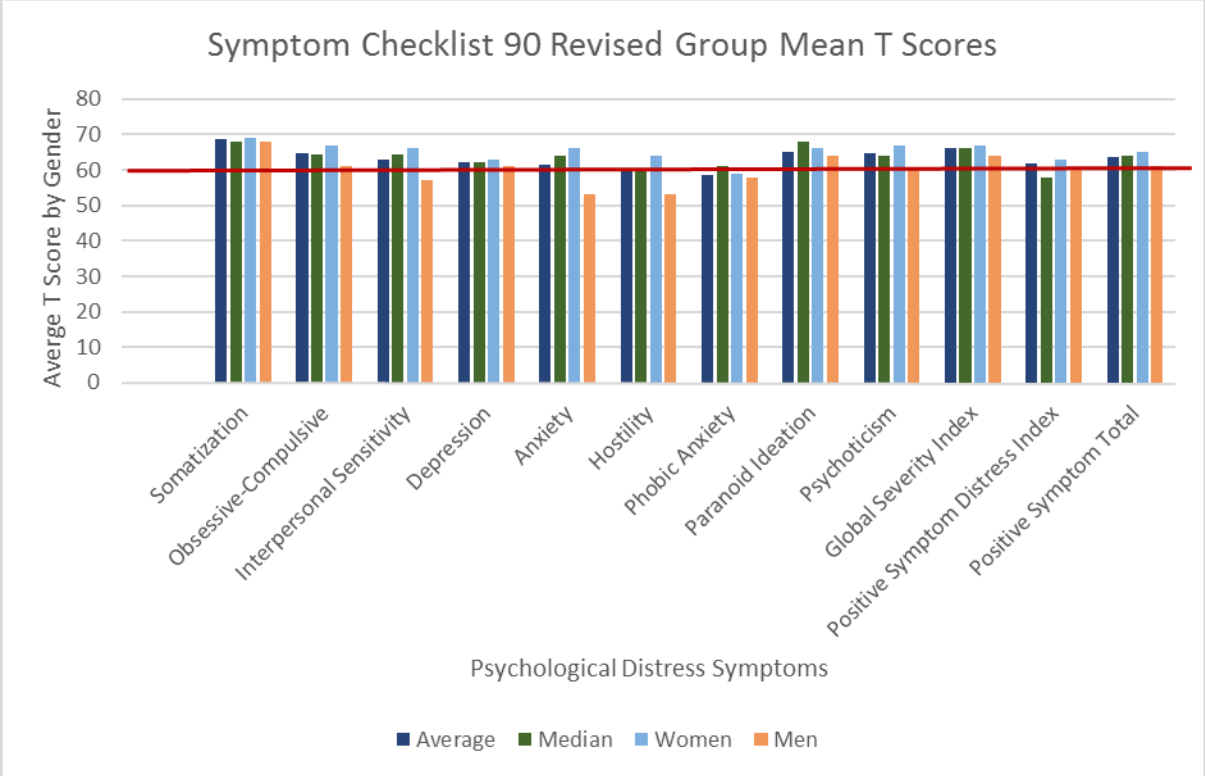

Figure 8: Symptom Checklist-90-Revised Group Mean T Scores

As can be seen on the above chart, as a group, the parents scored just above or below the 1 standard deviation line (T- Score of 60) on most measures, meaning that they are for the most part doing adequately, but there may need to be some psychological

interventions if a crisis or some other trauma occurs. Interestingly, the subscale for anxiety, which was reported as elevated for the majority of parents on the ASI, was within the norm on this instrument. This may suggest that parents experience this issue as a greater concern than clinicians may indicate. The subscale of greatest concern is somatization, or the reporting of psychological concerns manifested as physical complaints. This is particularly interesting given the high number of physical health concerns reported by the parents on the ASI and during the qualitative interviews. It may be that the parents are experiencing physical pain due to emotional and psychological experiences. As a group, the women seemed to have slightly higher than average scores on each of the subscales, but that average is skewed by the results of one parent that scored above 2 standard deviations on every measure. One of the fathers scored above 2 standard deviations on 6 of the measures as well. These two parents are from the two families in which the parents are struggling the most with their sobriety and report continuing to use marijuana and prescription drugs occasionally. It is possible that they are using the marijuana to treat their symptoms of psychological distress. Also, both of these families reported that they are not participating in services as recommended, which is different than the other two families who have actively embraced a sober lifestyle and attending Narcotics Anonymous meetings and other social services for support. It seems as though it may be easier to achieve total sobriety if the parent has fewer mental health concerns. Again this study is too small to make any correlations, but it suggests the need for a further larger study to examine the intersection of total sobriety and mental health

concerns among parents. There does not seem to be any similar trend of level of psychological distress and the number of risk factors reported by the families.

Children – PPVT-III. The Peabody Picture Vocabulary Test, 3rd ed. (PPVT-III) measures vocabulary response abilities in children and is considered indicative of intellectual functioning. The test is important for consideration in this study as it identifies whether children have the language ability to understand and respond adequately to interview questions, as well as indicating how well the children are cognitively functioning in their daily lives. Five children from four of the five families participating in the study were evaluated with the Peabody Picture Vocabulary Test-III.

	Ave	Boys	Girls
Chrono Age	10.4	9.0	11.5
Raw Score	131	116	141
Standard Score	99	98	100
Percentile Rank	49	56	50

Table 16: Peabody Picture Vocabulary Test -III Average Scores

The children range in age from 7 to 12, with an average age of 10.4. The girls are slightly older than the boys, with and average age of 11.5 for the girls and 9 for the boys. The children's raw scores ranged from 107 to 152, while their standard scores ranged from 96 to 106. The percentile ranks show how they compare to the general population, and as can be seen the boys did slightly better than the girls at the 56th percentile, but overall the children seem to cluster around the average on their performance. The two highest scoring children, the oldest of the group and the two girls, were also from the two

families that reported the highest number of risks of maltreatment. There was not a similar trend among the two lowest scoring families and the PPVT-III performance of their children. Given the above scores, it seems as though the children should have been able to understand the questions given to them, and should be functioning reasonably well in their daily lives.

Children – TSCC. Considering that all of the children have experienced maltreatment as indicated by their parents' reports of substance use in their presence as well as involvement by child protective services, it would be expected that they would be impacted by these traumatic experiences. The Trauma Symptom Checklist for Children (TSCC) is used to measure trauma and abuse experience symptoms in these children. The children respond to questions regarding their feelings and emotions, and their answers are combined into subscales that may indicate clinical concerns. The subscales are; Under response (UND), Hyper response (HYP), Anxiety (ANX), Depression (DEP), Anger (ANG), Posttraumatic Stress (PTS), and Dissociation (DIS).

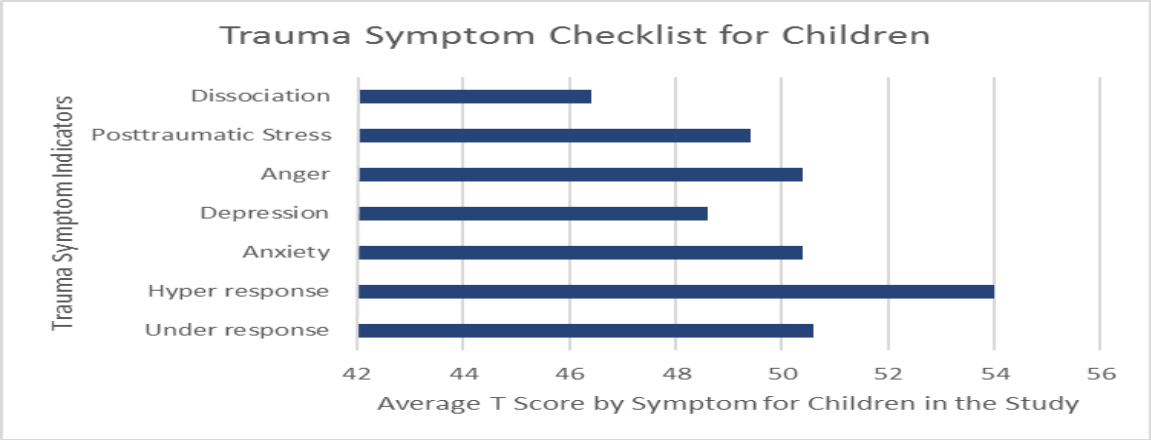

Figure 9: Trauma Symptom Checklist for Children Scores

Although one would expect the children to report significant trauma symptoms, as can be seen above, as a group, the children scored less than 1 standard deviation above the mean (T score of 60) on all subscales and seemed to cluster around the norm of 50. It should be noted that one child scored in the clinical concern level for under responding and one child scored in the clinical concern level for hyper responses. Despite this the child responding high in the hyper response level, only scored in the clinical concerning area of one subscale, anxiety, where she scored just over 2 standard deviations above the norm. Given the information learned in the qualitative interviews with both her and her mother, this seems to be a likely score. The only other child's score that was of clinical concern was in the subscale of posttraumatic stress and this score was also 2 standard deviations above the norm and consistent with information shared by him and his parents in the qualitative interviews. Interestingly, both of these children were from the two families reporting the highest number of child maltreatment risk factors. Both of these children were also reported to be receiving counseling services so these concerns were being addressed.

Children – CBCL. The Child Behavior Checklist (CBCL) is a standardized instrument used to measure emotional and behavioral problems in children and adolescents. Unlike the TSCC which asks children directly, the CBCL is answered by parents about their children. The CBCL is a more complete and comprehensive tool, but consists of similar although not identical subscales, which are also separated for internal and external behaviors. The subscales on the CBCL include the internal subscales of

Anxious/Depressed, Withdrawn/Depressed, and somatic complaints; the external subscales include Rule-breaking behavior and Aggressive Behavior; rounding out the instrument are the subscales of Social Problems, Thought Problems, and Attention Problems. The scores are reported as T scores, with the normative score of 50, and 1 standard deviation each 10 points above or below. Generally speaking, a score of between 60 and 70 indicates a level of concern that the subscale items should be explored further and a score of above 70 indicates a need for clinical intervention.

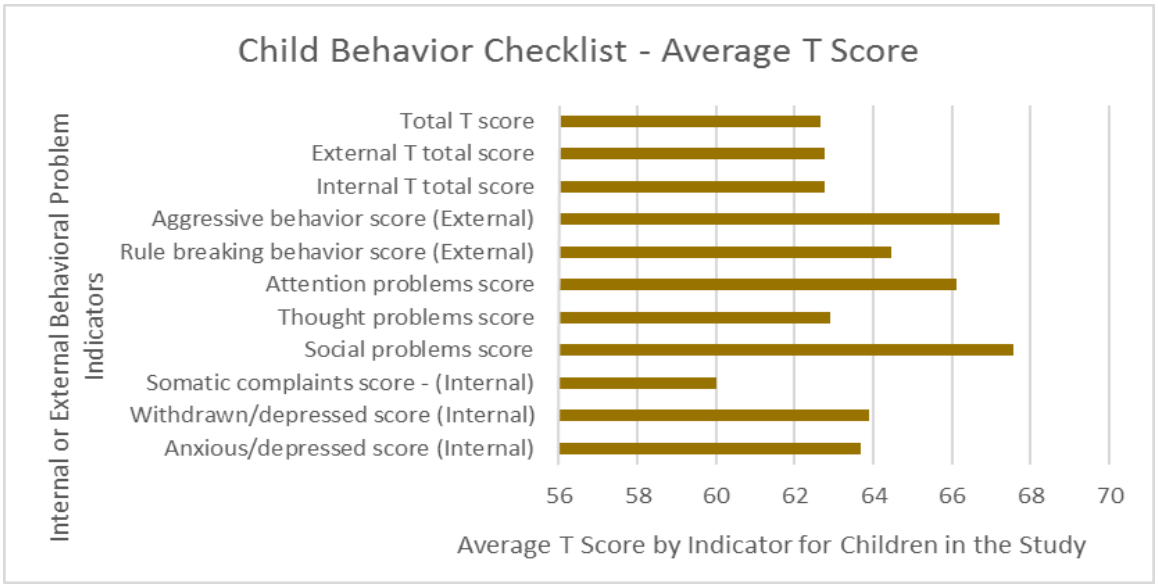

Figure 10: Child Behavior Checklist – Average T Score

As can be seen above, the children on average scored above 1 standard deviation above the norm (T- score of 60) on all subscales with the exception of somatic complaints. This is particularly interesting because it is the opposite of the parent findings, in that for the parents as a group, the somatization subscale was their highest score. The interviews revealed only one child had any physical health concerns and that may explain this score for the children. As a group, the greatest concern for the children

were the subscales of aggressive behavior and attention problems, with rule-breaking following close behind. Only two of the children, the two oldest girls, scored above the average of 64 and only one of the boys scored above 60 with a score of 61. The two youngest children had no scores above 60 on any subscale, and they also came from the families that reported the lowest number of risk factors. Two of the children, a boy and girl, came from the family reporting the highest number of risk factors, and they had the second and third highest subscale scores of the children's group, although the boy's scores never went above 64, and his cumulative Internal behavior score was at the norm of 50, and his External behavior score was 64, so an area of concern but not reaching the level of clinical intervention needed. His sister's internal and external scores were 62 and 70 respectively, which again, indicate some concern but not necessarily a need for clinical intervention. Given that the CBCL questions are answered by the parents, it should be added that for this family, the parents seemed to overstate their son's cognitive and academic abilities, and understate their daughter's abilities. When the CBCL scores are compared to the TSCC scores for these two children, the son's responses actually result the highest subscale score of 70 for post-traumatic stress. His sister's highest score is 67 for anger. This could however relate to the elevated external behavior score she received on the CBCL. The two instruments have been studied for concurrent validity with each other and have been found to be valid (Briere, 1996), so it is possible this situation is unique for this particular family.

The child that scored the highest had elevated scores above 70 or 2 standard deviations for all of the subscales. These scores are also substantially higher than her scores on the TSCC, where she scored above 80 for hyper responses, even though her only score above 70 was for anxiety, and her only score between 60 and 70 was an anger score of 62. This compares to the CBCL aggressive subscale score of 88 and a composite internal behavior subscale score of 80. Given that this is the family that also reported the greatest level of problems in parent/child relationships, it seems these scores may be more indicative of that issue. At the same time, the child was observed by the researchers and reported herself to be involved in situations in which she acted aggressively toward her siblings.

Risk assessment tools

The use of systematic methods of intervention planning seem to be a useful process for child protective services social workers. As stated earlier, most CPS social workers are familiar with and use a risk assessment tool such as the SDM to identify which problems to prioritize. Given the extensive risk factors that were identified by families in this study, having an actuarially based tool to prioritize problems seems to be very useful.

Across families, the highest risk category scores identified on the SDM were for neglect, with three of the five families scoring at the high risk level and two scoring at the moderate risk level. Only one family scored in the high risk category for abuse and that was the family that had just had a maltreatment determination for abuse. Within the risk

factor items, the risk factors most commonly identified were; number of children in the home is two or more which was all five families, primary caregiver has/had a mental health problem which also applied to all five families. The next most common risk items were; either parent has a history of domestic violence which applied to three of the five families, and either caregiver has/had an alcohol or drug problem during the last 12 months. The drug or alcohol problem risk factor would have included all five families if not for the 'last 12 months' qualifier. The risk factor of 'number of children in the home' was scored for all five families, but none of the families identified that as a risk factor in their interviews, nor was it listed as a factor on the Child Welfare Information Gateway list. Only one parent commented about the number of children, Ellie Edwards mentioned that with six kids in her home, she felt that things were often chaotic.

The SDM Strengths and Needs Tool was fairly consistent with the needs that were determined to be of highest priority. The most common parent needs were resource management/basic needs, mental health/coping skills, and alcohol and other drugs. Some of the needs identified in Part 1 however, did not seem to rise to the level they should have, for example, for almost every family, the researchers noted safety issues in the environment, however that was not specifically identified as a priority by the SDM. This may not be a problem in practice however as the CPS social workers are able to use their practice judgment and provide services in addition to the problem areas that are prioritized. The SDM Risk Assessment tool also identified a number of risks such as age of parents and number of children that cannot be corrected by the parents, so while they

are risk factors, it may be more important to consider the factors that are within the caregiver control.

It also seems to be important to include the client perspective on the problems they see as most pressing, in order to improve engagement in the change process. As stated in many individual instances, by classifying the lowest scoring items as "strengths" it seems to misrepresent the degree of difficulty many families face in those areas. For example, one of the most common "strength" items was physical health, and yet it is clear from reading the interviews that this is one of their top concerns. It seems as though family members could feel as though their prioritized concerns are dismissed if they are presented as a strength area and do not receive the attention the parents feel is warranted. Worse yet, when a particular item is scored as a strength, families may perceive it as something that should be ignored, when in fact it may be something that does in fact require an intervention.

As the Omaha system demonstrates, each plan can be personalized according to the specific intervention needs based on Knowledge, Behavior and Status (KBS ratings) of the client. It also seems useful in recognizing the nuanced differences in family functioning by item level. Two families with the same problem may in fact be experiencing them in very different ways and the Omaha system seems to represent that really well. By using the KBS ratings at regular intervals, the social worker is able to ascertain whether progress is being made, even when the problem may still exist. Given that problems that families face are unlikely to simply disappear, it seems helpful to

consider during the course of services if progress is being made and if not, discontinue the specific intervention and try something else. In addition, it seems as useful to use the KBS ratings to evaluate program level interventions and pinpoint the areas where greatest success is happening and the areas where new interventions need to be developed in order to address improvements that need to be made.

Chapter 6 Conclusion

Child protection social workers are encountering methamphetamine involved families more than ever before. As such, it is important that social workers understand the unique risks and needs of these families. While substance abusing parents with children is not a new phenomenon, meth contributes to the risks of maltreatment in a few ways that are different from other drugs. First, use of the drug itself is more likely to contribute to long periods of parental incapacitation and inability to respond to their children's needs. Second, meth, unlike other street drugs, is able to be manufactured in makeshift labs that pose additional environmental hazards to the children. Currently, children from methamphetamine involved families are more frequently placed in out of home care than children whose parents use other drugs. This is due to the social workers' perceptions that the situations for the children of parents using meth are more dangerous. Yet we know very little about the parents' perceptions of family life during their methamphetamine use and the degree to which they are aware of the risks it poses. Through intensive case studies and cross case analyses, the experiences of the family members within the context of risk of child maltreatment, the psychosocial contexts within which they exist, and the typical child protective services responses were examined. The findings of this study however, should be understood within its strengths and limitations.

Findings

One of the benefits of case study research is that it rests in the gap between research and practice (Lee, Mishna, & Brennenstuhl, 2015). This is certainly the case for this study. It is important that this research provide information that can guide not only future studies but also the ways that current child protection social workers approach and engage families that experience methamphetamine use and child maltreatment. Rather than provide a one size fits all approach to ensuring child safety, this study sheds some light on the nuances of parenting while using methamphetamine, and should help child protection workers understand the need for individualized interventions.

1.) How do family members and other professionals engaged with the family describe the experience of parenting while involved with methamphetamine, within the framework of child maltreatment risk?

It was somewhat surprising the relative consistency in the number and types of risks that children were reported to have been exposed. Similar to the findings of Walsh, MacMillan, & Jamieson, (2003) the families in this study reported risks related to neglect most often, and the children most commonly suffered from a lack of food, adequate shelter, and supervision. Similar to the findings of Black, Haight, Ostler, (2006), inadequate shelter was of particular concern noted by the researchers in this study, however it is unknown the degree to which family members found this to be a concern as only one parent in this study spontaneously discussed this issue, but others said that their minimally adequate housing options were clearly a result of their meth use. All of the

parents reported instances when they did not supervise their children, either because they were in the act of using, or they were sleeping for long periods of time after a binge.

This lack of supervision was present in 100% of the families as was a subsequent chaotic household, similar to findings by Asanbe, Hall, & Bolden (2008) and Grant (2000). As they found, the parents in this study were unable to establish the home environment with necessary structure and routine, often leaving the children to fend for themselves. The parents then had to respond to numerous crises that were created by the children's problematic behaviors, similar to the findings of O'Connor, et. al. (2005).

However, like Klee (2002) established, many of the parents in this study discussed efforts that they had taken to both minimize the impact of their use such as at least initially using in another room, and ensure their children's basic needs were met by cleaning and cooking meals ahead of time so that when they "crashed" their children would be able to live in a clean environment and be able to eat. It is possible that these strategies are why none of the families in the study were referred to child protective services as a direct result of their methamphetamine use. This action also seems to indicate a potential strength in the knowledge area of parenting skills, however as Klee (2002) also found, as the addiction progressed for the parents in this study, they either underestimated the impact of their use on their children or they simply ignored that knowledge and it wasn't until they became sober that they acknowledged the extent to which they had been neglectful.

Unlike the findings of Asanbe, Hall & Bolden (2008), few of the families in this study reported physical abuse to their children. Only one instance of physical abuse was determined, and that was after the mother had stopped using methamphetamine.

Similar to the findings of Haight, Jacobsen, Black, Kingery, Sheridan, & Mulder (2005), the children in three of the five families were reported to have been exposed to severe domestic violence. This violence was often directed at their mothers by their biological fathers (none of the abusive fathers were part of the study.) The children in these families seemed to remember this domestic abuse more vividly than the drug use of their parents, although they reported knowledge of that as well. The two oldest girls in the study, who had observed the most severe domestic abuse, were also reported to have the highest levels of externalizing trauma behaviors, similar to what was found by Haight, Ostler, Black, & Kingery in 2009.

Surprisingly, 100% of the parents reported being involved in criminal activity as well, including the production of methamphetamine. While it was expected that some of the families would report some involvement, it was surprising that 100% of the families reported involvement. This may have more to do with the location of the study in a rural, poverty stricken Midwestern community, an issue that was found to be a contributing factor by Covey (2014), Beckkett (2012) and Haight, Ostler, Black, & Kingery, (2009). As was also reported in the Haight study, all of the parents in this study stated that an impetus for the manufacturing was to reduce the cost of their own use, and also

supplementing their incomes, all of which even after achieving sobriety remain under the poverty threshold.

Although the reports of criminal activity by the parents in this study were quite high, their subsequent arrest and prosecution rates seemed fairly low, as only two of the parents reported ever facing charges directly related to the methamphetamine use or production. Several parents noted however that they "were very lucky" to not have had more consequences. This is important in light of the fact that it is common for reports of methamphetamine involved parents to come to CPS from law enforcement agencies. If prosecution rates are low, it could mean the number of families impacted by this problem is significantly higher than currently thought.

All five mothers reported getting pregnant while using methamphetamine, similar to the findings of Rutherford, Potenza & Mayes (2013). Unlike those findings however, only two of the mothers reported to continue using after they knew they were pregnant. The reporting may have been minimized however, as several of the mothers reported not being aware they were pregnant until well into the second trimester. As Rutherford, Potenza, & Mayes (2013) also found, the mothers seemed to be stressed by their parenting responsibilities and turned to methamphetamine to cope.

Interestingly, of the three families that had fathers involved in the study, all three fathers reported taking specific steps to protect their children by both minimizing the meth use of the mothers, and at times ensuring the family followed regular schedules of eating and sleeping so someone would be available to care for the children. This was true

even for the fathers of children that were not theirs biologically. The fathers as a group were somewhat older than the mothers, so their own increased needs for routine may have been the impetus, but they seemed to take a more active role in household management, than would maybe be traditionally expected. In addition, all three of the fathers contacted child protection for help when they felt the children were not being cared for by the mothers. This may have been an element of power and control, but nonetheless suggests that fathers should be actively included in case planning for recovery.

2.) Are the reported risks of child maltreatment, addiction histories of the parents, and psychosocial symptomologies of family members unique for each family, or are there similarities across the methamphetamine-involved families participating in the study? Do other similarities or differences emerge from the analysis of the reported experiences across families?

While it is neither possible nor ethical to diagnose people from simply reading documents about them, it seems that all of the parents would have met the DSM V criteria for severe substance abuse disorder, in that they discussed at least 6 of the criteria for the diagnoses. Most of the parents made statements that would be consistent with meeting all eleven criteria for the disorder (American Psychiatric Association, 2013). This may indicate that the sample for the study was more severely addicted than most parents who use methamphetamine and thus may potentially have contributed to the existence of more maltreatment risks than parents meeting fewer criteria.

When considering the theories of addiction models – the biopsychosocial model seems to be most consistent with the experiences of this parents in this group. The biopsychosocial model suggests that a history of addiction in the family of origin and other biological factors intersect with cognitive and mental health problems, environmental factors, and stress from parenting or other sources. These factors interact with each other to create "the perfect storm" for addiction to take hold. This seems to have been the case for the parents in this study, as almost all came from a family background of addiction, all report physical and mental health concerns, and all discussed the stresses of being poor and at times unemployed. This finding seems to emphasize the need for interventions for the children in these families as even without the other maltreatment risk factors they face, it appears likely that they themselves will struggle with addiction problems when they are parenting.

Across families, it was clear that the parents in this study had many serious physical and mental health problems, although it is not clear the directional relationship with methamphetamine addiction. None of the parents discussed any mental health or physical health problems they had before they started using methamphetamine, but they weren't specifically asked that question either. The most common mental health problem reported for these parents was somatization or the physical manifestation of psychological symptoms. This seems consistent with the majority of the parents who also reporting receiving medication for pain. Depression and anxiety seemed to be the most commonly reported mental health diagnoses described by the parents in their

interviews, but their standardized SCL-90-R scores actually placed paranoia ahead of those two diagnoses.

Interestingly, the children seemed to be doing better both psychologically and academically than was expected given the multiple areas of risk to which they had been exposed. As a group, all but one of the children were performing at grade level or even above according to the reports of the parents, despite two of the children scoring lower than average scores on the PPVT-III test for vocabulary response. The mean scores for the children as a group, on all of the psychosocial measures, were near the population mean. Only two of the children, the two oldest girls, were within levels of clinical concern for mental health issues. This is similar to findings by Haight, Ostler, Black, & Kingery (2009) who found that girls are more likely to demonstrate external aggression as a result of methamphetamine involved families. Both of these girls were also exposed to severe domestic violence however, and had the highest number of years of their life exposed to parental drug use, so it is difficult to know if this behavior could be correlated to parental methamphetamine use. It is possible that the other children, if they continued to be exposed to drug use, would also increase their externalizing behaviors. Given the multiple risk factors experienced, it is difficult to accurately study the root causes of the children's subsequent dysfunction.

Struggles for these two girls also showed up within the descriptions of the parent/child relationships. Both girls discussed difficulty in trusting that their parents were no longer using drugs, or fearing that they may begin to use again. They also

discussed feeling as though their mothers in particular had abandoned them during her drug use. The researchers collecting data in the original study confirmed the disharmony in these two families, and also identified a third family that they noted did not seem to engage in any warm interactions or communication with each other. Neither the parents nor children in the third family identified any concerns, but it is unknown whether they believed there were no concerns or if they simply did not feel comfortable enough discussing the issues.

The child maltreatment risk of problems in parent/child relationships is consistent with previous research by Haight, Marshall, Hans, Black, & Sheridan (2010), as well as Asanbe, Hall, & Bolden (2008a) who found that 42% of children, especially girls, from methamphetamine involved families displayed aggressive externalizing behavior. Additional research suggests that the discord in the parent child relationship may be related to parents avoiding their children when actively using (Arria, Mericle, Meyers, & Winters, 2012). This avoidance also seems to be a reasonable explanation for the older girls externalizing aggressive behaviors when considered in the context of the research by Chaplin & Sinha (2013). They found children of substance abusing parents often learn to use negative behaviors in order to get the attention back from their parents. For the older two girls, this cycle of parental avoidance and then children's negative acting out would have had more time to solidify than for the younger children in the study.

Similar to the findings of Sheridan, Haight, & Cleeland (2011), many of the children in this family also had grandparents who were assisting in their care which may

also explain why some of the children were not having as many difficulties as we might expect. All but two of the children in the study stayed with grandparents at various points in their parents' use and recovery. Only one of the two girls with the behavioral issues stayed with extended family however, and the one that did, stayed with a grandmother and aunt that the mother reported was still using drugs themselves.

3.) How would child protective services social workers identify the family needs, and plan interventions to address the child maltreatment risks described by the families in the study? Do the child protective services tools prioritize and recommend interventions in a similar manner to those intervention priorities discussed by the family members?

As was suggested by Chuang, Wells, Bellettiere & Cross (2013), child protective services may under identify substance abuse in families. At least three of the families had contact with child protective services during the period of time when they were actively using methamphetamine, but none of the parents reported any services beyond an investigation opened at that time. This included one family in which the parent was found to have used marijuana while pregnant, and one in which the father specifically told the worker about the mother's methamphetamine use. It is not clear why that was the case, and it is possible that the parents were minimizing their involvement, however it certainly seems to point to the need for better training among child protection social workers. This may be because neglect factors were found to be the most common risks present in methamphetamine involved families. Neglect factors are generally not "incident-based" meaning it is more the culmination of events rather than a single event

that contributes to harm. This makes it more difficult to "prove" maltreatment occurred, and in the spirit of strengths-based child welfare services, parents are often given great leeway until the evidence is overwhelming that the children are in imminent danger.

The systematic ways that CPS workers evaluate risk also may not capture the full extent of the problems families face. The SDM model focuses on only seven risk areas (Children's Research Center, 2012), and yet the average number of risk areas reported by the families in the study was 15, with 11 as the fewest number of risks reported by any family and 21 the total number of risks reported by all families. In addition, it was not uncommon for the risk factor items that were prioritized on the SDM Needs and Strengths, to be different from the items the parents seem to prioritize, which may pose a problem in engaging the parents to make changes.

The Omaha system is another assessment tool that is used by public health nurses as well as social workers, although not typically social workers working in CPS. It seems to be a good companion or even replacement to the SDM system. The Omaha system itself does not prioritize problem interventions but rather suggests that the problems that should be prioritized are those with the lowest scores of parental knowledge, behavior, and status (KBS ratings). This is also helpful because it allows social workers to demonstrate which interventions contribute to improvement, as well as where the focus of the interventions should be. In other words, the priority is given to intervention methods that can been shown to contribute to the largest amount of successful change in that individual client, rather than in the severity of the problem across clients actuarially.

The one area that seemed to be missing from the Omaha system was the area of child behavior problems, which could in some ways be considered within the mental health problem category but may warrant a category of its own given the information from the families in this study.

The Omaha system is also a useful tool given the surprising finding that most of the families wanted to engage in services. Four of the five families reported a need for protective services. The Omaha system allows for flexibility in responding to these parents who voluntarily request services and even for involuntary clients, it can be used to address priority items seen as important to the parents. This could improve overall engagement and may encourage families to accept interventions in other problem areas. It also allows for the identification of true strengths that can be seen as mitigating the risks in a particular family situation. Specifically, as was found by Suchman, Mayes, & Pajulo, (2014), parental responsibility is often a motivator for treatment. The parents in this study reported that parental responsibility along with possible criminal justice interventions were contributing factors to their active involvement in addressing their substance abuse problems.

It is noteworthy to also consider that while children from methamphetamine involved families have been found to be placed out of the home more frequently and are more likely to have parental rights terminated (Cunningham & Finlay, 2013), the children in the study were all in their parents' custody (they may have had other children voluntarily living with relatives) and for the most part seemed to be doing well. Even the

children who were struggling the most with their relationships with their parents, indicated that they loved their parents and were very concerned about that parent's wellbeing. The children that were doing particularly well were actively involved in their parents' recovery, often by attending elements of their parent's treatment programs or through open discussions with their parents about substance use. This seems to suggest that interventions that are focused on the family as a whole would be most likely to contribute to successful outcomes for the children similar to findings by Suchman, Mayes, & Pajulo, (2014).

Themes that relate to child maltreatment risks

The parents in the study voluntarily sought out services.

Parents seemed to be fairly knowledgeable during their use that it was impacting their ability to provide for their children. Of the five families, four of them at one time or another approached CPS agencies asking for help. This seems contrary to general perceptions that child welfare services must be adversarial to get parents to make changes. It seems likely that if voluntary supportive services were available, perhaps using a harm reduction model, parents would be likely to take additional steps to reduce the impact of their use on their children. It is possible they could make progress toward sobriety on step by step basis, rather than an all or nothing approach, as is currently required once CPS gets involved. Services should be available in a way that recognizes that even when parents become sober, it is a fairly long journey to recovery for all family members and services need to be available along the entire journey.

This issue also seems critical in that six of the eight parents were themselves children of parents who were drug addicted. The majority of parents in the study were introduced to drug use (not necessarily methamphetamine) by a family member. They grew up in environments where drug use was acceptable, and there was a natural progression into early use. At the same time, the children in this study who were reported to have the least amount of problems often stayed with their grandparents throughout their parents' active using and recovery. Having supports available to the grandparents or other extended relatives during these periods would seem to be another avenue for ultimately helping the children. It seems critical that if we are to make an impact on future generations, there must be some intervention efforts made with children of current drug users, whether or not they get involved in child protective services.

Parents reported instances of strengths in attempting to mitigate the risk of maltreatment to their children because of substance use.

The identification of parental strengths at times can seem to be more of a perfunctory exercise to fill out a form rather than a true exploration of the parents' ability to ensure their children are cared for. When using the standard SDM risk tool, the "true" strengths seem to be ignored, even when the family was voluntarily seeking help. In some ways this perpetuates the belief that child protective services can only be provided as an involuntary service directed by the social workers' negative view of the parent's failings. But as seen by many of the parents' descriptions, the parents often made active efforts to get help or to ensure their children's most basic needs were met, and in many

cases had a bar under which they would not allow themselves as parents to fall. By meaningfully incorporating genuine caregiver strengths and love for their children into the treatment plans, parents may be more invested in meeting their own goals for having a healthy family.

The currently used SDM Risk Assessment Tools do not seem to adequately reflect the strengths and needs of families. The Omaha System seems to be a useful tool in classifying family problems and suggesting interventions based on the nuances of parents' unique circumstances.

As stated earlier, the SDM Risk Assessment Tools, as used by almost half of the child protective services agencies in the nation, should be paired with other tools such as the Omaha system. The Omaha system is focused on measuring the success of the interventions, rather than if the risk levels have changed. This is particularly important given that many of the risk items on the SDM are items that the parent may not be able to change. The Omaha system is focused *only on* those items that can change, and it is useful for measuring whether positive change is occurring. Given that child welfare agencies are under constant scrutiny to improve outcomes, the use of the Omaha system or a similar tool would seem to help forward that agenda.

Parents consistently reported moving into the manufacture of methamphetamine as their use progressed.

Surprisingly, 100% of the families in this study reported getting involved in the production of methamphetamine, including stealing the precursors with the children

present, as well as manufacturing in the proximity if not presence of the children. All of the children reported being aware that their parents were involved in producing meth and were aware of the accompanying criminal activities. Yet this may not be an area that is assessed by child protection workers unless the family is already under law enforcement surveillance. This study seems to suggest maltreatment risk due to meth production should be explored as a standard practice by child protective services workers when parents are reported to use methamphetamine.

Fathers were actively involved and saw themselves as responsible for their children's well-being.

All of the fathers in this study took an active role in trying to ensure their children were cared for despite the methamphetamine involvement of the parents. At least two of the fathers reported being uncomfortable when other friends were exposing their children to meth use or production, indicating an awareness of the negative impact on the children. Despite the fact that the fathers were not the primary day to day caretakers of the children, they reported being aware of the children's well-being and their role in at least ensuring the kids basic needs were met. CPS agencies have often ignored the father's role in the family unless the father specifically comes forward to assert their rights. This practice seems to be ignoring a critical asset to the family system that could help achieve recovery for all family members.

The children who were actively involved in their parents' treatment seemed to be having the fewest problems.

The families in which the children seemed to be functioning best were those where the parents actively and openly discussed their addiction and steps to sobriety with their children. In one case, the mother talked about giving her children sobriety medallions at the same time she earned them because as she stated, "they went through this just as much as me."

12 step or group support services seem to have had the most impact on the parents, but biopsychosocial interventions could also be considered. Of the two families who were furthest along in their sobriety, the parents reported that the support that they got in their 12 step groups was instrumental in their ability to maintain their sobriety, especially through the tough times. The parents that attended 30-day inpatient treatment models, but did not follow-up with 12 step group membership seemed to be in the most precarious levels of their sobriety and ultimately family functioning. The parents specifically reported that being in a social environment with other parents who have made it out of methamphetamine addiction and who understand the journey was critical to their success.

Parents reported high levels of physical health concerns that seemed related to their ability to stay sober and parent their children effectively.

Every family in the study included a parent with significant, if not debilitating physical health problems. It appears as though significant health issues prolonged addiction problems, and addressing parental physical health may improve their

functioning in all other areas of parenting.

Further study in needed in a number of areas

Given the levels of mental health and physical health problems of the parents, these issues should be studied further to establish directional relationships between methamphetamine involved parenting and child maltreatment risk. Despite theories that indicate substance addiction is a disease, or may be a way for someone to self-medicate their existing mental health concerns, neither of these models could consistently explain the relationship between the significant mental health problems and substance use reported by the parents in this study.

Second, while there has been some previous research that indicates an association between methamphetamine involved parenting and children's subsequent mental health problems, those studies have been fairly small. This study, also very small, seemed to indicate that there was not a substantial relationship. Given the impact on the children's ability to overcome the maltreatment risk, it would be helpful to understand what contributes to the risks for some children and not others.

Finally, child welfare researchers should study response prioritization and assessment tools that include methods that allow for flexibility based on unique family needs, as well as providing the means to evaluate intervention effectiveness. The families in this study reported a significantly higher number of risks than would likely ever get addressed under the SDM system, which may explain why for some families, even multiple child protective services interventions fail to result in long term child safety.

Strengths

The main strength of this study is the depth of the data available and the use of quantitative data to understand the context of the experiences. By starting first with the qualitative analysis of the family member interviews, it allowed the voices of the family members to tell the story, understanding the risks to children living in meth involved families from the inside out. The quantitative measures gave a deeper understanding of the psychosocial contexts that may have influenced family member perspectives, and enhanced the credibility of the family reported experiences. Transferability of the findings to child protective services practice in poor, rural, and primarily Caucasian is enhanced by the use of multiple case studies and triangulation of the data elements by practicing child protection supervisors. The application of currently used risk assessment and problem intervention frameworks to describe the child protective services response recognizes that there may be strengths and needs of the families that contribute to risk or need for intervention.

Limitations

This study was intentionally focused on a rural Midwest community that has been disproportionately impacted by meth involved families. The findings for this group of families may not be transferable~~generalizable~~ to ~~for~~ families living in urban or even suburban areas. As with other recent research, this study only focuses on those families that are already involved in child protective services. It is possible that the families in the study are different in some way from families in which the parents use methamphetamine

but do not become involved with child welfare services. It is also probable that these family members' perspectives about the positivity or negativity of their methamphetamine involvement was impacted by the services that they had already received.

Conclusion

As the number of children living in methamphetamine involved families continues to increase, it is essential that child protective services social workers respond in a way that effectively addresses the risks of maltreatment to which those children are exposed. It is important that these social workers take a broad view of the problem, understanding the depth and the complexities of maltreatment risks from the perspectives of the parents and children experiencing them. Social workers must also understand how the problems of mental and physical health may influence both the parental substance use, as well as the ability of the parents to meet their children's needs. Finally, by using risk assessment tools that include the ability to evaluate interventions, child protection social workers can become more effective and efficient at ensuring that the outcomes for children include long term safety.

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Appendix A

Interview Questions

Part I: Parent Interviews

1. Tell me about your family
2. Tell me about your family when you were using methamphetamine
3. What do you see as the effects of parent methamphetamine abuse on your child?
4. How can adults support the well-being and development of children whose parents abuse methamphetamine?

Part II: Child Interviews

1. Tell me about your family
2. Tell me about a time your family was happy
3. Tell me about a time in your family that was sad or scary
4. If needed; probing questions such as
    a. What is methamphetamine?
    b. Sometimes adults use methamphetamine. How does that make them act?
    c. How about your mom/dad?
    d. Tell me about a time they used methamphetamine, what did you do
    e. What advice can you give to other kids whose parents use methamphetamine?
5. Tell me about a time in your family that was fun.

Appendix B

Risks Identified by Family

	Anderson	Brown	Carter	Duncan	Edwards		Total
Substance use while parenting	1	1	1	1	1		5
Prenatal Exposure	0	1	1	0	1		3
Meth Production	1	1	1	1	1		5
Criminal Activity of Parent	1	1	1	1	1		5
Children witnessing domestic violence	1	0	0	1	1		3
Neglect: Failure to Meet Basic Needs	1	1	1	1	0		4
Neglect: Lack of Supervision	1	1	1	1	1		5
Physical Abuse	1	0	0	1	1		3
Emotional Abuse	1	0	0	1	1		3
Sexual Abuse	0	0	0	1	0		1
Parenting Ability	1	1	1	1	1		5
Chaotic Household	1	1	1	1	1		5
Lack of Resources	1	1	1	1	0		4
Parent/Child Rel	1	0	0	1	0		2
Sibling Rel	1	0	0	1	0		2
Child Behavior Problems	1	0	0	1	1		3
Cog/MH Status Parent	1	1	1	1	1		5
MH Status of Child	1	0	1	1	1		4
Educational Progress	0	0	1	1	1		3
Physical health of family mem	1	1	1	1	0		4
Participation in services	1	0	1	1	0		3
	18	11	14	20	14		15