Sonoma County Methamphetamine Prevention Plan

Developed by the Sonoma County Methamphetamine Task Force

August 2008

Copies of this plan are available online at http://www.sonoma-county.org/health/ph/data/
Acknowledgements

The Sonoma County Methamphetamine Task Force would like to extend sincere thanks to the many youth, parents, educators, health care professionals, employers, policy makers and others who brought their community and professional experience as well as their cultural, ethnic, and geographic viewpoints to the development of this plan.

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EXECUTIVE SUMMARY

In October of 2007, with support from the California Endowment, the Sonoma County Methamphetamine Prevention Task Force was formed to develop a plan to address methamphetamine use and its impact on individuals, families, community, and systems. The Sonoma County Methamphetamine Prevention Plan is the culmination of work that has spanned more than two years and represents the efforts of all members of the Task Force, community members, professionals, and policy makers. It is the intent of the Task Force that this plan be used to guide methamphetamine prevention and treatment efforts in Sonoma County over the next five years, and that it be viewed as a living document that will grow and change as needed in order to respond to the substance abuse prevention and treatment needs of our communities.

The Plan aims to address methamphetamine problems within the larger context of general substance abuse prevention and treatment. While methamphetamine problems are its immediate concern, the Task Force believes that long term efforts to prevent methamphetamine addiction must also address the abuse of alcohol and drugs if they are to be successful. Further, methamphetamine prevention efforts must be fully integrated within other community planning processes aimed at improving system integration and service effectiveness. Current projects such as the Criminal Justice Master Plan process, the Juvenile Justice Master Plan process, the Mental Health Services Act planning process, the Upstream Investment Project of the County Strategic Plan, and related efforts must be coordinated and integrated to assure the effective use of resources and to maximize alignment among health, human service and criminal justice organizations charged with promoting the health and safety of our community.

It is important to note that the Plan does not include strategies to reduce methamphetamine availability i.e. manufacture, distribution and sale as this is the primary focus of the Sonoma County Multi-Agency Drug Task Force, which is represented on the Prevention Task Force. The Multi-Agency Task Force will continue to provide information on law enforcement drug suppression and prevention activities to assist the Methamphetamine Task Force in understanding the scope and impact of drug crime in Sonoma County.

In addition to outlining the activities of the Task Force, the Prevention Plan presents methamphetamine prevention and treatment goals and recommended strategies to achieve those goals. These are presented in summary below:
GOAL 1:
Sustain and expand the countywide Methamphetamine Prevention Task Force in order to support the implementation of the Methamphetamine Prevention Plan Strategies.

Strategy 1: Maintain and expand the Task Force membership in order to continue to engage policy leaders and key community stakeholders

GOAL 2:
Increase public awareness and strengthen policy supports for prevention and treatment of methamphetamine problems.

Strategy 1: Implement a countywide methamphetamine public information campaign, using materials from the “MeNotMeth” State campaign and other sources.

Strategy 2: Increase public access to existing methamphetamine prevention and treatment resources through new 211 community information telephone system and websites.

Strategy 3: Develop and implement a three-year recurring Methamphetamine Report Card to track trends and impacts of methamphetamine use over time.

Strategy 4: Advocate for changes in treatment reimbursement, discretionary funding and other Federal and State policies to strengthen prevention and treatment systems.

GOAL 3:
Identify and provide support and services to children and youth at highest risk for methamphetamine use.

Strategy 1: Improve data collection and sharing across Child Protective Services (CPS), Probation, Jail and Alcohol and Other Drug Services (AODS) treatment systems to early-identification of children in methamphetamine-involved families.

Strategy 2: Mobilize a multi-sector partnership to develop and secure resources to implement three pilot projects with CPS, Probation and Department of Health Services (DHS) to intervene with methamphetamine-using parents and their at risk children.

Strategy 3: Gather data to inform the development of enhanced prevention services for at-risk transitional age youth.
GOAL 4:
Promote the effective delivery of age-appropriate alcohol and other drug (AOD) prevention by teachers and/or other school personnel to students in grades K-12.

**Strategy 1:** Support Sonoma County Office of Education (SCOE), school districts, and Task Force organizations to implement ongoing training for classroom and administrative staff in school-wide prevention strategies.

GOAL 5:
Strengthen school policy and program development to support early identification and intervention with youth at risk for substance use at elementary all comprehensive and alternative high schools.

**Strategy 1:** Build on current partnerships (SCOE, DHS, Probation, community-based organizations, and School Districts) to implement Student Assistance Programs (SAP’s) in all districts for all grade levels.

**Strategy 2:** Advocate for in-school alternatives to school zero tolerance suspension and expulsion policies.

GOAL 6:
Promote methamphetamine treatment on demand.

**Strategy 1:** Implement a system to annually monitor and measure publicly-funded methamphetamine and other alcohol and other drug treatment needs.

**Strategy 2:** Develop a long-term treatment expansion plan to improve treatment access for non-criminal justice clients in all geographic regions.

GOAL 7:
Support treatment effectiveness and reduce recidivism.

**Strategy 1:** Increase early entry into publicly-funded methamphetamine treatment through application of best practices and enhanced public information and referral.

**Strategy 2:** Increase the availability of community-based services and supports for individuals transitioning out of treatment programs in order to support their on-going recovery i.e. Sober Living Environments.
NEXT STEPS

With the continued support from its membership and many community partners, the Task Force will begin work on first steps toward the implementation of the comprehensive Methamphetamine Prevention Plan. These include activities to sustain the Task Force; connect and coordinate with existing planning efforts; secure resources to fund pilot projects, and engage, inform and involve the broader community. Strategies selected for this initial phase of implementation are based on the following criteria: they are stage-dependent, representing the first step of a multi-level activity; they are of high importance and require urgent action; existing resources can be utilized for implementation; and/or a high level of community support is in place.

Continue the Task Force: The Task Force will seek financial resources to continue and strengthen the Sonoma County Methamphetamine Prevention Task Force. The Department of Health Services, Prevention and Planning Division will seek grant funding for a staff position to support the Task Force. Members will be actively engaged in ongoing implementation efforts and the development of key partnerships that will support the work of Task Force.

Enhance Coordination with Other Planning Efforts: The Task Force will work to identify effective strategies to coordinate and integrate methamphetamine planning efforts with other ongoing system-development and prevention efforts including, but not limited to: Criminal Justice Master Planning, Juvenile Justice Master Planning, Upstream Investment Project of the County Strategic Plan, AOD System Re-design Project, Perinatal AOD Action Team, Mental Health Services Act planning, Santa Rosa Mayor’s Gang Task Force, and other related community planning processes.

Develop Resources for AOD Expansion and Pilot Projects: The Task Force will seek grant funds to support program design and implementation planning for AOD Treatment expansion planning projects and three pilot programs focusing on High Risk Youth and their families.

Develop School-Based Prevention Capacity: The Task Force will collaborate with partner agencies to develop a model for ongoing teacher and staff training efforts. A student resiliency model will be identified for implementation. The Task Force will also work with members and partner organizations/agencies to secure funding to support the expansion of student assistance programs. The Task Force will coordinate this work with the Mental Health Services Act (MHSA) planning process.

Increase Public Awareness: The Task Force will work to launch a countywide public information campaign to educate and inform the community about the impacts of methamphetamine. Materials developed by federal and state public information campaigns will be adapted for local implementation. A methamphetamine website providing prevention, resource and services information will be developed and launched.
SECTION I: TASK FORCE DEVELOPMENT

BACKGROUND

In early 2006, concerned about the impacts of methamphetamine problems on children, families and the community-at-large, the Sonoma County Board of Supervisors requested that County staff develop a report on the impact of methamphetamine on the community and County service systems. A multidisciplinary Methamphetamine Workgroup was formed with representatives from the Sheriff, Public Defender, and District Attorney and the Probation, Human Services and Health Services Departments. In July 2006, the Workgroup brought the Sonoma County Methamphetamine Profile to the Board. The data profile included a recommendation that a countywide Methamphetamine Prevention Task Force be convened to develop systems and policy approaches to reducing methamphetamine problems.\(^1\) The Department of Health Services, as lead agency for the Workgroup, began to look for resources to fund this planning effort and, in August 2007, secured a grant from The California Endowment to convene a countywide task force to develop a comprehensive methamphetamine prevention plan.

The Methamphetamine Workgroup led the effort to convene a task force with a diverse membership drawing from all geographical regions of the County and including representatives from government, education, criminal justice agencies, substance abuse and mental health services, health care, business, child welfare, community-based organizations, the faith community, persons in recovery, parents, and community members at large. Interviews with prospective task force members were conducted in September and October 2007. A total of 34 individuals representing the full range of stakeholders agreed to become task force members.

In November, the Sonoma County Methamphetamine Prevention Task Force convened and adopted the following Charter:

> To develop a countywide comprehensive methamphetamine prevention plan focused on policy and systems change.

The Task force also ratified the following member roles and responsibilities:

- Attend and participate in regularly scheduled meetings, ad hoc workgroups, and Task Force sponsored events;
- Share organizational resources, data, and information to support prevention plan development and implementation; and,
- Educate and engage the larger community, linking key organizations with the Task Force to support prevention planning activities.

Department of Health Services staffed the Task Force. John Abrahams, Sonoma County Public Defender, chaired the Task Force.

\(^1\) Sonoma County Methamphetamine Profile, Report to the Board of Supervisors, July 2006, See Attachment A.
Over the course of the one-year planning period the full Task Force met a total of eight times. A timeline was prepared to chart the planning process and included four core phases: member education, data development, priority and strategy identification, and plan production.

**Member Education**
Because the Task Force membership represented wide-ranging perspectives and expertise, initial meetings focused on informational presentations to ensure that all members entered the planning effort with a shared understanding of local methamphetamine issues. Presentations addressed the impacts of methamphetamine within the criminal justice, prevention, treatment, and child welfare systems. To present the viewpoint of individuals and families personally impacted by methamphetamine use, members also shared their personal stories and experiences.

**Data Development**
A key objective of the Task Force work was to develop additional local data to inform the planning effort. A number of strategies were employed including: community focus groups; key stakeholder interviews; treatment resource mapping; identification and review of best practices and promising models; review of existing local, state, and national data sources; and, assessments of methamphetamine impact on existing treatment and human service systems.

**Priority and Strategy Identification**
Five ad hoc committees were formed to analyze data, identify priorities and formulate preliminary recommendations in the areas of media/public information; school-based prevention; high-risk populations; data enhancement/systems collaboration; and access to treatment. Recognizing that methamphetamine addiction often occurs in an environment of poly-drug abuse and that prevention and treatment systems must be strengthened across the board, the subcommittees affirmed the importance of addressing methamphetamine problems within the context of a global substance abuse prevention framework.

**Plan Production**
Project staff, working with representatives from each of the ad hoc groups, developed the draft plan and presented it to the Task Force for approval in August, 2008.
DATA DEVELOPMENT

As noted in the Sonoma County Methamphetamine Profile and reinforced by Task Force members at the initiation of the planning process, local data on behaviors, attitudes, beliefs, and needs of individuals, families, and the community as they specifically relate to methamphetamine, are not readily available. In addition to developing data in these areas, the Task Force also recognized the need to develop better information on current attitudes, practices and policies of local business, health, education, and criminal justice systems. A data development plan was formulated to answer the following set of core questions:

- What data are currently being collected on local methamphetamine use?
- Which groups and populations are most at risk for methamphetamine use?
- Where is methamphetamine being acquired and used?
- What are the key factors that influence the use of methamphetamine?
- How is methamphetamine use impacting individuals’ and families’ health, and well-being?
- How is methamphetamine impacting the workplace and workforce?
- To what extent are systems of support and care seeing the impact of methamphetamine?

To answer these questions the Task Force sponsored a series of focus groups with target populations; interviews with key stakeholders; a scan of existing treatment data and services; and, an assessment of unmet treatment needs. Additionally, the Human Services Department, Family Youth and Children’s Services Division, conducted an assessment to identify the impact of methamphetamine on child welfare in Sonoma County in order to inform the work of the Methamphetamine Task Force.

Focus Groups

During the months of January and February 2008, 10 focus groups were conducted with a diverse population of service providers, youth, parents, methamphetamine users and their families. The focus groups included a total of 80 methamphetamine users and their families and were designed to provide information on how methamphetamine has impacted various high-risk populations within the County. Males represented 47.5% of focus group participants, and 52.5% were female. The average age was between 31 and 35. Approximately 54% of participants identified themselves as White, 26% as Hispanic, 3% African-American, 16% of mixed race and less than 1% Native American and Asian/Pacific Islander. The majority of participants had been in recovery for less than one year. The table below provides further detail on the focus groups. A report of key findings is included as Attachment B to the Plan.

2 See Attachment D for the full Methamphetamine Use and Child Welfare In Sonoma County report.
<table>
<thead>
<tr>
<th>Sponsoring Organization</th>
<th>Target Population</th>
<th>Total # Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sierra Youth Center</td>
<td>Adolescent girls in residential treatment</td>
<td>11</td>
</tr>
<tr>
<td>Turning Point</td>
<td>Long-term adult users in residential treatment</td>
<td>11</td>
</tr>
<tr>
<td>Drug Abuse Alternatives Center</td>
<td>Parenting women in intensive day treatment</td>
<td>8</td>
</tr>
<tr>
<td>COTS</td>
<td>Homeless adults in various stages of recovery</td>
<td>12</td>
</tr>
<tr>
<td>Vineyard Worker Services</td>
<td>Mono-lingual Spanish speakers/ immigrants</td>
<td>13</td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td>Adult users in recovery</td>
<td>14</td>
</tr>
<tr>
<td>Clean and Sober School</td>
<td>Adolescents in recovery</td>
<td>3</td>
</tr>
<tr>
<td>R House</td>
<td>Adolescent males and females in residential treatment</td>
<td>8</td>
</tr>
<tr>
<td>Drug Abuse Alternatives Center</td>
<td>Gay men in outpatient treatment</td>
<td>2</td>
</tr>
<tr>
<td>Hall of Justice</td>
<td>Parents of methamphetamine users</td>
<td>7</td>
</tr>
</tbody>
</table>
**Key Stakeholder Interviews**

Key stakeholders were identified as individuals in the public and private sectors who have either been impacted by methamphetamine and/or were viewed as having unique insights into prevention or treatment. These included informants in health care; mental health, human services, AOD treatment, criminal justice, schools, elected officials, faith communities, and business.

Thirty individuals were interviewed to gather perceptions related to: methamphetamine use and its impact on the systems/sectors within which they operated; current activities and efforts to address methamphetamine or its impact; and, policies, procedures, and/or practices that might aide in prevention. The findings of the Key Stakeholder interviews are included as Attachment C to the Plan and were reviewed by each of the Task Force ad hoc subcommittees described in the **Priorities and Strategies Development** section of the Plan. Of note is the fact that many key stakeholder observations, particularly those related to methamphetamine access, treatment issues, and community awareness were consistent with those captured in the focus groups process.

**Treatment Scan**

A scan of the current continuum of methamphetamine treatment services and related resources was also conducted to identify the extent to which: local treatment data is available; treatment capacity is available; clients are being referred to treatment; treatment gaps and barriers exist. Four distinct treatment spheres were included in this scan: Non-licensed programs usually run by religious organizations; licensed publicly-funded programs (serving the poorest); Kaiser (HMO); and private programs (serving insured or private pay clients).

The Treatment Scan revealed several findings of note. One is that most publicly-funded treatment serves the criminal justice population with referrals coming primarily from the courts, probation and parole systems. Unfortunately, this translates at the community to a perception that the only way to get methamphetamine treatment, if you are uninsured/under-insured, is to commit a crime. The Scan also reflected the fact that mental health needs exert the greatest pressures on treatment programs serving methamphetamine users. Resources are needed to support the treatment of co-occurring conditions – particularly among methamphetamine users who typically arrive in treatment with cognitive dysfunction directly related to their drug use. On a positive note, the Scan also revealed that many interviewees felt that Proposition 36 has shown that close proactive collaboration between law enforcement, courts, probation/parole, and treatment providers can lead to successful treatment for nonviolent adult offenders addicted to methamphetamine.
Methamphetamine Use and Child Welfare in Sonoma County

To further inform the work of the Sonoma County Methamphetamine Task Force, The Human Services Department Family Youth and Children’s Services Division conducted a study to identify the impact of methamphetamine on child welfare. A workgroup of 23 managers and supervisors developed the study design and selected the following research questions and hypotheses.

TABLE 1: Research Questions and Hypothesis

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Hypotheses</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many cases in the Sonoma County child welfare system are impacted by methamphetamine?</td>
<td>- Anecdotally, the members of the Methamphetamine Workgroup believed that approximately 50% of child welfare cases and referrals involve parents who use methamphetamine.</td>
</tr>
<tr>
<td>Are there demographic differences between Sonoma County child welfare cases impacted or not impacted by methamphetamine?</td>
<td>-This analysis was exploratory in nature. The members of the work group did not propose any hypotheses related to child demographics.</td>
</tr>
<tr>
<td>How are methamphetamine-impacted Sonoma County cases similar or different in terms of severity from cases not impacted by methamphetamine?</td>
<td>-Families impacted by methamphetamine will have higher rates of domestic violence. - Children impacted by parent methamphetamine use will have higher rates of medical issues and behavioral issues.</td>
</tr>
</tbody>
</table>

To complete the study, the workgroup designed a data collection instrument for use in case review by social workers. The tool was used with a total of 360 open cases. The report found that methamphetamine abuse is a major factor affecting child welfare services in Sonoma County. The cases of children from methamphetamine impacted families are more complex and require greater resources to address. The report also suggests the need for a comprehensive analysis of the adequacy and effectiveness of the range of available community resources for methamphetamine-affected families and suggests that current resources may need to be enhanced to fully meet these families’ needs and adequately protect children. The full set of findings can be found as Attachment D - Methamphetamine Use and Child Welfare in Sonoma County.

3 For the complete Methamphetamine Use and Child Welfare in Sonoma County report see Attachment G
4 Defined as children involved in an open child welfare case.
Unmet Treatment Need Assessment

An assessment of unmet need for AOD treatment was undertaken by the Department of Health Services to better understand treatment needs and access barriers. Nine local drug treatment agencies/programs including: Orenda Center; Women's Recovery Services; Drug Abuse Alternatives Center (DAAC)-Outpatient and Perinatal Services; DAAC-Turning Point; Santa Rosa Treatment Program; Henry Ohlhoff North; California Human Development (CHD); and R House collected data on telephone requests for services. The data set included information on gender, primary drug of choice, the reason the individual was denied/not admitted, and referrals patterns. The assessment was conducted simultaneously at each of the sites over a period of two weeks and collected information on 189 individual calls for treatment. The report found that many of the clients who requested services and were turned away/denied were methamphetamine users. Findings also revealed that the main reasons for denial of service/non-admittance included a lack of available treatment beds and/or a lack of client funds.

\[5\] See Attachment F: Unmet Treatment Need Report
PRIORITY AND STRATEGY DEVELOPMENT

The Task Force created five ad hoc committees to focus on priority areas of interest: school-based prevention; high-risk populations; data enhancement/systems collaboration; media/public information; and access to treatment. Task Force members selected one or more ad hoc committees to join based on their expertise and personal interest. Committees met from February through April of 2007 to review the Focus Group, Key Stakeholder, Treatment Scan, Unmet Need, and HSD Family Youth and Children’s Services data. In addition, the groups reviewed local, state, and national data, and best practice models. Draft strategies and target populations were prioritized and gaps in existing knowledge and available information were identified.

The key findings for each of the ad hoc committees are presented below along with the draft recommendations that were developed for Task Force for review. An Availability and Enforcement section also includes findings related to the production and distribution of methamphetamine. The Task Force did not develop recommendations for the Plan related to availability of methamphetamine, not wanting to duplicate efforts of the Sonoma County Multi-Agency Drug Task Force, composed of Federal, State and local law enforcement agencies and the Sonoma County District Attorney’s office, many of which are represented on the Task Force.

School-based Prevention

The ad hoc group identified the following findings of relevance in developing its recommendations:

- The California Healthy Kids Survey data documents a difference in methamphetamine use between students in comprehensive schools and alternative high schools.
- The community generally expects schools to deliver early intervention and prevention programs on a variety of social concerns.
- There are many challenges to consider when addressing school-based prevention education including: fiscal conditions; securing teacher participation and buy-in, inappropriate pressure on schools to act as the safety net for all social problems.
- Schools need more information about community resources for children and families and should develop partnerships with these agencies to prevention supports.
- Prevention efforts should be school-wide and should focus on building resiliency and school connectedness for all students.
- Evidence-based programs in all grades (Elementary-Second Step; Middle School-Project Alert; and High Schools-Project Success) should be implemented in all schools.
- Parent education and involvement is critical to the success of school-based prevention efforts.
• More data is needed on rates of use among the 18-24 year old age range, junior college and university students.
• Methamphetamine is available for sale on most high school and several middle school campuses.

Draft Recommendations to Task Force:
• Develop partnerships to implement ongoing teacher and administrative staff trainings in school-wide prevention strategies.
• Expand implementation of evidence-based alcohol and other drug prevention programs.
• Develop and secure resources to support an integrated system of prevention services for at-risk transitional age youth.

High Risk Populations

The ad hoc group identified following findings of relevance in developing its recommendations:
• Defining and identifying those at highest risk and how to best serve these populations is difficult. High risk populations include: children of addicts, adolescent girls, gay males, youth in juvenile justice system or alternative schools, homeless, pregnant women, construction/trades workers
• With limited resources, priority should be given to children of methamphetamine involved families, who can be identified through existing systems: probation, mental health, criminal justice, and high risk youth of transitional age
• Most methamphetamine users seek services late in their addiction. The focus should be on reaching groups for prevention or those in early stages of use.
• Criminal Justice, Health and Human Service Agencies report coming into contact with and providing services to multi-generational families in which methamphetamine use is entrenched in the family system.
• Broad-based primary prevention efforts should focus on schools, with understanding of the challenges schools face and the need for support from the community.
• Many methamphetamine users view the drug as a tool for coping with depression and other emotional problems.
• Several youth and adult focus group respondents reported that they had received a diagnosis of ADD prior to the onset of methamphetamine addiction.

“It’s easier and more common to get it in the high school than on the street. It’s about connections. Someone always knows who to call if they want it. Word gets out.”
- Focus Group Participant

“When I was 14 years old my mom gave it to me and my older brother. She said, ‘do it with me, not on the street.’”
- Focus Group Participant
• Many young people and gay men are introduced to methamphetamine through sexual partners and use it to enhance sexual experiences.
• The majority of (focus group) youth using methamphetamine were introduced to it either by family members or adult friends/neighbors.
• Approximately 49% of open child welfare cases in Sonoma County are impacted by methamphetamine. These are more likely to be court cases and less likely to be voluntary cases.
• Parent methamphetamine use is correlated with caretaker absence or incapacitation, general neglect, and severe neglect and with higher rates of domestic violence and child medical issues.
• Recovery from methamphetamine can take longer than recovery from other substances. Mandated permanency timeframes may not recognize this difference and may be too short for adequate recovery – even if a parent begins recovery immediately upon removal of his or her child.

Draft recommendations to the Task Force
• Improve information sharing across systems to early-identify children in methamphetamine-involved families and implement effective interventions with them.
• Develop and secure resources to support an integrated system of prevention services for children of methamphetamine-involved families.
• Collect data on other youth at-risk as a result of cultural isolation, homelessness, school drop-out, or foster care age-out to identify risk factors and service needs and inform program development.
• Develop and secure resources to support an integrated system of prevention services for at-risk transitional age youth.
• To most effectively protect children and strengthen families, interventions for methamphetamine using individuals should start as soon as a problem is identified, and, if possible, before legal outcomes have been determined.
• Treatment priority should be given to methamphetamine users who have children in the home, particularly pregnant and parenting women, as a means of reducing the incidence of intergenerational methamphetamine use.

Data Enhancement/Systems Collaboration

The ad hoc group identified the following findings of relevance in developing its recommendations:
• Accurate local data is needed to inform the community and measure change over time; to identify groups at highest risk; to assess prevention, intervention, and treatment needs; and to enhance data sharing and program integration.
• Areas for improved data collection include: local prevalence; community impact markers; methamphetamine related crime, physical health data; numbers seeking treatment; child abuse cases; and demographic data on at risk youth.
• Better coordination and data-sharing across systems is seen as essential in developing effective intervention strategies.
• Development of standardized intake and screening protocols across systems would be very helpful in developing effective intervention strategies.

Draft Recommendations to Task Force:
• Develop and implement a recurring methamphetamine report card to track trends and impacts of methamphetamine and other drug use over time.
• Improve information sharing across systems to early-identify children in methamphetamine-involved families and implement effective interventions with them.
• Collect data on other youth at-risk as a result of cultural isolation, homelessness, school drop-out or foster care age-out to identify risk factors and service needs and inform program development.
• Measure and monitor methamphetamine and other alcohol and drug treatment needs.

Media and Public Information

The ad hoc group identified the following findings of relevance in developing its recommendations:
• The public needs accurate local information on the scope and impacts of methamphetamine problems and better information on existing prevention and treatment resources.
• Information and referral to methamphetamine services and resources is not easily accessible to the public. The new countywide 211 system should be utilized to address this gap.
• Policy-makers and other key stakeholders lack information on methamphetamine problems.
• The Statewide public information campaign should be tailored for local use to educate the public and mobilize key decision-makers.
• The majority of users described maintaining a highly negative view of methamphetamine and people who use it both prior to and following their own use.
• Many users associate methamphetamine use with the loss of physical attractiveness.
• Among users, there is concurrence that the message that “methamphetamine robs them of their physical, spiritual, intellectual and moral resources”, is powerful.
Draft Recommendations to Task Force:

• Implement a countywide methamphetamine public information campaign to increase awareness, educate community regarding resources, and build public policy support.
• Develop and implement a recurring methamphetamine report card to track trends and impacts of methamphetamine and other drug use over time.
• Coordinate information/education activities with the 211 system.
• Advocate for State and Federal policy development to support recommendations outlined in Prevention Plan.

Access to Treatment

The ad hoc group identified the following findings of relevance in developing its recommendations:

• There is insufficient access to treatment, especially for pregnant and parenting women.
• Treatment is underfunded.
• Methamphetamine users need more time in residential treatment programs and transitional/ongoing aftercare for recovery to be effective.
• There is a need for more affordable and accessible transitional/clean and sober housing
• Dual-diagnosed individuals need enhanced services, not currently available broadly.
• Non-criminal justice involved self referred individuals, have long wait times for publicly-funded treatment. Better data is required on the treatment needs of the general population.
• The majority of funding comes with specific regulations that make access to available resources difficult for some groups.
• The threat of jail/prison is effective at helping some users accept treatment.
• Homeless service providers report a number of clients who are homeless, addicted to methamphetamine, suffer from co-occurring mental health disorders and have chronic health issues.
• Because of the cognitive impairment and other mental health conditions, it takes longer to effectively treat methamphetamine addiction. Procedures, attitudes, and approaches should be oriented to promote client retention.
• The threat of homelessness is effective at helping some users accept treatment.
• When confronted with pregnancy and/or child custody issues, some addicted women will accept treatment.
• Parents of methamphetamine users believe that they must receive parallel treatment to effectively support the sobriety of their children.

“If you are destitute or rich you can get it, but if you have a modest income and are working its hard to afford.”

- Focus Group Participant
The majority of methamphetamine users believe that prevention activities will have little to no impact on those individuals with an addictive predisposition.

**Draft Recommendations to Task Force:**
- Advocate for State and Federal policy development to support recommendations outlined in Prevention Plan.
- Measure and monitor methamphetamine and other alcohol and drug treatment needs.
- Increase access to community based methamphetamine treatment services in all geographic regions of the County.
- Increase access to community based methamphetamine treatment services for pregnant/parenting and non-criminal justice clients.
- Enhance community based services and supports for individuals transitioning out of treatment programs to support ongoing recovery.
- Recognize the occurrence of co-occurring disorders among the jail inmate population and provide appropriate mental health and substance abuse treatment services.
- Regulations must be brought into line with evidence-based practices.
- Bring reimbursement rates into alignment with actual costs of treatment.
- Increase capacity of the treatment system to address methamphetamine.
- Increase funding to support treatment for the non-criminal justice involved.

**Availability and Enforcement**
- Methamphetamine is widely available and easily accessible.
- The price of methamphetamine is determined by the quality a user’s contacts and his/her ability to ‘work the system.’
- The manner in which methamphetamine is used (i.e. injection, smoking etc.) determines where and with whom it is generally used.
- Changes in the chemical composition of methamphetamine, to improve profits, have shortened its effects and spurred users to consume larger amounts more often to maintain their desired high.
- Methamphetamine is often used in combination with alcohol and other drugs to extend or enhance their effects.
- Some youth report getting the drug from their methamphetamine-using parents.
- Some individuals receiving SSI are targeted by methamphetamine dealers.
- Methamphetamine is “bought” and “sold” through bartering transactions almost as often as it is paid for in cash.

“I used it because I was going to school and working and needed to be ‘up’. My employers asked me to use it to be a more productive worker.”

- Focus Group Participant
The majority of focus group participants report having been both users and dealers.

Controls on precursor chemicals have moved large scale production into Mexico, for import by organized crime/drug cartels, reducing the numbers of “meth labs” and the corresponding environmental threats.

Local production is commonly small scale – for personal and shared use - and often takes place in public places including motel rooms, workplaces (after hours), and in private vehicles.

Law enforcement officials report that methamphetamine use, sales, and trafficking among gangs has increased in recent years and is a significant community safety issue.

Methamphetamine is commonly used at some workplaces, often with the knowledge of employers and/or managers.

Community stakeholders report that methamphetamine use is more likely among workers in physically demanding jobs, low skilled construction work, production or assembly work, the hospitality industry, or among workers who work long hours or multiple jobs to make ends meet.

HR managers report a need for training and protocols to identify methamphetamine-using workers and refer them to appropriate treatment.

\textit{Draft recommendations to the Task Force}

- Agencies serving the homeless population must have access to resources to address the large number of clients, who are addicted to meth, suffer from co-occurring mental health disorders and have chronic health issues. These clients are extremely challenging to serve due to their multiplicity of problems and lack of social supports.

- Develop strategies involving law enforcement, treatment and social service providers and the community at large to address the use, sales, and trafficking of methamphetamine

- Provide training to HR managers, EAP staff and other managers/supervisors to identify methamphetamine involved workers and refer them to appropriate treatment.

The ad hoc committees presented their recommendations to the Task Force for review and discussion in May 2008. Based on Task Force direction, staff worked with committee representatives to finalize them for inclusion in a comprehensive prevention plan.
Prevention Principles
Methamphetamine prevention is a relatively new field. Very few research-based studies have been conducted from which to develop tested strategies, yet numerous sources suggest that methamphetamine use is a problem that requires community-wide solutions. Methamphetamine prevention must include multiple strategies that, where possible, utilize best or promising practices based on research and evaluation findings (evidence-based).

Based on review of current literature, recommendations for the development of effective methamphetamine prevention programs include the following:

- **Avoid Single Strategies.** Methamphetamine abuse is a complicated drug problem with wide ranging impacts that require multiple strategies.
- **Insure Collaboration/Coordination.** Involvement of many sectors of the community is needed for effective methamphetamine prevention. Multidisciplinary, coordinated strategies involving the criminal justice and health sectors are particularly critical. It is also important to involve youth, parents, educators, media, social service, community and faith-based organizations in prevention strategies.
- **Conduct Data Collection/Surveillance.** Target populations and risk factors must be identified so that prevention and education strategies can be designed to address specific needs of local communities. Multi-system data collection and monitoring should be ongoing and used to select priority prevention approaches.
- **Build Integrated Prevention and Treatment Programs.** Targeted prevention education and outreach for high-risk populations should be linked to treatment and should explore pathways to recovery other than through the criminal justice system.

Within the framework of these prevention principles, the Sonoma County Methamphetamine Prevention Plan has been developed to identify priority strategies to prevent methamphetamine use and reduce the negative impacts of methamphetamine on individuals, families, and community. The Prevention Plan has seven major goals:

- To sustain and expand the countywide Methamphetamine Prevention Task Force
- To increase public awareness and strengthen policy supports for prevention and treatment of methamphetamine problems.
• To identify and provide support and services to children and youth at highest risk for methamphetamine use.
• To promote the effective delivery of age-appropriate AOD prevention by teachers and/or other school personnel to students in grades K-12.
• To strengthen school policy and program development to support early identification and intervention with youth at risk for substance use at elementary all comprehensive and alternative high schools.
• To promote methamphetamine treatment on demand.
• To support treatment effectiveness and reduce recidivism.

The Plan is organized into seven sections corresponding to each of these goals. Each section includes an introduction and overview of the problem; a description of recommended strategies to support each goal; and highlights of best practices and promising models for consideration. A work plan detailing key activities, lead organizations (indicated by an asterisk) and key partners, resources needed, and a timeframe for implementation are provided in the tables following the introduction sections for each strategy. A quick guide to acronyms and abbreviations can be found in Attachment E. At the conclusion of the report, a Next Steps section outlines the Task Force’s priorities for immediate action.

The Plan does not include strategies to reduce methamphetamine availability i.e. manufacture, distribution and sale as this is the primary focus of the Sonoma County Multi-Agency Drug Task Force, which is represented on the Prevention Task Force. The Multi-Agency Task Force will continue to provide information on law enforcement drug suppression and prevention activities to assist the Methamphetamine Task Force in understanding the scope and impact of illegal drug crime in Sonoma County.

Last, it is important to note that methamphetamine problems must be addressed within the larger context of general substance abuse prevention and treatment. While methamphetamine problems are the immediate concern of the Task Force, long-term efforts to enhance both prevention and treatment systems must address the use of alcohol and drugs if they are to be successful. Further, methamphetamine prevention efforts must be fully integrated within other community planning processes aimed at improving system integration and service effectiveness. Current projects such as the Criminal Justice Master Plan process, the Juvenile Justice Master Plan process, the Mental Health Services Act planning process, the Upstream Investment Project of the County Strategic Plan, and related system-design efforts must be coordinated to assure the effective use of resources and to maximize alignment among health, human service and criminal justice organizations charged with promoting the health and safety of our community.
GOAL 1

Sustain and expand the countywide Methamphetamine Prevention Task Force in order to support the implementation of the Methamphetamine Prevention Plan Strategies.

Methamphetamine prevention is a relatively new field. In spite of the growing number of groups that have assembled to address this issue in communities across the nation, very few research-based studies have been conducted from which to develop tested strategies. Yet, numerous sources suggest that methamphetamine use is a problem that requires community-wide solutions.

“The effective drug (methamphetamine) prevention requires the involvement of many segments of the community – e.g. educators, youths, parents, law enforcement officials, business leaders, members of the faith community, social services providers, and representatives of other community based organizations.”

The Western CADT tip sheet on Methamphetamine Prevention, May 2005

The impact of methamphetamine production, distribution, and use reaches across economic strata, geographic boundaries, and professional sectors. The social, medical, legal, economic and environmental consequences demand a multi-faceted, multi-agency response. To accomplish this, the Sonoma County Methamphetamine Task Force proposes:

Strategy 1:
To maintain and expand the Task Force membership in order to continue to engage policy leaders and key community stakeholders in the implementation of the Sonoma County Methamphetamine Prevention Plan.

While the current membership of the Sonoma County Methamphetamine Task Force represents a range of key stakeholder groups, the core membership cannot implement the plan without engaging a broader sector of the community. Individuals, associations, professionals, and organizations that have crucial knowledge, experience and/or history of the issues and problems associated with methamphetamine will be invaluable as the Task Force works to reach the goals outlined in the Methamphetamine Prevention Plan. Additional resources are also needed to accomplish the goals of the Task Force. The continuation of the Task Force will allow membership to make connections with other organizations working to accomplish similar goals to strengthen the base of support and resources going toward the prevention and treatment of methamphetamine use.
**Strategy 1:**
*Maintain and expand the Task Force membership in order to continue to engage policy leaders and key community stakeholders in the implementation of the Sonoma County Methamphetamine Prevention Plan.*

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members will join workgroups to focus on implementation of Plan strategies</td>
<td>Members understand their roles with respect to specific workgroups and or strategies</td>
<td>Task Force members</td>
<td>Oct. 2008 – Jan. 2009</td>
<td>DHS-P/P - .5 FTE Health Info Specialist (HIS)</td>
</tr>
<tr>
<td>Identify additional members needed to implementation plan strategies</td>
<td>Recruitment list</td>
<td>Task Force members</td>
<td>Jan 2009 – Feb. 2009 and ongoing as needed</td>
<td>See above</td>
</tr>
<tr>
<td>Recruit, orient, and actively engage members in the implementation of Plan strategies.</td>
<td>New members are successfully recruited, oriented to work groups, and actively involved in the implementation of Plan Strategies</td>
<td>Task Force members</td>
<td>Feb. 2009 - ongoing as needed</td>
<td>See above</td>
</tr>
<tr>
<td>Coordinate and facilitate workgroup activities.</td>
<td>Work groups are provided with support and technical assistance as needed</td>
<td>Task Force members</td>
<td>March 2009 - ongoing</td>
<td>See above</td>
</tr>
<tr>
<td>Secure resources to support the ongoing work of the Task force and the implementation of strategies</td>
<td>Human and financial resources will be secured in order to support the implementation of key strategies and the ongoing work of the Task Force</td>
<td>Task Force members</td>
<td>September 2008 - ongoing</td>
<td>See above</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
GOAL 2

Increase public awareness and strengthen policy supports for prevention and treatment of methamphetamine problems.

In order to implement the Plan’s recommended strategies, the Task Force must engage the entire community in a long-term effort to enhance programming, develop new resources and systems, and build policy support for comprehensive prevention. Individuals, families, employers, elected officials, community leaders and other key stakeholders must be informed about the impacts of substance abuse on our community and the critical importance of prevention. Policy-makers at all levels must be mobilized to create the systems, supports and the “public will” to address methamphetamine problems.

The Task force recommends three strategies to raise awareness of methamphetamine problems and mobilize individuals, organizations, and policy bodies to support a comprehensive prevention effort.

Strategy 1:
Implement a countywide methamphetamine public information campaign to increase awareness of local methamphetamine problems; educate the community about available resources; and build public policy support for the Prevention Plan.

The Task Force recommends that a public information campaign be designed to raise awareness and educate the general community about methamphetamine problems and available resources/services; increase stakeholder support for policy changes to enhance resources for prevention and treatment; and gain commitments from a range of local partners to support the implementation of the Prevention Plan.

The public information campaign should include three components:

- Development and broad dissemination of methamphetamine information and educational resources;
- Informational presentations to policy makers, community leaders, and civic groups and organizations using the National Partnership for a Drug Free America model;
- Local adaptation of the California Methamphetamine Initiative campaign.

“The community is totally unaware of the magnitude of the problem… and that it’s everyone’s problem…”

Sonoma County Superior Court Judge
The Task Force believes that the public needs better information about how methamphetamine impacts individuals, families, and communities and about available resources, services and opportunities to join the prevention effort. Public information activities should focus in these areas, with an emphasis on building public support for policy and systems change and on creating an accessible web-based clearinghouse of information on local prevention, intervention and treatment resources.

To increase awareness and promote public support for prevention, the Task Force members and partner agencies should implement the METH360 framework developed by The Partnership for a Drug Free America. The model brings together law enforcement, treatment, and prevention professionals to co-deliver methamphetamine education to policy bodies, community groups and organizations. The METH360 program provides online training, promotional materials, handouts, and presentation guidelines that have been tested in a variety of communities throughout the nation and have been shown to be effective at raising awareness and motivating people to take action. In addition, the Partnership for a Drug Free America has developed public information campaign materials including television, radio and print ads that are available for local adaptation.

In addition to a general awareness campaign, the Task Force has recognized the need to address the special health risks associated with the use of methamphetamines within the gay/bi-sexual community. The use of methamphetamines contributes to risky sexual behavior that facilitates the transmission of sexually transmitted diseases, including HIV. The California Department of Alcohol and Drug Programs, California Methamphetamine Initiative (CMI) has developed a targeted public information campaign, “MeNotMeth”, to reduce the use and abuse of methamphetamine among gay/bi-sexual men and other men who have sex with men. The campaign was launched in 2008 with a 30-second TV ad that appeared on cable TV throughout California. A range of collateral materials have been made available to support local adaptation of the campaign. The campaign’s second phase will target young women, ages 12-24, and will provide similar opportunities for local implementation beginning in 2009.

Lastly, the Task Force found that parents, teachers, school administrators, and health care and social service providers often have difficulty locating available prevention, intervention and treatment resources, despite their availability in the community. For this reason the Task Force recommends the development of a methamphetamine resource clearinghouse – ideally, through the newly developing 211 community information system – to provide both telephone and web-based information and referral for methamphetamine problems.

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Strategy 1:
Implement a countywide methamphetamine public information campaign to increase awareness of the extent of local methamphetamine problems; educate the community about available resources; and build public policy support for the Prevention Plan.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Publicly release Methamphetamine Prevention Plan to key policy/decision-makers and healthcare providers/professionals and other key stakeholders.</td>
<td>Methamphetamine Plan will be presented at Board of Supervisors, Law Enforcement Chiefs Association, City Councils, Criminal Justice Council, School Districts, AOD treatment, Child Welfare, and health care providers at the local and statewide levels.</td>
<td>Task Force</td>
<td>Sept. 2008</td>
<td>Printing and postage ($700)</td>
</tr>
<tr>
<td>Present plan via meetings, conferences, convening’s, and/or community events to AOD treatment and healthcare providers, civic groups, service clubs, faith based organizations, PTA’s, non-profit organizations serving youth and families, parents etc.</td>
<td>Methamphetamine Plan will be presented/distributed at convening such as DAAC Conference, and the California Endowment Northern CA regional Methamphetamine Task Force meeting. Increased engagement in the implementation and/or support of the Methamphetamine Prevention Plan strategies and activities</td>
<td>Task Force</td>
<td>Sept. 2008 – Sept. 2010</td>
<td>None identified</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
## Strategy 1 (continued):

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Work with CBO partners and other AOD networks to integrate methamphetamine awareness/prevention messages into ongoing education and outreach efforts.</td>
<td>Consumers will become more informed/aware about methamphetamine and available resources for treatment and/or services.</td>
<td>DHS-P/P*, Task Force, CBO’s, community organizations</td>
<td>Jan. 2009 – Jan. 2010</td>
<td>None identified</td>
</tr>
<tr>
<td>Design and implement a targeted methamphetamine information campaign using “Me Not Meth”; distribute/make available materials countywide to selected populations.</td>
<td>Efforts of Gay/MSM/Bisexual communities will be supported through connection to the statewide campaign</td>
<td>DHS-P/P*, Task Force, CBO’s</td>
<td>Sept. 2008 – Sept. 2010</td>
<td>Media consultant (30 hours)</td>
</tr>
<tr>
<td>Coordinate with CMI campaign to adapt Phase II materials for local use targeting young women ages 12-24.</td>
<td>Local adaptation of CMI campaign Phase II</td>
<td>DHS-P/P*, Task Force</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
### Strategy 1 (continued):

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<tbody>
<tr>
<td>Develop, promote, and maintain a methamphetamine resource website to provide information on resources, services, prevention information and link with countywide “211” system; include group-specific fact sheets.</td>
<td>Families, youth, educators, healthcare and social service providers and other community members will become aware of and have access to updated information and resources.</td>
<td>P&amp;P*, Task Force. 211 partnership orgs.</td>
<td>Oct. 2008 - Sept. 2010</td>
<td>TBD</td>
</tr>
<tr>
<td>Provide media support including public information, awareness, and advocacy for Prevention Plan strategies as needed and/or requested.</td>
<td>Increased public awareness and support for Prevention Plan implementation.</td>
<td>Task Force, key partners.</td>
<td>Oct. 2008 – Oct. 2010</td>
<td>TBD</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 2: 
Develop and implement a three-year recurring methamphetamine report card to track trends and impact of methamphetamine and other drug use over time.

Local data on changes in the character and scope of methamphetamine problems is necessary to inform prevention planning and measure the impact of prevention programs and services over time. For this reason, the Task Force recommends the development and community-wide dissemination of a recurring 3-year Methamphetamine Report Card tracking the prevalence of methamphetamine use among youth and adults, treatment admissions for methamphetamine addiction, methamphetamine-related crime and other key indicators which can help to identify significant changes and trends over time. Some of this data is readily available, for example, the number of individuals entering publicly-funded treatment for methamphetamine or the number of high school juniors who have ever used methamphetamine. Other data is more difficult to obtain, for example, the prevalence of adult methamphetamine use or the number of jail inmates who are methamphetamine addicted. In this case, the Task Force recommends advocacy with both local and state-level agencies and organizations to enhance the collection and sharing of county-specific data. Priority data objectives focus on the development of local data on adult prevalence and methamphetamine-related crime.

Adult Prevalence - While local prevalence data is readily available for adults who access treatment through the criminal justice system, data on the prevalence of methamphetamine use in general adult population is not currently collected at the local level. A number of existing State wide surveys collect data on adult health status and behaviors. Adding lifetime and 30-day use of drugs, by type, to one or more of the following surveys would allow counties across the State to better understand the scope and depth of substance abuse, including methamphetamine, among adults in their communities:

- The California Health Interview Survey (CHIS): a statewide telephone survey of adults (age 18+) conducted every two years and providing county-level self-reported health risk data. CHIS 2007 surveyed more than 50,000 households CHIS 2009 is currently being planned.

- The California Women's Health Survey: an annual telephone interview coordinated by California Department of Health Care Services and California Department of Public Health, in collaboration with the California Department of Mental Health, the California Department of Alcohol and Drug Programs and the California Department of Social Services. Questions cover a range of topical areas specific to women’s health. The annual statewide sample size is approximately 4,000 participants.

Youth Prevalence - Lifetime and 30-day methamphetamine use by grade, gender, ethnicity, and by school is currently collected in both comprehensive and alternative high schools for grades 9 and 11 on a bi-annual basis via the California Health Kids Survey. This information is, however, not routinely
reported. The Task Force will work with the survey management team to generate regular reports on methamphetamine use with an emphasis on demographic data which can be used to target prevention efforts.

**Methamphetamine-related Arrests and Crimes** - Most agencies within the criminal justice system collect some data on crimes associated with drug use. However, data collection is not standardized and, in most cases, is not methamphetamine-specific. Further, there is little data-sharing between agencies and currently no mechanism to develop unduplicated estimates of methamphetamine-related crime. More often than not, data related to methamphetamine represents crimes of use, possession, production or sales/distribution of methamphetamine only and do not include other crimes (such as assault, robbery etc.) committed by individuals using methamphetamine. Anecdotal information collected during focus groups and key informant interviews suggests that methamphetamine use is responsible for a much greater percentage of crime than is currently being reported. The Task Force proposed strategies that will build the capacities of the County jail to capture lifetime and 30-day substance use data, by drug type, for all who are arrested and booked into the jail system.

**Methamphetamine-related AOD treatment admissions** - Data on admissions to publicly-funded treatment in Sonoma County are collected through a State-mandated data collection system. These data include information on the demographics of treatment clients, risk factors and other data valuable for prevention planning. While this data is very useful for treatment planning, because most publicly-funded treatment clients enter treatment through the criminal justice system, it provides only a partial picture of methamphetamine use in the community. Better data on non-criminal justice involved methamphetamine users is needed.

**Methamphetamine-related Child Protective cases** - Until recently, data on the number of methamphetamine-related child protective cases was largely anecdotal. To support the Task Force data collection effort, County Human Services, Children and Family Services Division conducted a data snapshot to provide a more accurate estimate. The Division currently utilizes a State-mandated data collection system which does not capture data on parental methamphetamine involvement. While this database captures hundreds of pieces of information about each case and referral, it does not record whether or not a family is impacted by methamphetamine. Other risk data, such as medical problems, behavioral issues, and family domestic violence, while collected by case workers, is not available for easy data abstraction. However, the database can be tailored by local child welfare agencies to collect additional data (i.e methamphetamine involvement).

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7 The results of this inquiry are discussed further on page 7. The full report is included as Attachment G.
**Strategy 2:**
*Develop and implement a 3-year recurring methamphetamine report card to track trends and impacts of methamphetamine and other drug use in Sonoma County over time.*

<table>
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<tbody>
<tr>
<td>Convene a representative team of partner agencies including DHS, CPS, Criminal Justice, etc. to design and plan a strategy for data collection and sharing</td>
<td>Core group of planning partners established.</td>
<td>HSD – FYC*, Task Force partners, DHS, Criminal Justice, etc.</td>
<td>June 2008</td>
<td>Staff Support (HSD .5 PPA)</td>
</tr>
<tr>
<td>Identify sources/systems and qualities of current/available data on methamphetamine use across partner systems and create process for data sharing. For data not yet available, finalize prioritized data development plan.</td>
<td>Agreements in place to collect report card data across the range of care/service systems</td>
<td>HSD-FYC*, Task Force partners, DHS, Criminal Justice, etc.</td>
<td>October 2008</td>
<td>Staff Support (HSD .5 PPA)</td>
</tr>
<tr>
<td>Develop and refine set of core indicators for report card and design report card format</td>
<td>Design development of a MA Prevention report card</td>
<td>HSD-FYC*, Task Force, DHS, Criminal Justice, etc.</td>
<td>Jan 2009</td>
<td>Staff Support (HSD .5 PPA)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner  
Note: Please see Attachment E for a guide to acronyms and abbreviations
**Strategy 2 (continued):**

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</tr>
</thead>
<tbody>
<tr>
<td>Begin data collection and refine over time as necessary</td>
<td>Core indicator data will be regularly collected and delivered to Task Force for analysis and reporting.</td>
<td>HSD-FYC*, Task Force, SCOE, other key partners as determined.</td>
<td>December 2008 - Oct. 2009</td>
<td>Data collection tools development/update, data entry, and delivery. ($10,000)</td>
</tr>
<tr>
<td>Phase in additional partner agencies</td>
<td>Complete set of partners participating in collection and sharing of core data elements</td>
<td>HSD-FYC*, Task Force, SCOE, other key partners as determined.</td>
<td>Jan. 2009 – ongoing</td>
<td>None</td>
</tr>
<tr>
<td>Prepare a draft Report Card for public distribution on core indicators</td>
<td>Report Card will be developed.</td>
<td>HSD-FYC*, Task Force, SCOE, other key partners as determined.</td>
<td>March 2009 – June 2009.</td>
<td>Staff Support (HSD .5 PPA)</td>
</tr>
<tr>
<td>Release Report Card</td>
<td>Report Card will be made available to key stakeholders and the general community</td>
<td>Task Force</td>
<td>June 2009 – Oct. 2009 and every 3 years</td>
<td>Web content development ($500)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 3:  
*Advocate for State and Federal policy development to support recommendations outlined in the Methamphetamine Prevention Plan.*

The Task Force recommends the development of a policy advocacy agenda focused on promoting local, state and federal policy changes necessary to support a robust prevention system and a treatment system with sufficient capacity to meet local needs and deliver effective, evidence-based treatment. Advocacy activities should be conducted in partnership with other California methamphetamine task forces, CADPAAC, CCLHO and NACO and would include, but would not be limited to, advocacy for:

- Changes in the Drug/Medi-Cal system to better align program reimbursement with best practices;
- Increases in State General Fund discretionary funds for county-level prevention, treatment and recovery programs;
- Funding for a comprehensive adolescent treatment system; and
- Better recognition by policy-makers of AOD addiction as a chronic, relapsing condition.

Treatment advocacy efforts would focus primarily on enhancing both capacity and flexibility within local systems. Currently, SAMHSA’s Center for Substance Abuse Treatment is leading the shift from an acute care model to a chronic model of care. Research is now available to assist communities in developing “recovery-oriented systems of care” in order to intervene with substance abusers earlier, improve treatment outcomes, and support long-term recovery. The Task Force has an opportunity to join with other advocacy groups to educate policy makers about this significant shift and advocate for resources to improve local treatment systems.

As always, a lag exists between the development of recommendations based on treatment research and funding to implement those recommendations. While the federal government encourages the use of best practices and often requires evidence of their use, State cost containment measures limit flexibility for providers reimbursed under Drug/Medi-Cal to modify treatment methods to align with changes in professional treatment practices, academic research, or changes in federal law. For example, there is a strong relationship between length of time in treatment and positive outcomes. However, when a woman using methamphetamine is identified at labor and delivery, Drug/Medi-Cal will only reimburse for treatment up to 60 days postpartum for daycare rehabilitative services. And, while research supports conducting urine screening on a regular basis as part of all treatment protocols, urine screening is not a billable expense in Drug/Medi-Cal.

In general, the reimbursement rates set by the State do not cover actual expenses. During the mid 1990s, the State Legislature and the administration initiated a series of statutory and regulatory changes in treatment services with the primary intention of slowing growth in the Drug/Medi-Cal Program budget.
During this same period, a federal court order implemented an expansion of opiate replacement treatment services within Drug/Medi-Cal. This emphasis on opiate replacement treatment, combined with Drug/Medi-Cal restrictions has increasingly “crowded out” those seeking publicly-funded treatment for alcohol or methamphetamine problems.

A significant portion of AOD treatment funding comes with specific restrictions on which services can be provided to which populations. For example, Substance Abuse and Crime Prevention Act (SACPA) limits treatment to one year and aftercare to six months. As restrictions have increased, counties have less flexibility to make programmatic decisions based on local needs. The Legislative Analyst's Office, in its February 2004 Report, "Remodeling the Drug/Medi-Cal Program," recommended that the system be redesigned to provide counties with broad new authority under a new financial structure to select the modes of treatment to be provided within their jurisdictions and determine how such services should be provided.

Traditionally, youth have received AOD treatment through systems designed for adults. Research indicates that these programs are not effective. Programs for youth are generally more costly and require more experienced staff, additional safety precautions and a range of developmentally appropriate services. In 2000, the California Office of Alcohol and Drug Programs (ADP) published the first version of its Youth Treatment Guidelines on evidence-based standards of practice for youth treatment. Despite broad agreement on these guidelines, there is insufficient funding for local youth AOD treatment, and care coordination among systems serving youth is lacking. In addition, though ADP encourages counties and providers to implement the guidelines, there is no State requirement that programs implement them. Nor does the Drug/Medi-Cal program cover the wide range of services recommended in the guidelines (residential treatment, family counseling, case management and aftercare). In order to meet the needs of youth addicted to methamphetamine, a coordinated, statewide youth treatment system must be developed and funded.
Strategy 3:  
Advocate for State and Federal policy development to support recommendations outlined in the Methamphetamine Prevention Plan.

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</thead>
<tbody>
<tr>
<td>Advocate with the County Alcohol and Drug Program Administrators' Association of California (CADPAAC) and elected officials to prioritize changes within Drug/Medi-Cal to align funding with treatment best practices</td>
<td>Reimbursement for client centered services</td>
<td>DHS-AODS*, AOD Advisory Board, County Board of Supervisors</td>
<td>To begin Jan. 2009</td>
<td>DHS staff support to communicate with CADPAAC</td>
</tr>
<tr>
<td>Work with County’s Legislative Lobbyist and other advocacy groups to increase State General Fund discretionary dollars for county level prevention, treatment and recovery programs.</td>
<td>Advocacy strategy and timeline Budget changes</td>
<td>County leadership</td>
<td>To begin Nov. 2008</td>
<td>DHS staff support</td>
</tr>
<tr>
<td>Work with CADPACC and local advocacy partners to strengthen state-level efforts to develop and fund a comprehensive adolescent treatment system</td>
<td>Legislation and/or appropriations for adolescent treatment</td>
<td>DHS-AODS*, HSD, Sonoma County Medical Association, Maternal, Child, Adolescent Health Advisory Board, others to be determined</td>
<td>To begin Nov. 2008</td>
<td>None</td>
</tr>
<tr>
<td>Educate policy makers at all levels to recognize AOD addiction as a chronic, relapsing condition</td>
<td>Service decisions will be aligned with chronic care model</td>
<td>Task Force, consumers, treatment providers</td>
<td>To begin Jan. 2009</td>
<td>Communications (20 hours)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner  
Note: Please see Attachment E for a guide to acronyms and abbreviations
GOAL 3

Identify and provide support and services to children and youth at highest risk for methamphetamine use.

The Task Force undertook the difficult assignment of identifying and prioritizing high-risk groups to target in this plan. While there are many distinct risk groups in the larger population, two were selected by the Task Force for priority focus: youth whose parents are known to be methamphetamine users, and high risk youth of transitional age.

Adult client intake practices and procedures within County Alcohol and Other Drug (AOD) Services, Mental Health Services, and Criminal Justice agencies focus primarily on the legal and treatment issues of the client. Problems affecting family systems may be identified at intake but are not currently addressed though a holistic intervention and treatment service plan for the client and his or her family. Numerous child welfare studies identify families, where parents or other caregivers use methamphetamine, as highly chaotic with caregivers emotionally and physically unavailable to care for their children. These children are at very high risk to develop a range of social and emotional problems necessitating long-term intervention. Without early identification and intervention, many of these youth will enter the child welfare system, juvenile justice system, and/or disconnect from their families, schools and communities. Many will become methamphetamine users themselves.

High-risk transitional age youth are defined, for the purposes of this plan, as youth who have “aged out” of foster care; homeless and/or runaway youth; school dropouts; and/or, otherwise culturally isolated youth, 18-24 years of age. The Task Force’s initial work in this area surfaced three findings:

- Our knowledge of high-risk transitional age youth as a whole is limited;
- Research does exist on a number of subgroups within the transitional age population; and,
- Attempts to accurately describe the characteristics of this ethnically and racially diverse population are very difficult because transitional youth don’t interact with schools, service providers, or community based organizations in a consistent or predictable way.

The Task Force recommends several strategies which focus on enhancing support for children at risk for methamphetamine use as a result of parent substance use. The common objectives of these strategies are to:

- Early-identify substance using parents/caregivers,
- Facilitate their early entry into substance abuse treatment,
- Enhance treatment to deliver developmentally appropriate parenting education, specifically focused on reducing risks for youth substance use,
- Provide ongoing prevention-focused support and intervention for these children.
**Strategy 1:**
*Improve data collection, management, and sharing across systems to enable early-identification of children in methamphetamine-involved families.*

Presently, there is no standardized process across County Health, Human Service and Criminal Justice agencies for identifying children of substance abusing parents. The National Longitudinal Study of Health\(^8\) concluded that the mere presence of drugs, alcohol, or tobacco in the home increases the likelihood of adolescents using substances. Methamphetamine abuse by parents or other caregivers often results in home environments that fail to provide for the physical, developmental and emotional well-being of children due to multiple factors including: inconsistent parenting, abuse and or neglect, dangerous living conditions, poverty, exposure to domestic violence and temporary loss of parent due to incarceration. The link between methamphetamine and adult high risk sexual behaviors also puts these children at higher risk for sexual abuse/exploitation.\(^9\) Studies show that children whose parents use drugs and alcohol are 3 times more likely to be abused and 4 times more likely to be neglected than children whose parents do not use drugs or alcohol.\(^10\)

The County Jail processes 20,000 bookings annually. The average age of incarcerated individuals is 34 years. Ten percent of misdemeanors and 32% of felony offenses are drug-related. Given these data, it can be reasonably assumed that a sizeable percentage of inmates are both drug involved and parents of minor children. In FY 2006/2007, AOD Services provided treatment to 3,270 clients. Of these 45% were self/family referred and 55% were referred through the criminal justice system. Over half (53%) of the self-referred clients were in the primary child-bearing/parenting years (18 – 50), making it likely that there are children in the home. For criminal justice referred clients, however, this number rises dramatically to 87%.

Within the County Child Welfare system, approximately 49% of open cases are impacted by methamphetamine. Parent methamphetamine use is strongly correlated with caretaker absence or incapacitation, general neglect, and severe

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neglect. Methamphetamine is also correlated to higher rates of domestic violence and child medical issues.  

For clients in AOD treatment, methamphetamine is identified by 46% as the primary drug of abuse. While some programs identify clients at intake who have minor children in the home, most program services are client rather than family-centered. Focus group participants and many stakeholders clearly identified the need for enhanced services to assist families in the process of recovery, including parenting classes and children’s counseling.

The Task Force recommends several strategies to support the development of a system to identify children at risk and provide treatment and prevention-focused support to them and their families. First, County Health, Human Services and Criminal Justice agencies should develop intake protocols standardizing data collection on clients’ substance use history and relationship to minor children. This data collection effort will result in: a better understanding of the scope and depth of the problem; a better understanding of the need for intervention, support and/or treatment services; and, serve as a platform for development of a coordinated early intervention management system for children. In addition to enhancing data collection, efforts should be made to promote coordination and cross-training between the substance abuse treatment and child protective systems with the goal of developing shared protocols and enhancing expertise in addressing the complex needs of addicts and their children.

“I would use meth when I needed courage, when I was losing my kids or getting a summons. I would do a line before opening mail or opening the door. Being a single mom it helped me not to worry so much. When I lost my husband it helped me deal with the grief.”

- Focus Group Participant

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12 Sonoma County Department of Health Services Alcohol and Other Drug Service SWITS data report, December 2007.
**Strategy 1:**
*Improve data collection, management, and sharing across systems to enable early-identification of children in methamphetamine-involved families.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify data to be collected across systems in order to identify children of drug involved families/households</td>
<td>Data elements are identified</td>
<td>HSD-FYC, DHS-AODS, MH, Jail, Probation</td>
<td>Sept. 08</td>
<td>None</td>
</tr>
<tr>
<td>Secure agreements among partner agencies to collect and share data.</td>
<td>Data agreements from each partner agency to collect key data</td>
<td>HSD-FYC, DHS-AODS, MH, Jail, Probation</td>
<td>Oct. 2008</td>
<td>None</td>
</tr>
<tr>
<td>Develop and or improve existing data collection and management systems within partner agencies to facilitate data collection</td>
<td>Each agency will have a process in place to collect and deliver data.</td>
<td>HSD-FYC, DHS-AODS, MH, Jail, Probation</td>
<td>March 2009</td>
<td>Project consultant (see pg. 45) Programming costs - TBD</td>
</tr>
<tr>
<td>Begin data collection, data-sharing and analysis to assess needs and inform program design process.</td>
<td>Initial data will be collected, shared and analyzed.</td>
<td>HSD-FYC, DHS-AODS, MH, Jail, Probation</td>
<td>Sept. 2009</td>
<td>TBD</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 2:
Mobilize a multi-sector partnership to develop and secure resources to support a culturally appropriate, integrated, and comprehensive system of prevention services for at risk children of methamphetamine-involved families.

The methamphetamine epidemic has had a devastating affect on children and families in Sonoma County and across the nation. Parental use continues to be a powerful predictor of youth initiation for all substances. If the cycle of familial drug use is to be interrupted, systems must be created to: identify children living in methamphetamine involved households; assess their risk; and, arrange for needed services for the both child and family. The Task Force recommends that Human Services (Family, Youth and Children’s Services), Probation (Adult Division Domestic Violence Program and Juvenile Division Sierra Youth Center) and Health Services (Alcohol and Other Drug Services) collaborate with other stakeholder organizations to implement three pilot projects to demonstrate systems change strategies aimed at achieving these goals.

Human Services Department (Family Youth and Children Services) Pilot Project
Keeping families together when parents or caregivers are using methamphetamine is extremely challenging for child welfare staff. National data indicate that, in the child welfare system, substance abuse is a factor in nearly two-thirds of substantiated cases of abuse and neglect and two-thirds of the cases in which children are placed in foster care. In a 2005 survey conducted by the National Association of Counties, 71% of the California counties surveyed reported an increase in out-of-home placements due to methamphetamine use over the past 5 years.

Human Services, Family, Youth and Children Services Division surveyed active Child Protective cases in November 2007 and found 49% of open cases were impacted by parent or caregiver methamphetamine use. Methamphetamine use was found to be associated with child abuse, higher rates of domestic violence, and child medical and behavioral issues. Methamphetamine involved families were found to require higher levels of intervention and services, including placement of children in foster care, due to the complexity of problems and family dysfunction.

The Task Force recommends the development of a Family, Youth and Children Services pilot project, based on best practices where available, to address the impacts of methamphetamine on the families served by the agency. Key goals of the pilot project are to: identify methamphetamine involved families as early as possible; provide priority access to enhanced treatment and support services; reallocate and/or identify new funding sources to expand existing services;

improve interagency coordination with partner agencies; provide staff training and enhanced data collection; and, implement strategies to support case tracking and referral to community prevention services. Lessons learned from the pilot project should be used to examine additional system change strategies, where appropriate, in other service programs delivered by the Department.

**Promising Practices and Model Programs**

**The SAFERR Model (Screening, and Assessment for Family Engagement, Retention and Recovery)**
Recognized by Substance Abuse and Mental Health Service Administration (SAMHSA) and National Center for Substance Abuse and Child Welfare (NCSACW). SAFERR projects are designed to improve screening, assessment and treatment services, develop evidenced based practices, cross agency collaboration between partners to improve outcomes for methamphetamine involved families and children, and develop of case management and data collection systems.

**Shields for Families, Los Angeles, California**
A collaboration between Los Angeles County Health and Human Services Departments and community based organizations to operate “one stop shopping” community assessment and treatment centers which provide comprehensive substance abuse, mental health services and family preservation services in addition to other supportive services such as parenting skills, vocational training, housing and transportation services.

**Illinois Department of Children and Family Services Demonstration (DCFS) Project**
A partnership with the Juvenile Court and State Department of Alcohol and Drug Services. In 2002 DCFS obtained a federal waiver to provide flexible funding for enhanced alcohol and drug services to child welfare families. Child welfare families with substance abuse issues receive expedited assessments and priority for treatment services. Recovery coaches collaborate with child welfare workers to provide intensive case management services.
Domestic Violence Pilot Program

A 2006 survey of 500 law enforcement agencies by the National Association of Counties Organization (NACO) found that 48% of the participating law enforcement agencies reported increases in domestic violence due to methamphetamine.\(^\text{15}\) Researchers have found that one-fourth to one-half of men who commit acts of domestic violence have substance abuse problems and that a sizeable percentage of these batterers were raised by parents who abused drugs and or alcohol.\(^\text{16}\) Studies also show that women who abuse alcohol and other drugs are more likely to be victims of domestic violence.\(^\text{17}\) Additionally, an estimated three million children witness acts of violence against their mothers every year, and some researchers believe “violence in the family of origin is consistently correlated with abuse or victimization as an adult”.\(^\text{18}\) Although substance abuse is not the direct cause of intimate partner violence, most evidenced-based risk assessments such as SARA, Mosaic, and the Campbell Danger Assessment, identify alcohol and drug abuse as a primary risk factor. Alcohol and drug abuse is known to exacerbate a broad array of personal and environmental factors linked to battering behavior and increase the complexity of recovery and safety issues for batterers, survivors, and children.

Probation Department program managers, staff, and other professionals within the criminal justice and treatment systems have observed an increase in recent years in the number of domestic violence defendants abusing methamphetamine. California Penal Code 1203.097, enacted in 1994, mandates that all persons convicted of domestic violence participate in and complete a 52-week batterer’s treatment program under the direction of the county Probation Department. While a defendant may also be required to participate in drug treatment as a part of his or her sentencing or probation, services and support for the children is not part of the treatment plan.

Currently, the Sonoma County Probation Department manages over 750 individuals who have enrolled in or completed a certified domestic violence treatment program. The Department assesses each defendant’s risks and needs as they relate to his/her domestic violence and substance issues. To enhance this effort, the Probation Department will soon implement a validated risk assessment and targeted case plan instrument for the adult probation system. The assessment process, which is expected to be fully operational in March 2009, will evaluate all defendants for risk levels and protective factors to determine their treatment and service needs and track case outcomes.

\(^{17}\) De La Rosa, Mario; Lanbert, Elizabeth; & Gropper, Bernard. National Institute on Drug Abuse and the National Institute of Justice Research Monographs, Drugs and Violence: Cases, Correlates, and Consequences. 1990.
The Task Force recommends that, using these enhanced capabilities, the Probation Department implement a pilot program, based on best practices where available, targeting defendants mandated to participate in domestic violence treatment who are identified as parents/caregivers of minor children and have a history of methamphetamine use. The pilot should focus on: facilitating entry into treatment, as appropriate; delivery of parenting education and support specifically tailored to reduce the risk of youth substance use; and, linkage to community prevention supports. When assessment indicators determine it is appropriate, treatment and supportive services for parents and children will focus on the interrelated cycles of violence and substance abuse. Intervention strategies will support children in dealing with the trauma of family violence and provide them with education and or counseling assistance to avoid future substance abuse problems and involvement in family violence, either as a perpetrator or victim, as they age into adulthood. Lessons learned from the pilot program will potentially allow for future system changes in other Adult Probation Department programs, especially those where defendants' methamphetamine use impacts families.

**Sierra Youth Center Pilot Program**

The California Department of Alcohol and Drug Programs reports that since 2000, treatment admissions for methamphetamine use among adolescents and young adults have been on the rise.\(^{19}\) Data from the Matrix adolescent programs in Los Angeles and San Bernardino Counties found that methamphetamine users, especially females, experienced more severe psychiatric distress, legal problems, and problems in school at treatment admission than adolescents who did not use methamphetamine.\(^{20}\) A 2006 California statewide screening indicated that youth at risk for crime, and those involved with the juvenile justice system, reported higher rates of alcohol/drug use as well as other mental health symptoms compared to youth in mainstream schools.\(^{21}\)

The Sierra Youth Center is a residential treatment program operated by the Probation Department for girls, ages 12 to 18, who are under the jurisdiction of the Juvenile Court. The program admits approximately 55 girls annually with an average length of stay of 7 months, followed by a period of post-discharge aftercare services and supervision. A common family profile of girls entering the program, although not representative of all girls and their families, is one of poorly functioning family systems exposing children to some or all of the following: poverty; neglect; abuse; parental criminality; and, inconsistent parenting due to parental mental health and or substance abuse issues. Girls present with a range of problems and treatment issues including: anger and poor impulse control; low self esteem; unresolved trauma from victimization;

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\(^{21}\) Shulman and Cauffman, MAYSI-2 Statewide Screening, Department of Psychology and Social Behavior, University of California, Irvine.
underachieving school performance; delinquent values; gang affiliation; and, alcohol and substance use and/or addiction.

Sierra Youth Center program staff, Treatment, and AOD counselors estimate that 80% of girls admitted to the program have limited to moderate substance use histories and 20% have addictive use patterns, including methamphetamine exposure. These girls come from families in which methamphetamine use is prevalent among parents, other family members, and caregivers. This group of girls, estimated at 13 to 18 annually, has higher rates of: failing to complete the program; relapse and inability to maintain sobriety; and, re-arrest for criminal activity upon discharge from the program.

The Task Force recommends that the Probation Department develop a pilot program at the Sierra Youth Center targeting methamphetamine-involved girls whose families have methamphetamine or poly-drug history. All, or a significant portion, of the program could be delivered within the family home to reduce barriers to participation. High-risk youth and their families should be targeted with enhanced and specialized treatment to improve program completion rates. Interventions should focus on addressing girls’ psycho/social problems, improving parenting skills and overall family functioning, and providing appropriate treatment interventions for substance abuse with the girls, younger siblings and their parents or caregivers. Lessons learned from the pilot program will potentially allow for future system changes in other Juvenile Probation Department programs.

Examples of programs that meet the above criteria and are recognized by Office of Juvenile Justice and Delinquency Prevention (OJJDP) and SAMHSA as model programs include:

**Creating Lasting Family Connections (CLFC)**
A family strengthening, substance abuse and violence prevention program;
**Family In Targeted Transition (FIT)**
Individual/family treatment for juveniles leaving rehabilitation facilities who have mental health and substance abuse problems;
**Functional Family Therapy (FFT)**
Family based clinical intervention program to treat high risk youth and their families
**Multi Dimensional Family Therapy (MDFT)**
Family based treatment and substance abuse program.
**Strategy 2:**
*Mobilize a multi-sector partnership to develop and secure resources to support a culturally appropriate, integrated, and comprehensive system of prevention services for at risk children of methamphetamine-involved families.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop collaborative partnership with AODS, CPS, Probation and other stakeholders to develop and implement pilot programs.</td>
<td>Collaborative formed, planning in progress.</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS</td>
<td>Oct. 2008</td>
<td>Project consultant 600 hours @ $165/hr</td>
</tr>
<tr>
<td>Outreach to stakeholders and policy makers to build support and resources for pilot programs and potential systems changes.</td>
<td>Policy makers and stakeholders will be educated regarding the basis for pilot programs and will be supportive of future systems changes and the potential need for additional fiscal support.</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS</td>
<td>Nov. 2008 - Jan. 2009</td>
<td>See above</td>
</tr>
<tr>
<td>Design pilot programs</td>
<td>Program designs and services will reflect best/promising practices models</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>Jan 2009 2008- Mar. 2009</td>
<td>See above</td>
</tr>
<tr>
<td>Develop existing and or new resources to fund pilot programs</td>
<td>Funding will be secured to implement the pilot programs</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS</td>
<td>TBD</td>
<td>See above</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
**Strategy 2 (continued):**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify pilot program data to be collected and design collection system</td>
<td>Partner agencies will agree to data collection design and delivery system.</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>Jan. 2009 - Feb. 2009</td>
<td>See above</td>
</tr>
<tr>
<td>Develop contracts for pilot program implementation to include work plans and other deliverables</td>
<td>Agreements will be finalized with partner agencies and service providers</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>March 2009 - June 2009</td>
<td>See above</td>
</tr>
<tr>
<td>Train staff</td>
<td>Increase staff competencies to support program goals</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>June 2009 – Sept. 2009</td>
<td>Trainers - TBD</td>
</tr>
<tr>
<td>Implement pilot programs</td>
<td>Expand services to youth and families</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>FY 09/10</td>
<td>TBD</td>
</tr>
<tr>
<td>Reconvene partnership to evaluate program progress and modify as needed</td>
<td>Re-confirm program goals and strategies; modify if necessary</td>
<td>HS-FYCS*, Courts, Probation, DHS-AODS, CBO’s</td>
<td>FY 09/10</td>
<td>None</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 3
Collect and analyze data on other youth at-risk as a result of cultural isolation, homelessness, school drop-out or foster care age-out to identify risk factors and service needs and inform program development.

There appear to be a number of factors that contribute to youth becoming disconnected from home, school, or other social service systems. And, although substance abuse prevalence data on youth outside of any system is not currently available, the Task Force believes that these youth are at higher risk for substance abuse and other negative behaviors than their in-school counterparts by virtue of their situations. Studies reveal that the breakdown of the family, as a result of parental substance abuse or mental health problems, child abuse and neglect, familial conflict, and family homelessness can lead to children being removed from the family and placed in foster care. These high-risk transitional age youth often experience negative impacts as a result of their interaction with the child welfare, juvenile justice, and/or mental health systems. For these youth the chances for family reunification or an otherwise stable home life are marginal.22

Children in the foster care system, in general, are a population at risk, often experiencing high levels of emotional, behavioral, developmental, and health problems. Youth who age out of the system and are no longer legally entitled to assistance from the state, are even more at risk, facing enormous challenges in building successful lives.23 These youth often join the ranks of homeless and runaway youth whose lifestyles are characterized by high-risk behaviors including substance abuse, survival sex, and crime. Homeless youth are also at higher risk for HIV, suicide, physical victimization, and illegal activities.24 Research has shown that suspended or expelled students not in school and not in the labor force are at an exceedingly high risk of delinquency and crime.25 A recent California State Department of Education report indicated that 1 in 4 California students drop out during high school.26 And, it is believed that truancy is a symptom of a variety of other problems including conflict at home, substance abuse, gang involvement, criminal activity, poor academic success, or other personal problems.27

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26 [http://dq.cde.ca.gov/dataquest/DropoutReporting](http://dq.cde.ca.gov/dataquest/DropoutReporting)
27 Santa Rosa Mayor’s Gang Prevention Task Force Operational Team. School attendance Improvement, October 2007
**Strategy 3:**
*Collect and analyze data on other youth at-risk as a result of cultural isolation, homelessness, school drop-out or foster care age-out, etc. to identify risk factors and service needs and inform program development.*

<table>
<thead>
<tr>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>Convene a workgroup to gather data on youth at-risk as a result of cultural isolation, homelessness, school drop-out, and/or foster care age-out;</td>
<td>Data on demographics, risk factors, points of contact and service needs of transitional youth at-risk will be collected. Increased awareness among community partners of methamphetamine and other substance use among transitional youth.</td>
<td>Task Force DHS, CBO’s, Measure O Gang Prevention programs, shelters, tribal communities, cultural centers.</td>
<td>Nov. 2008</td>
<td>none</td>
</tr>
<tr>
<td>Create agreements with partner agencies/organizations for data collection, sharing and analysis.</td>
<td>Data on at risk transitional youth and substance use will be collected and shared across partner agencies.</td>
<td>Task Force DHS, CBO’s, Measure O Gang Prevention programs, shelters, tribal communities, cultural centers</td>
<td>Nov. 2008 - May 2009</td>
<td>Data collection and management support ($5000)</td>
</tr>
<tr>
<td>Develop recommendations for prevention and intervention strategies with at risk transitional youth.</td>
<td>Recommendations for prevention and intervention strategies will be developed to address methamphetamine and other drug use among transitional youth at risk.</td>
<td>Task Force DHS, CBO’s, Measure O Gang Prevention programs, shelters, tribal communities, cultural centers</td>
<td>May 2009</td>
<td>Staff/consultant facilitation of planning process (30 hours)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
### Strategy 3 (continued):

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<tr>
<td>Publicly release transitional youth methamphetamine prevention plan for to key policy/decision-makers, healthcare providers/professionals and other key stakeholders.</td>
<td>Transitional youth methamphetamine prevention plan will be presented at Board of Supervisors, Law Enforcement Chiefs Association, City Councils, Criminal Justice Council, AOD treatment and healthcare providers at the local and statewide levels.</td>
<td>Task Force, DHS, CBO’s, Measure O Gang Prevention programs, shelters, tribal communities, cultural centers</td>
<td>May 2009 – Sept.2009</td>
<td>Staff Time for production and mailing @ 20 Hours ($500) Printing and Postage ($500)</td>
</tr>
<tr>
<td>Present transitional youth methamphetamine prevention plan via meetings, conferences, convening’s, and/or community events to AOD treatment and healthcare providers, civic groups, service clubs, faith based organizations, PTA’s, non-profit organizations serving youth and families, parents etc.</td>
<td>Transitional youth methamphetamine prevention plan will be presented/ distributed to increase engagement in the implementation and/or support of the strategies, and activities.</td>
<td>Task Force, DHS, CBO’s, Measure O Gang Prevention programs, shelters, tribal communities, cultural centers</td>
<td>Sept. 2009 - Sept. 2010</td>
<td>Staff Time for planning presentation at larger conferences and convening @ 5 hours per event (ext. 3 annual events = $450)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner  
Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 4:  
*Mobilize a multi-sector partnership to develop and secure resources to support an integrated system of prevention services for at-risk transitional age youth.*

Sonoma County does not currently have a comprehensive system to support disenfranchised youth, and the needs of these youth as they relate to methamphetamine use are unknown at this time. The Task Force, however, believes that this segment of the population is vulnerable and recommends further research to better understand how to: 1) prevent disenfranchisement; and, 2) intervene to address the negative impacts of methamphetamine and/or other drug use on the lives of transitional age youth. Best and promising practices will be researched, and collaborative efforts initiated with community based organizations working directly with this population in an attempt to acquire information to inform a series of prevention and intervention strategies.

There are a number of programs that work to change the conditions that result in youth becoming “transitional”. These have been effective at delivering family focused early intervention strategies that address family support and parenting skills development:

**Transitional Housing Placement – Plus:** The Family youth and Children’s Division or the Sonoma County Human Services Department, will utilize California Department of Social Services funds to support community-based services to provide affordable housing and comprehensive supportive services for up to twenty-four months to help former foster care and probation youth ages 18-24 make a successful transition from out-of-home placements to independent living.

**Social Advocates for Youth:** Social Advocates for Youth (SAY) offers education, counseling, family support, psychotherapy, job training, mentoring and substance abuse prevention services for children, youth and their parents residing in Sonoma County. They provide 24/7 crisis intervention for runaway and homeless youth at the Rev. James E. Coffee House Shelter. Young adults at risk of homelessness who have aged out of foster care or who are living with serious mental illness can apply for housing at SAY’s Tamayo House Transitional Living Facility.

**Santa Rosa Mayor’s Gang Prevention Task Force:** A collaborative effort involving private citizens; city, county, and state government; local community-based organizations; schools, parents, faith community, and local law enforcement. The focus is to intervene in the lives of youth to provide positive socialization opportunities as alternatives to criminal involvement and to deter them from other maladaptive behaviors. In FY 2008-2009, 12 Santa Rosa agencies are funded to provide services in youth activities and support groups; parent/family support; job readiness training/placement; gang mediation and intervention services; and, community gang awareness.
Valley of the Moon Children’s Foundation: The Valley of the Moon Children’s Home is a Sonoma County’s shelter for abused, abandoned, and neglected children 0-18 years of age. The Foundation supports four key areas: (1) continued supplemental support for at-risk children in the home; (2) support for emancipated children including education, housing and employment guidance; (3) support for children in foster care and foster parents; (4) community child abuse prevention.

Padres Unidos/Parent Project: A comprehensive parenting skills program serving high risk families. At its center is a parent training component designed specifically to give parents the effective tools, knowledge and support they need to successfully prevent and/or intervene in the most destructive of adolescent behaviors, including alcohol and drug use, gang affiliation, truancy, family conflict, violence and running away. It has been adopted for use by state departments of education, school districts, courts, local law enforcement agencies, probation departments, health and mental health care professionals, the U.S. military, and communities nationwide.

Family Support Services of the Bay Area: Provides intermittent childcare to parents and other caregivers; provides intensive home-based services to families whose children are at imminent risk of removal from their homes; offers support to grandparents and other relative caregivers who are caring for children who have been removed from the care of their biological parents; and, serves children of incarcerated parents by creating lasting one-on-one mentoring relationships to break the cycle of incarceration.

Teens Aging Out of Foster Care in Oregon: A guide for caseworkers, judges and youth advocates designed to increase awareness of the challenges faced by foster youth transitioning out of care; to increase awareness of federal and state law pertaining to transition planning; and to provide tools necessary to make a youth’s transition out of care more successful. Addresses the obstacles faced by youth transitioning that include family instability, educational disruption and mental health problems. These youth demonstrate a substantially increased likelihood of homelessness, mental and physical health problems, incarceration, pregnancy, and drug use.
**Strategy 4:**

*Mobilize a multi-sector partnership to develop and secure resources to support an integrated system of prevention services for at-risk transitional age youth.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with partner groups to advocate for in-school alternatives to school zero tolerance policies&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Alternatives to zero tolerance policies will be identified, advocated for, and adopted uniformly by Sonoma County school districts.</td>
<td>SCOE*, Project Success, Measure O Gang Prevention programs, Probation, Youth oriented CBO’s, Task Force</td>
<td>Dec.2008-Dec. 2009</td>
<td>Staff 129 staff hours based on the activities detailed in Goal 5.</td>
</tr>
<tr>
<td></td>
<td>A readily accessible comprehensive resource list will be available to transitional age treatment and support providers and the general public.</td>
<td>SCOE, Project Success, Measure O Gang Prevention programs, Probation, Youth oriented CBO’s, Task Force, United Way (211 developers).</td>
<td>May 2009 - Sept. 2009</td>
<td>Staff 5 hrs/month</td>
</tr>
</tbody>
</table>

<sup>*</sup> Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations

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<sup>28</sup> See Goal 5, Page 63 for additional details on school-based strategies to address zero tolerance policies.
### Strategy 4 (continued):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
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<th>Timeline</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Work with CPS and key partner groups to identify strategies to prevent AOD involvement among youth transitioning out of foster care.</td>
<td>Strategies will be developed to address the needs of youth transitioning out of foster care, specifically to prevent AOD involvement</td>
<td>CPS, AODS, Probation, CBO’s, other Task Force members</td>
<td>Sept. 2008 – March 2009</td>
<td>Staff 4 hrs./month</td>
</tr>
<tr>
<td>Develop and present AOD prevention recommendations for youth transitioning out of foster care to key stakeholders and decision makers.</td>
<td>Increased awareness of the range of issues associated with youth transitioning out of foster care; Increased support for methamphetamine/other drug prevention recommendations.</td>
<td>CPS, DHS, Probation, CBO’s, other Task Force member organizations</td>
<td>April 2009 – June 2009</td>
<td>None</td>
</tr>
<tr>
<td>Secure resources for implementation of methamphetamine/other drug prevention recommendations.</td>
<td>Strategies to address AOD issues of youth transitioning out of foster care will be implemented.</td>
<td>CPS, DHS, Probation, Task Force member organizations</td>
<td>April 2009 – Dec. 2009</td>
<td>Grant writing $5000</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
GOAL 4

Promote the effective delivery of age-appropriate AOD prevention by teachers and/or other school personnel to students in grades K-12.

Information collected from focus groups and key informant interviews revealed widespread community beliefs that prevention education on a wide variety of health and social concerns, including alcohol and other drugs, is the primary responsibility of schools. Schools continue to be viewed as the major institution outside of the family that affects children’s lives.

Recent studies have shown that traditional models of prevention education (i.e., teacher lectures, films/videos, posters, school assemblies, and outside expert lecturers), alone are not effective prevention strategies. According to a National Institute on Drug Abuse study, “…merely teaching the ‘facts’ about the dangers of drugs…” is not an effective method for reducing alcohol and drug use. Successful prevention curricula must include elements such as interactive teaching techniques; development of personal, social, and resistance skills; program development based on risk and protective factors; regular teacher training and support; and, active family and community involvement.

Strategy 1:
Strengthen the partnership among Sonoma County Office of Education (SCOE), school districts, and Task Force organizations to implement ongoing regular trainings for classroom and administrative staff in school-wide prevention strategies.

The Task Force recommends the formation of a workgroup group to plan and implement a training and technical assistance strategy to provide ongoing teacher and school personnel training based on a three-pronged approach:

- Teaching age-appropriate, evidence-based prevention curriculum to the general student population;
- Identifying evidence-based school connectedness and student resiliency models and training school staff, teachers, administrators, and counselors in campus-wide implementation strategies; and,
- Researching availability of community-based mentoring programs and creating a referral protocol.

The goal of the effort should be to increase the number of districts and schools in Sonoma County that adopt one or more of these elements, thereby providing more comprehensive alcohol and other drug prevention education programs to their student populations.

School districts are required by the California Education Code to provide instruction on personal and public health and safety, including the effects of alcohol and drug use (Ed. Code Section 51202) and on the nature of alcohol, narcotics, restricted dangerous drugs, etc. (Section 51203). Instructors in drug education must be appropriately trained (Section 51260). As reported in the 2006-07 California Healthy Kids Survey Annual Report Summary, the most commonly implemented, evidence-based curricula in Sonoma County schools are:

- **Second Step (elementary level)** - A classroom-based social skills program designed to reduce impulsive and aggressive behaviors and increase children’s’ social-emotional competence and other protective factors.
- **Project Alert (middle school level)** - Drug prevention curriculum that motivates adolescents against drug use, teaches skills and strategies needed to resist drug pressures, and establish nondrug-using norms.
- **Project Toward No Drug Abuse (high school level)** - An interactive school-based program designed to help high school youth resist substance use through teaching coping and self-control skills and an awareness of misleading information that facilitates drug use.

However, only 12 districts out of the 32 reporting in Sonoma County are implementing the Second Step program; 11 Project Alert; and 8 Project Toward No Drug Abuse.

A recent national teacher survey revealed that 26% of teachers who actively teach alcohol and drug prevention in the classroom haven’t received any training in the subject; 13% have received only one half-day’s worth of training; and 21% would like training, but haven’t received any. The survey also found that 77% of teachers report that other teaching demands limit the time and resources they have for instruction on alcohol and drugs. Current fiscal limitations, coupled with demands on teachers’ classroom time to meet State and federal standards, are significant and often create barriers to teacher participation in trainings, adoption of curriculum within districts, and the teaching of the curriculum with fidelity. Professional development opportunities are also impacted by the lack of time for teachers to participate, inconvenient dates/times for training and lack of substitute teachers. It is well documented that drug prevention programs are

32 [http://hk.duerrevaluation.com](http://hk.duerrevaluation.com)
33 Individual school implementation information is not available in this report
34 [http://hk.duerrevaluation.com](http://hk.duerrevaluation.com)
most successful when teachers receive training and support from program developers and prevention experts.\textsuperscript{37} Effective AOD prevention education programs are needed in the schools, yet a number of challenges must be addressed. The Task Force recommends the development of an ongoing partnership to provide regular teacher training while also addressing the barriers to teacher participation and classroom program delivery. This partnership should be supported and implemented through collaboration between the Sonoma County Office of Education (SCOE), the County Department of Health Services (DHS), individual school districts, and community based organizations.

In the 2007-08 school year, SCOE and DHS partnered to provide training for middle schools teachers in Project Alert. DHS funded substitute teachers for school districts which allowed the teachers release time to attend; SCOE was responsible for the logistics, including notifying and following up with the schools, and providing the facility. The speaker costs and a complete set of materials for each attendee were jointly covered. Building on this model to include additional community partners, is a key strategy in expanding prevention education to more classrooms.

In addition to classroom-based efforts, the greater school and community environments also have a role in reducing risk factors and enhancing protective factors for students.\textsuperscript{38} Creating an \textit{asset-rich}\textsuperscript{39} environment for students from the classroom to the playground to the principal’s office, positively impacts students’ abilities to make good choices. Studies show that 38\% of youth in 6-12 grades who identify with 10 or fewer assets tend to engage in more illicit drug use and other risky behaviors than those youth with more assets.\textsuperscript{40} According to the 2004-06 California Healthy Kids Survey (CHKS), 75\% of 5\textsuperscript{th} grade students scored high in reporting caring relationships at school and at home; teachers and parents having high expectations of them; and feeling that they had opportunities for meaningful participation at school and home. By 7\textsuperscript{th} grade, there is a dramatic shift with only 38\% of students reporting high scores for these assets. The decline continues into the 8\textsuperscript{th} and 11\textsuperscript{th} grades. The National Longitudinal Study on Adolescent Health found that students who felt connected to their schools were less involved in risky behaviors, including substance use and violence.\textsuperscript{41} High ratings of school connectedness are reported among 5\textsuperscript{th} grade students, but also show patterns of decline in the middle and high school grade levels. In addition, sustained, high-quality youth-adult mentoring relationships serve as an


\textsuperscript{39} \url{http://www.search-institute.org/research/assets/assetpower}

\textsuperscript{40} \url{http://www.search-institute.org/research/assets/assetpower}

\textsuperscript{41} Resnick, M.D., Bearman, P.S., Blum, R.W., et.al. (September 19, 1997) Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. \textit{Journal of the American Medical Association}. Vol.278 No.10.
important developmental asset in the lives of youth. School-based comprehensive prevention programs, focused on building these assets across developmental stages, are a core strategy in reducing the risk of adolescent AOD involvement for school-age youth.

Promising Practices and Model Programs

Orange County Office of Education: has been implementing a school and community-wide program since 1999 based on the Search Institute’s 40 Developmental Assets, identified as the building blocks of healthy development. As assets increase, alcohol and other drug use, and violence decrease, and academic performance improves. The assets fall into two main categories—external and internal with parent, family, other adult, schools, and neighborhood/community components. Trainings for teachers, other school personnel, and community members focus on how to build stronger school-student-family-community relationships, youth empowerment, and opportunities for meaningful involvement.

Riverside County Office of Education: is working with school districts to implement “Capturing Kids Hearts”. This program is aligned to the 40 developmental assets and focuses on relationship-building and changing the culture and climate on school campuses. Initial results show an increase in attendance related to the relational capacity component, an increase in grades, and major decreases in discipline referrals, suspensions, and expulsions.

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43 http://www.search-institute.org/research/assets/assetpower
44 www.flippengroup.com
**Strategy 1:**

*Strengthen the partnership among Sonoma County Office of Education (SCOE), school districts, and Task Force organizations to implement ongoing regular trainings for classroom and administrative staff in school-wide prevention strategies.*

<table>
<thead>
<tr>
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<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update list of current of in-classroom and school-wide AOD prevention activities by district</td>
<td>Current summary of what programs/which schools are implementing programs</td>
<td>SCOE*, DHS – P/P</td>
<td>Sept. 2008</td>
<td>None identified.</td>
</tr>
<tr>
<td>Establish a planning group of partner organizations to develop a plan for ongoing teacher trainings in evidence-based curriculum.</td>
<td>Core group of planning partners will be established.</td>
<td>SCOE*, DHS-P/P, Districts</td>
<td>Nov. 2008</td>
<td>None identified</td>
</tr>
<tr>
<td>Develop an implementation plan and schedule grade-appropriate teacher trainings specific to best practices and evidence-based curriculum.</td>
<td>Training plan and implementation agreements.</td>
<td>SCOE*, DHS-P/P, Districts</td>
<td>Jan. 2009 - June 2009</td>
<td>None</td>
</tr>
<tr>
<td>Work with school districts to insure teacher participation in trainings. Identify funds for substitute teachers.</td>
<td>Teacher participation</td>
<td>SCOE*, DHS-P/P, Districts</td>
<td>Jan. 2009 - June 2009</td>
<td>TBD (Approx. $150/ teacher)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
## Strategy 1 (continued):

<table>
<thead>
<tr>
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<th>Timeline</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Research model programs for training administrative, other school personnel, and parents using school connectedness, asset building, and resiliency models.</td>
<td>Training models will be identified.</td>
<td>SCOE*, DHS-P/P</td>
<td>Nov. 2008</td>
<td>None identified</td>
</tr>
<tr>
<td>Select model programs and present information to districts for program planning.</td>
<td>Model programs for all grade levels will be approved; districts will begin planning for implementation.</td>
<td>SCOE, DHS – P/P, Districts,</td>
<td>Jan. 2009</td>
<td>None identified</td>
</tr>
<tr>
<td>Organize countywide workshops and/or district consultations to train teachers, school personnel, and parents in program model.</td>
<td>Schools will adapt a campus-wide approach toward providing a supportive school environment for all students.</td>
<td>Districts*, DHS-P/P, SCOE</td>
<td>Spring, 2009</td>
<td>Approximately $5,000 for speaker fees, travel, room rental, food, participant materials, etc.</td>
</tr>
<tr>
<td>Research complementary community-based programs to support the school model i.e. mentoring programs.</td>
<td>A list will be created and periodically updated of prevention-focused community resources available to schools and families.</td>
<td>DHS-P/P, CBO’s</td>
<td>Nov. 2008</td>
<td>None identified</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner  
Note: Please see Attachment E for a guide to acronyms and abbreviations
GOAL 5

Strengthen school policy and program development to support early identification and intervention with youth at risk for substance use at elementary schools and all comprehensive and alternative high schools.

According to the California Student Survey\(^{45}\), use of alcohol or drugs by California students increases significantly in the middle and high-school years. The number of “excessive alcohol users” increases by about 30% between 9\(^{th}\) and 11\(^{th}\) grade and the number of “high risk drug users” doubles. In Sonoma County alcohol continues to be teens’ leading drug of choice. Over the last two years, alcohol use among teens has increased at significantly higher rates than for their peers statewide and is consistently higher among youth in alternative schools. According to the 2004-2006 California Healthy Kids Survey, 54% of Sonoma County 11\(^{th}\) graders in comprehensive high schools reported using alcohol at least once in the past 30 days. Among 11th graders in alternative schools this rate is 75%. Forty-six percent (46%) of high school and 76% of alternative school 11\(^{th}\) graders reported being high on drugs at least once. While reports of methamphetamine use among 11\(^{th}\) graders in comprehensive high schools remains relatively low at six percent, over one quarter (27%) of 11\(^{th}\) graders in alternative schools report having tried methamphetamine.

While traditional school-based strategies have shown some success with youth who are not already engaged in risk behavior, prevention education is less effective with students who are already using. Substance abuse prevention efforts have historically focused on changing attitudes by increasing awareness and knowledge of associated risks. Early intervention efforts, on the other hand, focus on identifying individuals who demonstrate a pattern of high-risk behavior associated with alcohol or drug use or those who are in the initial stages of use. Warning signs include: school-related violence, victimization, poor academic performance; truancy; discipline issues; and low school connectedness. Youth already engaging in risk behaviors require interventions that are appropriate to the variety of risk factors and issues that make them vulnerable to substance use. Comprehensive, school-based early intervention programs, in coordination with school-based AOD prevention education, can be effective in preventing initiation of substance use, and building protective skills for avoiding escalation of use.

\(^{45}\) Austin, G. Ph.D., Skager, R. Ph.D., 10\(^{th}\) biennial California Student Survey Drug, Alcohol and Tobacco Use 2003-04, California Department of Justice
The Task Force recommends that the Sonoma County Office of Education (SCOE), the County Health Services and Probation Departments continue their partnership to bring Safe and Drug Free Schools and Communities and other funds to local school districts to implement Student Assistance Programs. According to the American School Counselor Association, “…Student Assistance Programs (SAP’s), which can deal with substance abuse as well as other high-risk situations, serve as a systematic effort to help students understand themselves…while helping them to accept responsibility for their own actions.46

SAP’s are school-based programs providing focused services to students seeking support or needing interventions for academic, behavior, and/or attendance problems often due to substance abuse, mental health, or social issues. SAP’s are a process, rather than a curriculum or treatment center, that connects students with a network of support programs and services across school and community systems. These programs identify students in need of intervention, assess students’ specific level of need, and provide them with support and referral to appropriate resources. 47

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is an evidence-based SAP model that prevents and reduces substance use among moderate to high-risk, multi-problem high school adolescents. The program places highly trained Project SUCCESS counselors in schools to provide a full range of substance use prevention and early intervention services to identify and help youth who are at risk for developing alcohol and other drug problems. Intervention strategies include: information dissemination: normative and prevention education; problem identification and referral; community-based process; and, environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught. The counselors primarily work with adolescents individually and in small groups; conduct large group prevention/education discussions and programs; train and consult on prevention issues with school staff; contribute to the substance abuse services and policies of the school; and, make referrals and follow-up with students and families needing substance abuse treatment or mental health services. To date, three Sonoma County school districts are implementing Project Success at the high school level. Currently, there are no SAP programs being implemented on middle school campuses.

The Task Force recommends the expansion of Project Success at additional secondary school districts in Sonoma County and enhancement of existing Project Success programs to reach more school sites within districts and larger numbers of students at current sites. In recognition of the need to support early intervention models across grade levels, the Task Force recommends that the

partnership identify and work to implement SAP model programs for the middle school level. The Task Force also recommends the adoption of the Primary Intervention Program (PIP) SAP-type model at the elementary school level. PIP is designed to enhance the social and emotional development of young students (grades K-3) who are experiencing mild to moderate school adjustment difficulties.

Students’ substance abuse problems and behaviors can also put them on a direct collision course with their school district’s mandated zero tolerance policies that often entail the suspension and expulsion of students as an automatic consequence of school rules/regulations. After years of implementation and evaluation, these policies are becoming increasingly more controversial. Not for their intended goals of addressing school safety, but for their unequal and broad applications to behaviors that do not necessarily threaten the safety or welfare of others. Zero tolerance policies that are inconsistent and unequally applied can result in student suspension and/or expulsion leaving youth out-of-school and often unsupervised during school hours.

Many school districts are exploring alternatives to zero tolerance that incorporate the tenets of a Student Assistance Program (SAP) model. Rather than enacting punitive consequences for certain behaviors, the Task Force recommends that secondary school districts review and revise their existing policies, (maintaining compliance with the Ed Code requirements) adopting alternative strategies, standardized across the county, as a means of offering intervention and assistance for students who need help with their substance abuse problems. Many effective, evidence-based proactive behavioral strategies exist that include violence prevention, positive behavioral supports and social skills training, early intervention, in-school suspension, adult mentors, and teacher support teams.

Clean and Sober Schools were developed to provide a safe, AOD-free and supportive environment for students in recovery. These schools provide onsite group and individual counseling to help students achieve and maintain sobriety and develop a positive self-image. Students in grades 9-12 experience a safe and supportive school environment free of negative peer influence. Referrals to the program are currently received from school districts, the Probation Department, health or social service agencies, school-based programs, and/or parents. At this time there are two Clean and Sober campuses serving all of Sonoma County. The Task Force recommends that the number of Clean and Sober schools be increased to better meet regional needs.

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**Strategy 1:**
*Build on current partnerships (DHS, SCOE Probation, CBO’s and schools) to expand implementation of evidence-based AOD prevention programs.*

<table>
<thead>
<tr>
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<th>Partners</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Expand existing Project Success programs to include all H.S. sites in each district.</td>
<td>Project Success will be expanded and implemented.</td>
<td>SCOE*, DHS-P/P, Districts, CBO’s</td>
<td>Dec. 2008</td>
<td>None identified</td>
</tr>
<tr>
<td>Continue to expand SAPs by adding at least two secondary school districts</td>
<td>Project Success will be expanded to include two additional districts.</td>
<td>SCOE*, DHS-P/P, Mental Health, Probation, Districts, CBO’s</td>
<td>Jan. 2009</td>
<td>TBD</td>
</tr>
<tr>
<td>Research evidence-based models for SAP programs at the middle school level.</td>
<td>Programs will be identified</td>
<td>DHS*, SCOE</td>
<td>July 2008</td>
<td>None identified</td>
</tr>
<tr>
<td>Conduct SAP presentations for middle schools.</td>
<td>Commitment of middle schools to implement SAP models.</td>
<td>SCOE* DHS, Districts</td>
<td>March 2009 – ongoing as requested</td>
<td>None identified</td>
</tr>
<tr>
<td>Research evidence-based SAP models for elementary level including: the Primary Intervention Program and Caring Schools Communities models.</td>
<td>Appropriate evidence-based models will be identified for K-6.</td>
<td>SCOE*, DHS</td>
<td>Jan. 2009 - June 2009</td>
<td>None identified.</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
**Strategy 1 (Continued):**

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Organize and host an informational meeting with a group of potential partners to discuss alternatives to current zero tolerance, expulsion and suspension policies.</td>
<td>Partners will recognize the need to create alternative policies and identify the steps to make policy changes across districts.</td>
<td>SCOE, DHS, Regional School Superintendents’ Groups, Probation, Courts, Law Enforcement</td>
<td>Jan. 2009</td>
<td>None</td>
</tr>
<tr>
<td>Work with partner groups to advocate for in-school alternatives to school zero tolerance: suspension and expulsion policies</td>
<td>Alternatives to zero tolerance policies will be identified, advocated for, and adopted uniformly by Sonoma County school districts.</td>
<td>SCOE, Project Success, Measure O Gang Prevention programs, Probation, Youth oriented CBO’s, Task Force</td>
<td>Dec. 2008-Dec. 2009</td>
<td>Staff 129 staff hours based on the activities detailed in Goal 5. $3000 logistical support for meetings/convening as detailed in goal 5.</td>
</tr>
<tr>
<td>Form a workgroup of supportive partners to plan activities to educate and provide practical implementation assistance to interested districts.</td>
<td>A planning workgroup will be formed.</td>
<td>SCOE, DHS, Regional School Superintendents’ Groups, Probation, Courts, Law Enforcement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
### Strategy 1: continued

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Host follow-up workshop and/or consultation to develop, review, modify and/or change existing policies and market the need for policy change to the community, parents, and school board members.</td>
<td>District officers, superintendents, school board members and other local and county officials who can impact policy change will receive practical assistance</td>
<td>SCOE, DHS, Regional School Superintendents' Groups, Probation, Courts, Law Enforcement, Student reps</td>
<td>Winter 2009</td>
<td>Facility rental and food; publicity; Staff logistical support (10 hours)</td>
</tr>
<tr>
<td>Organize and host an informational meeting with a group of potential partners to discuss alternatives to current zero tolerance, expulsion and suspension policies.</td>
<td>Partners will recognize the need to create alternative policies and identify the steps to make policy changes across districts</td>
<td>SCOE, DHS, Regional School Superintendents' Groups, Probation, Courts, Law Enforcement</td>
<td>Jan. 2009</td>
<td>None</td>
</tr>
<tr>
<td>Identify Clean and Sober School models and possible funding sources for expansion to the north, east and/or west county.</td>
<td>Models and funding will be identified to expand access to clean and sober schools for students in recovery.</td>
<td>SCOE*, DHS-AODS, Districts</td>
<td>Dec. 2008</td>
<td>None identified.</td>
</tr>
<tr>
<td>Identify interested districts and provide TA on program design. Provide assistance with identifying funding to support program start-up and implementation.</td>
<td>Districts will be identified and supported in expanding Clean and Sober schools countywide.</td>
<td>SCOE*, DHS-AODS, Districts</td>
<td>April 2009</td>
<td>TBD.</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations.
GOAL 6

Implement methamphetamine treatment on demand.

To break the cycle of methamphetamine use, individuals and families must have access to effective, community-based treatment and recovery support. Yet, less than 10 percent of Americans who need substance abuse treatment each year get the help they need, according to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) 2006 National Survey on Drug Use and Health. Based on data from the National Survey of Drug Use and Health, in 2006, California had 849,000 residents who needed but did not receive treatment for an illicit drug problem.  

In our community, the lack of available treatment results in missed opportunities to help addicts before they become involved in crime, missed opportunities to help pregnant women deliver drug-free babies, missed opportunities to help parents create safe and nurturing families, and missed opportunities to protect young people from life-damaging addiction. Despite ongoing efforts to expand treatment capacity, requests for methamphetamine treatment continue to outstrip available resources.

Methamphetamine treatment is more readily available to individuals involved in the criminal justice system, thanks to the Substance Abuse and Crime Prevention Act (SACPA) and Drug Court programs. For example, in 2006-07 over half (53%) of all admissions to treatment in California were clients referred through criminal justice. However, access to community-based treatment remains extremely limited, especially for individuals without financial resources. Those seeking treatment at an early stage in their disease have few, if any, publicly funded treatment options.

While all publicly-funded treatment providers maintain waiting lists, the volume of total unmet treatment need is unknown. Data from waiting lists of individuals already accepted into treatment indicate that 200-300 individuals each month have to delay entry due to lack of an available bed or treatment slot. In spring 2008, Sonoma County publicly-funded treatment providers conducted a two-week survey to develop information on unmet drug treatment needs for individuals outside the criminal justice system. Of the 189 phone calls logged to these treatment providers, 78 individuals called regarding methamphetamine use. Fifty six (56) individual callers were eligible for services and requested treatment. Of these, 55% were denied services due to a lack of capacity/available beds. An additional 41% were denied services due to lack of

http://oas.samhsa.gov/2k5state/ageTabs.htm#Tab21
funds. This includes both a lack of appropriately funded treatment beds as well as lack of ability to pay.

The Task Force’s treatment-related recommendations focus on improving treatment access for substance abusers at the earliest possible stage in their disease and on making treatment more accessible to those seeking it outside the criminal justice system. To move toward a system which provides treatment on demand, the Task force recommends two strategies:

- Implement annual monitoring and measurement of non-criminal justice methamphetamine and other AOD treatment needs.
- Develop a plan to increase access to appropriate community-based methamphetamine treatment services for pregnant and parenting women, adolescents, and non-criminal justice clients in all geographical regions of the county.

**Strategy 1:**
Implement a system to annually monitor and measure publicly-funded methamphetamine and other alcohol and other drug treatment needs.

In order to create a more effective system of treatment services and strengthen that system’s ability to respond to local needs, the Task Force recommends the continuous monitoring and measurement of unmet need for publicly-funded treatment. While the unmet need pilot project, initiated under Task Force auspices in the spring of 2008, established a preliminary framework for the collection of this data, further work must be done to develop a system for annual measurement.

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50 Treatment beds are often categorically funded and reserved/held for clients who meet a certain set of specification and/or criteria such as criminal justice referred.
**Strategy 1:**
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**Implement a system to annually monitor and measure publicly-funded methamphetamine and other alcohol and other drug treatment needs.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize data from pilot survey to develop a snapshot of unmet methamphetamine treatment needs and develop a strategy to conduct ongoing monitoring and measurement</td>
<td>Pilot survey data summary, snapshot</td>
<td>DHS-AODS*, Task Force</td>
<td>March 2009</td>
<td>Evaluation consultant (10 hours)</td>
</tr>
<tr>
<td>Modify data collection process as appropriate and develop data collection protocols</td>
<td>Revised data collection protocols</td>
<td>DHS-AODS*, contract treatment providers</td>
<td>May 2009</td>
<td>Evaluation consultant (20 hours)</td>
</tr>
<tr>
<td>Develop and implement agreements with contract providers to implement data collection and provide training/technical assistance.</td>
<td>Data collection agreements and training plan</td>
<td>DHS-AODS*, contract treatment providers</td>
<td>May 2009</td>
<td>Training consultant (20 hours if site based; 5 hours if two centrally located trainings)</td>
</tr>
<tr>
<td>Work with health and human service systems to quantify unmet AOD treatment needs within their systems</td>
<td>Data collection and data sharing agreements</td>
<td>DHS-AODS*, Criminal Justice, Mental Health, HSD, others TBD</td>
<td>By May 2009</td>
<td>None identified</td>
</tr>
<tr>
<td>Compile an annual unmet treatment need estimate for use in program planning and advocacy</td>
<td>Estimate</td>
<td>DHS-AODS*, Task Force</td>
<td>By Sept. 2009, ongoing</td>
<td>Evaluation consultant (10 hours)</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
**Strategy 2:**

*Increase access to appropriate community-based methamphetamine treatment.*

Currently, most AOD treatment resources are concentrated in Santa Rosa, offering few options to residents in other communities and outlying areas. Because geographic barriers can negatively impact both treatment completion and outcomes, the Task Force recommends that a Treatment Expansion Workgroup be formed to assess unmet need by priority population and geographic region. The workgroup should identify requirements and opportunities for treatment expansion, quantify resource needs, develop strategies to reduce barriers to facility location, and develop a long-range countywide treatment expansion plan. The expansion planning process should be implemented in concert with the ongoing County Strategic Plan and the Corrections Criminal Justice Master Plan processes and should involve representatives from County agencies, local governments and the AOD treatment system.

This type of collaborative planning approach is supported by the recommendations of Join Together, a national initiative funded by the Robert Wood Johnson Foundation to prevent substance abuse and increase access to treatment. The recommendations highlight two strategies as critical in expansion planning:

- Collecting local data on the need for treatment capacity and using it to create alliances for expanded access, and
- Coordinating treatment expansion planning efforts with other long-term local planning efforts not linked to federal and state funding cycles (such as the County Strategic Plan and Corrections Criminal Justice Master Plan processes).

SAMHSA’s strategic plan "A Life in the Community for Everyone—Reducing Substance Abuse in America: Building the Nation’s Demand Reduction Infrastructure" focuses on a similar approach to build infrastructure for mental health and substance abuse services. SAMHSA is currently funding research and disseminating information on evidence-based policies, programs and practices which have been successful at increasing treatment availability using a comprehensive model which includes six major components: assessing resources and needs; improving services, organizations and financing; recruiting, training and retaining a quality workforce; creating interlocking systems of care; and promoting appropriate assessment and referral.

Even when expansion resources are available, residential alcohol and drug and mental health treatment providers are often unable to site new treatment programs or expand existing ones because local governments have created barriers through zoning and land use planning practices which may violate fair housing and other anti-discrimination laws. These laws offer protection to providers of residential treatment and other housing for persons with disabilities, including persons addicted to alcohol and other drugs and the mentally ill. The California Legislature, through
passage of SB 520-Chesbro, creates a window of opportunity (2008-2010) to address these barriers by requiring local governments to analyze any constraints that their regulations and practices have on the development and maintenance of housing for persons with disabilities, including residential treatment, and to demonstrate efforts to remove those constraints through modifications to their General Plan Housing Elements. The Solutions for Treatment Expansion Project (STEP), funded by The California Endowment, will pilot work for the next two years in four Southern California counties to mobilize, train and support providers of and advocates for residential treatment and other housing for persons with disabilities to generate the necessary community advocacy to change local governments’ approach to treatment facility location. As the project expands statewide, some Task Force members may participate in similar efforts locally.

Best Practice
“Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities,” from the University of Maryland School of Law, documented the effectiveness of using litigation to expand treatment services. For communities struggling to site treatment and recovery centers in areas where popular support is lacking, the study recommends four steps to expanding geographic access:

- Implement fair, non-discriminatory zoning standards for out-patient and residential alcohol and drug treatment services and a reasonable accommodations policy.
- Conduct a comprehensive planning process that assesses need for treatment services in a particular regions, map existing out-patient and residential services and appropriate locations for new services.
- Ensure that all entities that provide treatment services are certified or licensed and the licensure requirements are enforced.
- Implement planning practices that facilitate the inclusion of treatment programs in communities and resolve disputes quickly and fairly.

Finally, while the Task Force will not take a position on Proposition 5, the Nonviolent Offender Rehabilitation Act of 2008 (NORA), it believes that planning efforts should be undertaken now to assure effective local implementation in the event of passage. NORA is a very long, complicated, and controversial ballot measure that is currently opposed by law enforcement statewide associations and supported by the AOD treatment field and the American Society of Addition Medicine. It requires the State to expand and increase funding and oversight for individualized treatment and rehabilitation programs for nonviolent drug offenders and parolees. It establishes a comprehensive diversion/treatment system that expands PC 1000, SACPA and Drug Courts, and provides funding for adolescent treatment. It reduces criminal consequences of nonviolent drug offenses by mandating three-tiered probation with treatment and by providing for case dismissal and/or sealing of records after probation. NORA limits court authority to incarcerate offenders who violate probation or parole and shortens parole for most drug offenses, including sales, and for nonviolent property crimes. It creates numerous divisions, boards, commissions, and
reporting requirements regarding drug treatment and rehabilitation and changes
certain marijuana misdemeanors to infractions.

The Legislative Analyst and Director of Finance have developed estimates of fiscal
impact for state government but the net fiscal effect on expenditures for county
operations and capital outlay is unknown pending the jail and court policies
implemented if NORA passes. The Task Force recommends that local planning
efforts on implementation of NORA include Task Force representation to assure that
methamphetamine prevention and treatment are fully addressed in local program
design.
**Strategy 2:**
*Increase access to appropriate community based methamphetamine treatment.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Analyze opportunities/ requirements for enhanced/ expanded treatment capacity included in Corrections Criminal Justice Master Plan and County Strategic Plan</td>
<td>Expansion planning framework</td>
<td>DHS-AODS*, treatment providers</td>
<td>Coordinate with Master Planning timeline</td>
<td>Project consultant 100 hours</td>
</tr>
<tr>
<td>Convene a Treatment Expansion Work Group and implement expansion planning process</td>
<td>Expansion plan to include prioritized programs and services, budget and financing plan, and implementation plan.</td>
<td>DHS-AODS*, Task Force, CAO, Criminal Justice, Health and Human Services, Perinatal Action Team, schools, treatment providers</td>
<td>July 2009 – 2010</td>
<td>See above</td>
</tr>
<tr>
<td>Conduct outreach to stakeholders/policy makers to develop support for treatment expansion</td>
<td>Public and policy support for treatment expansion</td>
<td>Task Force</td>
<td>July 2010-12</td>
<td>See above</td>
</tr>
<tr>
<td>Develop resources to fund expansion plan priorities</td>
<td>Applications/requests for new funding</td>
<td>DHS-AODS*, Task Force</td>
<td>July 2010-15</td>
<td>Fund development consultant (TBD)</td>
</tr>
<tr>
<td>Implement expansion plan</td>
<td>Programs will expand to serve additional clients and offer services in all geographic regions</td>
<td>DHS and Contractors</td>
<td>July 2011-15</td>
<td>To be determined</td>
</tr>
<tr>
<td>Analyze opportunities/ requirements for enhanced/ expanded methamphetamine treatment related to (potential) passage of NORA</td>
<td>NORA implementation plan will fully address methamphetamine</td>
<td>DHS-AODS*, Task Force, Criminal Justice, Health and Human Services, schools, treatment providers</td>
<td>October 2008</td>
<td>None identified</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
GOAL 7

Support Treatment Effectiveness and Reduce Recidivism.

Because funding for community-based methamphetamine treatment is limited, it is imperative that communities use each dollar as cost-effectively as possible. Treatment for methamphetamine addiction is particularly resource-intensive because methamphetamine-related cognitive impairment often requires a longer treatment course than addiction to other substances. In Sonoma County, the majority of publicly-funded treatment is provided through a network of community-based non-profit contractors. While the quality of care is high and use of currently-recognized best practices is widespread, resources for training, program development, and technology acquisition are limited.

Once they enter treatment, methamphetamine addicts face significant barriers to success. Many do not complete treatment and among those who do, relapse is prevalent. While methamphetamine-specific data is not available, a statewide analysis of program completion and retention outcomes conducted in 2006-07 revealed that 47.2% of clients (all drugs) were discharged for dropping out of a program in which they were enrolled. Over one-fourth of these were individuals who were enrolled in treatment for 30 or fewer days. In Sonoma County for FY 07-08, 42% of participants in residential and outpatient treatment programs, who identified methamphetamine as their primary drug of choice, left treatment early with unsatisfactory progress, according to the SWITS data set. To address this problem, program strategies to promote retention must address the specific risk factors and unique treatment needs of methamphetamine users. For example, research indicates that methamphetamine clients with the following characteristics tend to do less well in both residential and outpatient treatment programs (as measured by treatment completion and program retention data):

- Clients with greater severity of methamphetamine addiction
- Clients who are injection drug users
- Clients with less than a high school degree
- Clients with a disability

Recovering methamphetamine addicts also face daunting challenges upon leaving treatment. These may include: loss of housing, loss of employment, debt and financial instability, deteriorated personal relationships, and return to a pro-use community environment. To help them succeed on the “outside,” methamphetamine users are taught to actively identify personal cues and triggers to relapse and to increase their level and use of relapse prevention skills. Treatment programs provide assistance with housing and job search. Once treatment is completed, most clients need an extended transition period where they can practice and use new abstinence.

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51 Sonoma County Methamphetamine Profile, Report to the Board of Supervisors, July 2006
skills in a clean and sober environment. Case management is often necessary during this transition time to support clients as they gain employment, begin to handle money, reunite with their families and address the normal stresses of life. At present, few transitional services are available to newly recovered addicts, resulting in far higher relapse rates than might be achieved with a comprehensive system of recovery supports including clean and sober housing, employment services, and case management.

To address these concerns, the Task force recommends three strategies:

- Build the capacity of the treatment system to adopt and implement best practices on an ongoing basis.
- Increase early entry into methamphetamine treatment through best practices and enhanced public information and referral
- Enhance community based services and supports for individuals transitioning out of treatment programs in order to support their on-going recovery.

The Task Force recommends that the County Alcohol and Other Drug Services (AODS), work with its contract treatment providers to implement a needs assessment to identify the capacity-building needs of providers and develop a multi-year training and technical assistance plan to strengthen administrative capacity, enhance program effectiveness and adopt new technologies and best practice models in treatment delivery. As part of the technical assistance effort, DHS should support contractors to develop agency-specific quality improvement plans.

The earlier in the disease that intervention can be offered the better the outcome. Studies suggest that engaging a client within 48 hours of that individual requesting services improves entry into treatment. Each day of delay into treatment increases the likelihood of an individual not completing an intake appointment. The State Office of Alcohol and Drug Programs reference for practitioners highlights the critical importance of early entry into treatment and recommends efforts to speed the admission process in order to help individuals engage with the treatment process.

For these reasons, the Task Force recommends continued efforts to streamline the treatment admissions process through participation in the Network for the Improvement of Addiction Treatment (NIATx) and other learning communities. AODS and its contract providers have recently begun to participate in the Network, which teaches drug and alcohol treatment centers to use process improvement strategies to improve access to and retention in addiction treatment. NIATx helps treatment providers break down barriers to care by: reducing the time between a request for help and a client’s first treatment session; reducing the number of clients

who don’t show up for appointments; increasing the number of treatment admissions; and increasing the number of clients who make it to the fourth treatment session. To achieve these goals, participants tackle one barrier after another in a rapid cycle of identifying a problem, testing solutions, and evaluating results. Over the last four years, more than 100 NIATx members nationally have realized significant improvements, e.g. a 34% reduction in waiting times; a 33% reduction in no-shows; a 21% increase in admissions and a 22% increase in treatment continuation.56

The Task Force also recommends that screening for methamphetamine use be expanded, particularly among high risk populations, by utilizing a collaborative planning approach to identify opportunities in Criminal Justice, Child Protective, Mental Health and the Probation systems to identify individuals at the earliest stage in their addiction and link them to treatment services. Protocols and agreements to enhance AOD screening and referral across multiple systems should be developed among participating agencies, using best practices such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) program. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services which includes the following elements:

- **Screening** to quickly assess the severity of substance use and identify the appropriate level of treatment.
- **Brief intervention** focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** for those identified as needing more extensive treatment with access to specialty care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community’s specialized treatment programs with a network of early intervention and referral activities in health and social service settings.57

Finally, the Task Force identified the urgent need to make more community-based services and supports available for individuals transitioning out of methamphetamine treatment programs in order to support their on-going recovery. Such supports include: case management, clean and sober transitional housing, employment assistance, financial counseling, and health services. The Task Force recommends that County AODS convene a work group of key stakeholders to better align the treatment system with a chronic care model and identify opportunities to enhance case management and support for transitional clients. This will require recognition among providers, consumers, and policy-makers that addiction is a chronic relapsing disease that requires life-long intervention. In addition, the Task Force recommends that a local mechanism be developed to register or certify sober living environments (SLE) in order to increase the number of subsidized and non-subsidized transitional living opportunities in the community.

56 [www.niatx.net](http://www.niatx.net)
57 [http://sbirt.samhsa.gov/index.htm](http://sbirt.samhsa.gov/index.htm)
**Strategy 1:**
*Build the capacity of the treatment system to adopt and implement best practices on an ongoing basis.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate a needs assessment of AOD treatment providers to assess infrastructure, work force, facility and technology needs and training needs program development needs.</td>
<td>Needs Assessment Grid</td>
<td>DHS-AODS*, treatment providers</td>
<td>Jan. 2009 – June 2009</td>
<td>Project consultant 75 hours</td>
</tr>
<tr>
<td>Develop and implement a technical assistance and training plan.</td>
<td>Technical Assistance and Training Plan</td>
<td>DHS-AODS*, treatment providers</td>
<td>July 2009 - June 2010</td>
<td>TA/Trainers 50 hours</td>
</tr>
<tr>
<td>Work with contract providers to develop quality improvement plans and incorporate into treatment contracts.</td>
<td>Quality Improvement requirements in contracts beginning July 2011.</td>
<td>DHS-AODS*, treatment contractors</td>
<td>July 2010 - June 2011</td>
<td>None identified</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner
Note: Please see Attachment E for a guide to acronyms and abbreviations
Strategy 2:
*Increase early entry into methamphetamine treatment through best practices and enhanced public information and referral.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilize methamphetamine planning data to identify opportunities in criminal justice, CPS, mental health, and probation systems to identify individuals with AOD problems at the earliest stage in their drug use and facilitate linkage with treatment services.</td>
<td>Individuals will be identified and linked with treatment services</td>
<td>DHS-AODS*, CPS. Probation, Mental Health, Criminal Justice agencies.</td>
<td>Coordinate with High Risk Youth pilot projects</td>
<td>High Risk Pilot Project Planning Consultant - additional 50 hours</td>
</tr>
<tr>
<td>Develop protocols and agreements to enhance AOD screening and referral across multiple systems.</td>
<td>Identified systems will implement screening and referral protocols</td>
<td>DHS-AODS*, CPS. Probation, Mental Health, Criminal Justice agencies.</td>
<td>Coordinate with High Risk Youth pilots</td>
<td>See above</td>
</tr>
<tr>
<td>Support mandated NIATx best practices implementation through technical assistance and training activities.</td>
<td>Improved client entry and retention</td>
<td>DHS-AODS*, treatment providers, SAMHSA TA provider</td>
<td>July 2008 - ongoing</td>
<td>None identified</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations
**Strategy 3:**

*Enhance community-based services and supports for individuals transitioning out of treatment programs in order to support their on-going recovery.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Desired Outcome</th>
<th>Partners</th>
<th>Timeline</th>
<th>Additional Resources Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with key stakeholders - providers, consumers, policy makers - to redesign the treatment system to address alcohol and other drug addiction as a chronic, relapsing condition and build public support for this model.</td>
<td>Service system alignment with chronic care model</td>
<td>DHS-AODS*, Task Force, treatment providers</td>
<td>December 2008</td>
<td>Planning consultant 50-75 hours</td>
</tr>
<tr>
<td>Working with stakeholders, identify opportunities to enhance case management and support for transitional clients and develop on-going agreements.</td>
<td>Enhanced coordination between service providers and better outcomes for clients</td>
<td>DHS-AODS* treatment providers, Human Services, CBO’s, schools, homeless service providers</td>
<td>March 2009</td>
<td>Consultant 50 hours In-kind technical assistance resources</td>
</tr>
<tr>
<td>Develop a local mechanism to register or certify sober living environments (SLE) in order to increase the number of subsidized and non-subsidized sober living opportunities throughout the county.</td>
<td>Increase the number of SLE that are registered or certified with the County of Sonoma</td>
<td>DHS-AODS*, County Counsel, Risk Management, homeless service providers, others TBD</td>
<td>January 2009 – 2010</td>
<td>See above</td>
</tr>
</tbody>
</table>

* Lead Agency/Partner

Note: Please see Attachment E for a guide to acronyms and abbreviations.
SECTION IV: NEXT STEPS

With the continued support from its membership and many community partners, the Task Force will begin work on first steps toward the implementation of the comprehensive Methamphetamine Prevention Plan. These include activities to sustain the Task Force; connect and coordinate with existing planning efforts; secure resources to fund pilot projects, and engage, inform and involve the broader community. Strategies selected for this initial phase of implementation are based on the following criteria: they are stage-dependent, representing the first step of a multi-level activity; they are of high importance and require urgent action; existing resources can be utilized for implementation; and/or a high level of community support is in place.

Continue the Task Force: The Task Force will seek financial resources to continue and strengthen the Sonoma County Methamphetamine Prevention Task Force. The Department of Health Services, Prevention and Planning Division will seek grant funding for a staff position to support the Task Force. Members will be actively engaged in ongoing implementation efforts and the development of key partnerships that will support the work of Task Force.

Enhance Coordination with Other Planning Efforts: The Task Force will work to identify effective strategies to coordinate and integrate methamphetamine planning efforts with other ongoing system-development and prevention efforts including, but not limited to: Criminal Justice Master Planning, Juvenile Justice Master Planning, Upstream Investment Project of the County Strategic Plan, AOD System Re-design Project, Perinatal AOD Action Team, Mental Health Services Act planning, Santa Rosa Mayor’s Gang Task Force, and other related community planning processes.

Develop Resources for AOD Expansion and Pilot Projects: The Task Force will seek grant funds to support program design and implementation planning for AOD Treatment expansion planning projects and three pilot programs focusing on High Risk Youth and their families.

Develop School-Based Prevention Capacity: The Task Force will collaborate with partner agencies to develop a model for ongoing teacher and staff training efforts. A student resiliency model will be identified for implementation. The Task Force will also work with members and partner organizations/agencies to secure funding to support the expansion of student assistance programs. The Task Force will coordinate this work with the Mental Health Services Act (MHSA) planning process.

Increase Public Awareness: The Task Force will work to launch a countywide public information campaign to educate and inform the community about the impacts of methamphetamine. Materials developed by federal and state public information campaigns will be adapted for local implementation. A methamphetamine website providing prevention, resource and services information will be developed and launched.
ATTACHMENTS

Attachment A: *Sonoma County Methamphetamine Profile, Report to the Board of Supervisors, July 2006*

Attachment B: *Focus Group Report*

Attachment C: *Key Stakeholder Interview Report*

Attachment D: *Methamphetamine Use and Child Welfare in Sonoma County*

Attachment E: *A Guide to Acronyms and Abbreviations*
Sonoma County
Methamphetamine Profile

Report to the Board of Supervisors

July 2006
SONOMA COUNTY METHAMPETAMINE PROFILE

Executive Summary

Methamphetamine has become a common drug of abuse in many regions of the United States. Once a primarily working class drug, methamphetamine users today cross all boundaries of race, socioeconomic status, sexual orientation, gender, age, and locality. The public impacts of methamphetamine addiction include increased levels of crime and violence, child endangerment, environmental degradation, and serious negative health outcomes. The use, abuse, distribution, and consequences of methamphetamine are taking a significant toll on public resources across a wide spectrum of service systems in Sonoma County including health care, criminal justice, alcohol and other drug (AOD) treatment, social services, mental health, and prevention.

This report provides background on methamphetamine addiction and current information on the production, distribution and sale of methamphetamine in Sonoma County. It highlights the scope and impacts of methamphetamine use on the community, with specific emphasis on how methamphetamine is affecting County service systems and resources. Last, the report overviews the County’s current prevention and treatment systems and discusses their use of “best practices” (i.e. documented through research to be effective) in the delivery of both prevention and treatment programs. Information in the report is organized around the following key findings:

- Methamphetamine is a highly addictive and dangerous drug.
- Methamphetamine use rates in Sonoma County exceed national rates.
- Patterns of methamphetamine use differ from other illicit drugs in some significant ways.
- Methamphetamine is readily available in Sonoma County. Most methamphetamine is imported from Mexico.
- The impact of methamphetamine use on County services and resources is significant.
- Treatment works. Sonoma County lacks sufficient treatment resources.
- Methamphetamine prevention must be comprehensive and community-wide. Prevention must include strategies to address both demand and availability.
- Better information on the local prevalence, impacts and costs of methamphetamine use is critical to future program planning.
Sonoma County Methamphetamine Profile

Methamphetamine is a highly addictive and dangerous drug.

Methamphetamine, a derivative of amphetamine, is a powerfully addictive stimulant that is twice as toxic as other amphetamines and has longer lasting effects. Widely used as a recreational drug, methamphetamine has several forms that can be smoked, snorted, injected, or ingested. Methamphetamine produces a high that can last from 6 to 8 hours, followed by a state of high agitation that, in some individuals, can lead to violent behavior. Users experience highly desirable and self-reinforcing neurological and physical effects that often lead to bingeing for several days at a time. Addiction occurs quickly and can result in increasingly heavy use with devastating effects on both physical and mental health.

Classified as a psycho-stimulant, as are cocaine and other amphetamines, methamphetamine differs from other drugs in a few important ways: methamphetamine is man-made, rather than plant-derived, and contains toxic chemical components. In contrast to cocaine, which is quickly removed and almost completely metabolized in the body, methamphetamine has a longer duration of action with a larger percentage of the drug remaining unchanged in the body. It takes 12 hours for the body to eliminate 50% of methamphetamine in contrast to one hour for cocaine. Because methamphetamine remains in the brain longer, stimulant and toxic effects are prolonged. Methamphetamine has a high addiction potential – estimated by the National Institute on Drug Abuse at 47% at first use and rising to 60% with a second use.

Compared with some other illicit drugs, methamphetamine is relatively inexpensive. The value of methamphetamine varies according to its purity, the region in which it is sold, the source of the drug (whether it was made locally or imported), and its availability. In Sonoma County, a bag (or gram)\(^1\) of methamphetamine costs about $40-$50, in contrast to $60-$120 for an equivalent amount of cocaine. One gram produces a two-hour “high” while day-long use may require 5-7 grams.

Methamphetamine is easily made with ingredients found in over-the-counter cold remedies (pseudoephedrine) along with other chemicals commonly found at the hardware store, including iodine, ammonia, paint thinner, and lithium from batteries. A clandestine lab can be set up in a kitchen, bathroom, or garage and detailed instructions on how to manufacture the drug – a relatively simple, but toxic and dangerous process – can be found on the Internet. A modest investment of about $150 can yield up to $10,000 worth of methamphetamine. Crystal methamphetamine (also called “ice,” or “glass,”), a form of methamphetamine that is becoming popular in Sonoma County, comes in clear, chunky crystals that are smoked. Users claim that it provides a more rapid “high” than the powdered form.

As a “cheap high,” methamphetamine gives the user – in the initial stages of use – energy to keep working, especially at manual jobs or work that requires long periods of wakefulness, such as truck-driving or shift-work. It is an appetite suppressant. Along with a

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*"Using methamphetamine is not like drinking alcohol or using marijuana. The grip is so quick. Meth addiction is very similar to nicotine addiction. A person can do long periods of habitual and social marijuana and alcohol. For methamphetamine and cigarettes, the addiction is more rapid.”*

*"The rise and fall is much more dramatic with methamphetamine. The bottom is similar to other AOD bottoms, but the fall is faster.”*

Focus group of Sonoma County AOD service providers
long euphoric high, users may become anxious, paranoid, and violent. Methamphetamine addiction requires more and larger doses as it progresses. Long-term methamphetamine abuse can result in dependence and methamphetamine psychosis. Health consequences associated with methamphetamine use include weight loss, tooth decay, cardiovascular problems, stroke, convulsions and prenatal complications. Chronic methamphetamine abuse can result in episodes of violent behavior, anxiety, paranoia, short-term memory loss, depression and brain damage. When use is stopped, abusers experience depression, anxiety, fatigue, paranoia, aggression, and an intense craving for the drug.

**Methamphetamine use in Sonoma County exceeds national rates.**

There is considerable controversy about the degree to which methamphetamine can be characterized as a “national epidemic”. While methamphetamine is taking a significant toll on public health and public resources in many communities, its use remains largely regional, reflecting the unique characteristics of local drug markets. In Sonoma County, based on treatment admission data, the number of users of stimulants significantly increased during the 1990’s, but has changed little since 2000. Incidence of methamphetamine use rose between 1992 and 1998 both statewide and locally. Since then, there have been no statistically significant changes.

The 2004 National Survey on Drug Use and Health (NSDUH) reported that 1.4 million Americans aged 12 or older (representing 0.6% of the population) had used methamphetamine in the past year, and 600,000 (representing 0.2% of the population) had used it in the past month.² (By comparison, 1.0% of this sample reported cocaine use within the past month).³ The rate of methamphetamine use in California is twice as high: 1.2% of Californians in the NSDUH survey reported using methamphetamine in the past 12 months, and 0.6% reported methamphetamine use in the past month. Extrapolating from the California rates, over 4,800 Sonoma County residents aged 12 or older are likely to have used methamphetamine in the past year, and about 2,400 residents³ are likely to have used methamphetamine in the last 30 days.

NSDUH survey data from 2004 also show that overall past 30-day use of methamphetamine by males and females 12 and older is fairly similar (0.3% and 0.2%, respectively). Past 30-day use is highest among 18-25 year olds (0.6%), followed by 26-34 year olds (0.4%), youth aged 12-17 (0.2%), and those 35 and older (0.1%). The study does not provide state-level demographic breakdowns. Thus, extrapolating from national rates to the county level is not feasible, given the significantly higher rates of methamphetamine use in California that were documented by the NSDUH survey.

Despite the lack of methamphetamine specific information for the general population, prevalence data is available for some groups.

**Alcohol and other drug (AOD) treatment population.** The Sonoma County rate of primary methamphetamine treatment admissions in 2003 (548/100,000 population aged 12 or older)⁴ was 2½ times higher than the California rate (212/100,000) and over nine times higher than the national rate (56/100,000).⁵ Sonoma County treatment data for
FY04-05 indicate that methamphetamine was identified as the primary drug of choice among 368 (66%) of Substance Abuse Crime Prevention Program (SACPA) clients, 313 (61%) of Treatment Accountability for a Safe Community Program (TASC) clients and 65 (71%) of Sonoma County Drug Court clients. Among the homeless population in AOD treatment in FY04-05, 34% or 686 individuals reported methamphetamine use. It should be noted that 80% of AOD treatment system admissions are criminal justice referrals. For this reason, this data cannot be used as an indicator of methamphetamine use in the general population.

**High school students.** Data from high school surveys are believed to under-represent substance use among the general youth population because they do not capture behaviors of youth that have dropped out of school. While methamphetamine is used much less frequently than alcohol or marijuana, 4% of Sonoma County 9th graders and 6% of 11th graders report having used methamphetamine one or more times, compared to state rates of 3% for 9th graders and 8% for 11th graders. Past 30-day use, which is considered a proxy for current use, is about twice as high among Sonoma County students (2% each for 9th and 11th graders) as it is nationally, but lower than statewide rates (3% of 9th graders and 5% of 11th graders). By comparison, 31% of Sonoma County 9th graders and 48% of 11th graders report having at least one full drink in the last 30 days, and 16% of 9th graders and 28% of 11th graders report using marijuana in the last month. The 2003 California Healthy Kids Survey found that 37% of students in “non-traditional” high schools (i.e. court and continuation schools) reported having used methamphetamine one or more times, and 24% reported using the drug four or more times. Twelve percent of non-traditional high school students reported having used methamphetamine in the past 30 days.

**Patterns of methamphetamine use differ from other illicit drugs in some significant ways.**

Patterns of methamphetamine use have changed over time. Once used predominantly by white working class males, and men who have sex with men, methamphetamine use now crosses all genders, ages, and socioeconomic strata. Methamphetamine is used for multiple and complex reasons. It is used as a stimulant to boost sexual performance, relieve depression and isolation, and increase energy. Adolescent females use methamphetamine to control their weight. Methamphetamine is used to alleviate emotional and/or psychological pain, heighten physical and mental performance and endurance, and stay awake to work extra shifts or get through school. Some individuals use it as a recreational drug and seem to avoid addiction.

Unlike other illicit drugs, methamphetamine is used fairly equally by women and men. A higher percentage of females – who are generally underrepresented in treatment programs – enter treatment for methamphetamine compared with other drugs. In 2004, females accounted for 38% of all methamphetamine-using clients in Sonoma County public AOD treatment programs. Methamphetamine-abusing female teens accounted for over half (54%) of youth under the age of 18 in Sonoma County AOD treatment programs. Treatment data also indicate that methamphetamine use for both genders tends to start later in life (most commonly between 18 and 25 years) as compared with alcohol and other drug use, which often starts in the early teen years.
The racial/ethnic composition of the Sonoma County treatment population is also changing. The percentage of white clients in treatment with a primary methamphetamine addiction declined from 80.4% in 2000 to 74.1% in 2004, while the percentage of Latino methamphetamine addicts rose from 11.9% in 2000 to 19.1% in 2004. This increase is likely attributable to increased availability of culturally appropriate treatment resources.

**Methamphetamine is readily available in Sonoma County. Most methamphetamine is imported from Mexico.**

According to local law enforcement sources, the production and distribution of methamphetamine in Sonoma County increased with the arrival of Mexican organized crime families in the early to mid-1990s. At that time, the easy availability of precursor chemicals made it feasible to manufacture methamphetamine locally. As local production increased, the price of methamphetamine dropped to about $4,000 a pound – today, by comparison, a pound of powdered methamphetamine costs about $7,000. In 1997, the organizations responded to the flooded market by cutting back on availability – although methamphetamine could still be purchased in quantity and Sonoma County remained an active distribution center. By the late 1990’s, local production was curtailed and most methamphetamine was imported from Mexico. Today, most of the drug available in Sonoma County is produced in Mexican “super labs” and brought across the border to Los Angeles, through San Jose or Fresno, to Santa Rosa.

Santa Rosa is a distribution “hub” for Northern California, particularly Lake and Mendocino counties. Distribution occurs through a network of established families and cartels, primarily Latino. Poly-drug distribution systems (i.e. dealers selling methamphetamine, cocaine, and heroin) are on the rise. In the past several months, undercover agents with the Sonoma County Narcotics Task Force have purchased large quantities of crystal methamphetamine, currently selling for $8,000-$9,000 a pound.

Local labs are producing only one to two ounces of methamphetamine at a time and currently represent only a minor fraction of the local supply. Since 2003, the Sheriff’s Department has raided 14 methamphetamine labs – about 4-5 annually. These seizures occur primarily in rural parts of the county where it is easier to conceal small drug labs operating out of homes. New federal restrictions have further reduced the local availability of precursor chemicals.

**The impact of methamphetamine use on County services and resources is significant.**

**Hospitalization** - Hospitalization where methamphetamine is the principal cause of admission is rare. From 2000-2004, there were 22 such hospital admissions in Sonoma County hospitals (about 5 annually) for a total cost of approximately $175,000 (excluding
physician costs). Sixty percent of these cases were covered by Medi-Cal or other public payors. Methamphetamine is more commonly reported as a “secondary” or “other” diagnosis. Cases within this category more than doubled from 244 in 2000 to 522 in 2004. In 2004, methamphetamine reported as a principal (n=4) or other diagnosis (n=522) accounted for 25% of all drug related hospitalizations (excluding alcohol).

Emergency room use - During the first six months of 2005, methamphetamine was reported as a principal diagnosis in 52 Sonoma County hospital emergency room visits and as an “other” diagnosis in 265 visits. According to national data collected by the Drug Abuse Warning Network, the most common reasons for methamphetamine-related ER visits are overdose (28%), unexpected reaction (23%), wanting to detoxify (22%), and chronic effects (22%).

Mortality – From 2001-2005, 85 methamphetamine-related deaths (methamphetamine listed as a primary cause or secondary factor) occurred in Sonoma County – about 17 per year. The majority was white (78%), followed by Latino (16.5%), African American and American Indian (2.4% each), and Asian/Pacific Islander (1.2%). Nearly 60% of methamphetamine-related deaths occurred among those 30-39 (24.7%) and 40-49 (34.1%). Young adults 20-29 accounted for 15.3% of deaths and older adults 50-59 made up 17.6%. Six teens (7.1%) died from methamphetamine-related causes.

Criminal Justice - Methamphetamine use is a significant contributor to crime and violence. Methamphetamine-related crimes include: drug-specific crimes such as manufacturing, distributing, or possession of methamphetamine; and crimes where methamphetamine use is associated with theft, assault, and homicide. Sonoma law enforcement officials report a direct correlation between methamphetamine use and property crimes such as mail fraud, burglary, shoplifting, and theft, including identity theft.

“Dangerous drug” arrests - which include methamphetamine – accounted for 24% (1,102) of all adult felony arrests (4,569) made in Sonoma County during 2004. In the past five years, dangerous drug arrests, which have remained fairly level, have accounted for approximately 44% of adult (18+) and up to half of juvenile (<18) non-alcohol drug arrests. Since 2003, the Sonoma County Sheriff’s Office alone (whose jurisdiction includes the unincorporated parts of the county, along with Windsor and Sonoma) has made 1,624 arrests for methamphetamine possession, 253 arrests for possession for sale, and 41 arrests for sale of methamphetamine.

From 2002 to 2004, felony dangerous drug (including methamphetamine) arrests among youth have accounted for 32% to 39% (about 24 annually) of all felony drug bookings at Juvenile Hall.

In 2005, adult bookings into Sonoma County jail totaled 19,300. Nearly half (48%) of these were for alcohol and other drug crimes – which does not include other crime categories that are likely influenced by AOD use or abuse. Data on methamphetamine-related crimes and arrests per se are not available, however, a history of methamphetamine use prior to arrest is reported by a significant number of inmates. In April 2006, the jail medical provider conducted a random review of the medical charts of 402 inmates, and found that 60% (240 cases) had self-disclosed using methamphetamine. Methamphetamine-specific detention costs and potential cost-savings are difficult to calculate for a variety of reasons: as noted, accurate data on the number of methamphetamine-users is not captured; jail bed unit costs are not available; and, because most methamphetamine users are poly-drug users, even if their methamphetamine use were discontinued, they would be likely to enter the system for other drug use or related crime.
Probation - The Probation Department currently supervises approximately 2,800 adult offenders. Initially, most adult offenders participate in an intensive drug-testing program. Over time, probationers who demonstrate abstinence are tested less frequently. For January 1 through June 12, 2006, of 4,637 drug tests administered, 766 (16.5%) tested positive for illegal substances or alcohol. Of those, 166 (3.6%) tested positive for methamphetamine.

The Probation Department also supervises 733 minors whose jurisdictional status ranges from informal probation to wards of the Court. Methamphetamine is a problem in this population. In a recent 13-month period, 5.6% (168 out of 3,000) drug tests of juvenile probationers were positive for methamphetamine. At the Department’s residential treatment program, Sierra Youth Center, four out of eleven girls currently acknowledge an addiction to methamphetamine.16

Alcohol and Other Drug (AOD) Treatment - Methamphetamine is the second most common primary drug of abuse – following alcohol – among those admitted for AOD treatment in Sonoma County. Adult treatment admissions for methamphetamine have increased by 85%, from 1,155 in 2000 to 2,132 in 2004, accounting for one-third of treatment clients over 18. About half of adult treatment admissions report methamphetamine use as a primary, secondary, or tertiary drug problem. Criminal justice referrals to treatment for methamphetamine abuse rose in Sonoma County from 62% in 2000 to 79.9% in 2004.17 While, most of the increase in this period is due to the implementation of Substance Abuse Crime Prevention Act in 2001, referrals for methamphetamine abuse climbed at a slightly higher rate than for other drugs.

The percent of young (<18) methamphetamine users referred to treatment by the justice system is also consistently higher than for youth using other drugs. In 2004, 60.9% of juvenile methamphetamine users were referred to treatment by the juvenile justice system, compared to 37.1% of other drug users. However, youth reporting methamphetamine as their primary drug problem declined from 12% of all youth treatment admissions in 2000 to 10% in 2004.

Annual costs for the public AOD treatment system are approximately $14 million. Because most individuals in treatment are poly-drug abusers, it is difficult to determine methamphetamine-specific costs, however, based on 35-40% of treatment admissions reporting methamphetamine as the primary drug of choice, annual County-funded methamphetamine treatment costs can be estimated at about $5 million.

Mental Health – Mental Health staff estimate that 60% of clients using County mental health outpatient programs have substance abuse problems, with a large portion reporting methamphetamine as their primary drug of choice. An estimated 10% of admissions to the Sutter Psychiatric Inpatient Unit are the direct result of a methamphetamine-induced psychosis - over 100 admissions annually. Based on a cost of approximately $1200 per day and an average stay of 8 days, annual costs for 100 methamphetamine-related inpatient admissions are estimated at $960,000.

An additional estimated 25% of admissions identify methamphetamine use or abuse as a factor contributing to their need for acute inpatient care. Approximately half of the clients in the County’s Forensic Assertive Community Treatment Team program report regular use of
methamphetamine. Anecdotal reports from Sonoma County psychiatrists and other treating staff reflect an increase in the number of otherwise healthy young adults who, secondary to methamphetamine use, develop an intractable psychotic condition characterized by frequent psychiatric inpatient admissions, episodic arrests, alienation from friends and family, and a life of victimization on the streets. In the last year, three female Mental Health clients in their early 20’s, fitting this profile, committed suicide.

Child Welfare – Parental and caregiver methamphetamine use has become a significant contributor to child abuse and neglect. Methamphetamine use affects the parent’s ability to care appropriately for children and is associated with argumentative, assaultive, and threatening behaviors. Children living around methamphetamine labs or with a methamphetamine using caregiver may be malnourished, neglected, abused or abandoned. Children living at or visiting methamphetamine production sites (e.g., home labs) face multiple health and safety risks from exposure to toxic chemicals used in the manufacturing process. The drug is sometimes stored in baby bottles, milk cartons, or mason jars, making it easily accessible to very young children. Law enforcement officials report cases where children are used to facilitate the movement and sale of methamphetamine.

Children living with substance abuse issues often need services for many years. Anecdotal data suggest that family reunification rates are lower with methamphetamine users than with users of other drugs, and that methamphetamine users seem less interested in making the changes necessary to reunify their families. Foster parents who provide care for these children are challenged daily with physical care needs and the emotional scaring that these children bring with them. For older children, their neglect and abuse often causes behavior problems that are difficult to manage, resulting in multiple placements or placement in group homes.

The State-mandated child welfare data collection system does not currently allow the Sonoma County Human Services Department, Family, Youth and Children’s Services to capture data on alcohol and other drug involvement among families in the child welfare system. However, in reviewing cases over a recent 6-month period, child welfare officials estimate about one-half of parents in the system have some significant involvement with methamphetamine. Methamphetamine-specific cost data is not readily available. However, based on a conservative assumption of 32 children (roughly 20% of the annual new custody caseload) who, absent their parents’ methamphetamine use, would not otherwise enter the child welfare system, annual child welfare costs can be calculated at approximately $810,000.

Birth Outcomes - Methamphetamine use during pregnancy may result in prenatal complications, higher rates of premature delivery, and altered neonatal behavioral patterns and may also be linked to congenital deformities. Sonoma County specific data are not available, however a national study found that 5% of women living in areas “known to have methamphetamine problems” used methamphetamine at some point during their pregnancies. Applying this finding to Sonoma County suggests that about 270 (5%) pregnant women who gave birth in 2003 may have used methamphetamine while pregnant. From 2000-2004, methamphetamine was identified as the primary drug of abuse for 247 adult women (18+) and 15 young women (<18) who were pregnant at admission to Sonoma County AOD treatment programs. Methamphetamine-using pregnant women represented 60% of all adult pregnant women and 27% of all pregnant teens in treatment during that five-year period.

Communicable Disease - Injection needle-sharing and risky sexual behaviors (multiple sexual partners, decreased use of condoms) put some methamphetamine users at high risk
for hepatitis C, HIV and other sexually transmitted disease (STDs). Studies show that methamphetamine use doubles the risk of acquiring STDs, including HIV. Methamphetamine is thought to be one of several factors contributing to an increase in syphilis cases among men having sex with men (MSM). Based on 2005 data, of the 1,055 males living with HIV disease in Sonoma County, 77% were MSM and another 12% were injection drug-using MSM. Recent data from Sonoma County Counseling and Testing Clinics indicate that nearly 20% of MSM tested for HIV report having used methamphetamine in the past two years.

Environmental Safety - Chemical waste and debris from methamphetamine production can pose a serious environmental threat. Significant levels of contamination may be found throughout residential properties where methamphetamine production has occurred. If the contamination is not remediated the public may be harmed by remaining materials and residues. Depending on the extent of contamination, adjacent buildings may be impacted. The drug can contaminate dwellings and adjacent buildings, get into paint, carpets, heating and air conditioning ducts, furniture, clothes, and other personal belongs.

Cleaning up a laboratory is expensive, dangerous, and time consuming. In 2001, clean-up costs for over 2,000 methamphetamine labs and dumpsites cost Californians nearly $5.5 million, or an average of $2,450 per lab. The Methamphetamine Contaminated Property Cleanup Act became law in January 2006. Under the law the local Health Officer is responsible for assessing the contamination risk associated with seized methamphetamine labs, monitoring remediation, and notifying the public of health risks. Prior to passage of this law, the State assumed responsibility for methamphetamine lab clean-up and associated costs in Sonoma County. This responsibility will now be the Department of Health Services. Under the law, clean-up costs are recoverable from the property owner. While there is no local cost history for lab clean-up available, other counties report costs ranging from $6,000 - $10,000 per site for clean-up activities.

Treatment works.
Sonoma County lacks sufficient treatment resources.

Evidence-Based Approaches to Drug Addiction Treatment. Numerous national, state and university studies have concluded that AOD treatment works and is cost effective. These studies indicate that up to 60% of persons completing treatment maintain sobriety and are crime free for two years following treatment. These cost benefit studies also show that AOD treatment saves taxpayers between $7.00 and $12.00 – in health care, criminal justice and lost productivity costs - for every dollar invested in treatment.

The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) routinely evaluates drug treatment approaches and strategies to determine their effectiveness. These approaches are then recommended as “evidence-based”. CSAT documents its findings through a series of publications, the Treatment Improvement Protocol Series (TIPS) and the Technical Assistance Publications (TAPS), both of which create standards for best practices in drug addiction treatment. (See Appendix B: Treatment Protocols).

The National Institute on Drug Abuse (NIDA) has also developed and tested a number of approaches to treat stimulant (i.e. methamphetamine and other drugs in this category) abuse. These studies have shown that drug treatment for methamphetamine abuse is as effective as treatment for other types of drug abuse. The research indicates that
methamphetamine addiction can be effectively treated with the same approaches that are successful with other drugs and that specialized methamphetamine-specific programs are not necessary. However, methamphetamine addicts generally require longer treatment episodes and more intense inpatient treatment, based on cognitive deficits related to methamphetamine damage to the brain and other internal organs. It is important to note that, although a significant number of individuals entering the local treatment system report methamphetamine as their primary drug of abuse, the majority of these clients are polydrug users, so treatment programs must be configured to deal with a variety of substance use issues.

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches, including rehabilitation, counseling, behavioral therapy, medication, case management, and other types of services. Traditional treatment approaches and programs, including outpatient drug-free treatment, and short- and long-term residential treatment programs have evolved to meet the needs and circumstances of changing and more complex client populations. For example, people with co-occurring drug abuse and mental health issues are often treated in specialized facilities. There are also gender specific programs and culturally competent programs for particular populations.

One or more of the following evidence-based approaches are typically combined in a drug treatment programs for stimulant abusers.

**Relapse Prevention** - is a cognitive-behavioral therapy based on the theory that the learning process plays a critical role in helping individuals learn to identify and correct problem behavior. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence and provide help for people who experience relapse. Research indicates that the skills individuals learn through relapse prevention therapy are retained after the completion of treatment.

**Individualized Drug Counseling** - focuses directly on reducing or stopping the addict's illicit drug use and addresses related areas of impaired functioning such as employment status, illegal activity, and family/social relations. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the client develop coping strategies and tools to abstain from drug use and maintain abstinence.

**Motivational Enhancement Therapy** - employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process.

**Behavioral Therapy** - incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals.

**The Matrix Model - A Combination of Proven Approaches**
The 16-week outpatient Matrix Model combines a number of proven treatment approaches by providing a framework to engage stimulant abusers in treatment and help them achieve abstinence. Clients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. Written materials draw heavily on the treatment
approaches discussed above and include relapse prevention, family and group therapies, drug education, and self-help participation.

The Matrix Model has been found to be an effective, if expensive, treatment modality. However, recent research indicates that while Matrix Model clients attended more counseling sessions and gave more clean drug tests during the 16-week program, when compared to clients in more traditional treatment, no difference was found between the two groups 12 months after treatment. Twenty-five percent of participants in both treatment models remained methamphetamine-free.

**Combining Criminal Justice Sanctions With Drug Treatment Can Be Effective In Decreasing Drug Use And Related Crime**

Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime. Individuals who are legally coerced tend to stay in treatment longer and do as well as or better than non-legally pressured individuals. Drug abusers also often come into contact with the criminal justice system earlier than they do with other health or social systems so that intervention through the criminal justice system may help to both interrupt and shorten a career of drug use.

**Local AODS Treatment System**

The Department of Health Services/Alcohol and Other Drug Services (AODS) Division operates treatment programs directly and administers 14 contracts with community-based treatment providers. This combination of treatment modalities is intended to create a comprehensive continuum of treatment services. This system has been developed in response to local needs and is aligned with research and scientific evaluation of treatment strategies and approaches to drug addiction treatment. Table 1 provides summary information on the current application of evidence-based practice within the local treatment system. The table below identifies the treatment modalities (i.e. short term residential, perinatal etc.) currently available in the local treatment system and identifies the evidence-based approaches utilized within each modality. Further detail may be found in Appendix A: Sonoma County Treatment System: Evidence-Based Approaches.

<table>
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<th></th>
<th>Outpatient Drug Free</th>
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<th>Long Term Residential 90+ days</th>
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*These programs include some, but not all, components of the matrix model

Despite the documented need for public treatment resources, the AOD treatment system in California is woefully under-funded. While local data on methamphetamine-specific unmet treatment needs are not available, a recent assessment indicated that, on any given day, approximately 412 Sonoma County residents may be seeking publicly-funded AOD.
treatment that is not available. Treatment for methamphetamine addiction generally requires more long-term residential and intensive outpatient care than is readily available in both local and statewide systems. In an effort to balance very limited resources with high drug-treatment demand, the local system is forced to utilize shorter treatment episodes, potentially reducing the efficacy of treatment for some individuals, to manage the waiting list for services.

**Methamphetamine prevention must be comprehensive and community-wide.**
Prevention must include strategies to address both demand and availability.

Methamphetamine prevention is a relatively new field. Very few research-based studies have been conducted from which to develop tested strategies, yet numerous sources suggest that methamphetamine use is a problem that requires community-wide solutions. Methamphetamine prevention must include multiple strategies that, where possible, utilize best or promising practices based on research and evaluation findings (evidence-based).

“*The most cost effective and productive way to address the harms of methamphetamine abuse is to prevent people from beginning to use the substance.*”


**Prevention Principles**

Based on review of current literature, recommendations for the development of effective methamphetamine prevention programs include the following:

- **Avoid Single Strategies.** Methamphetamine abuse is a complicated drug problem with wide ranging impacts that require multiple strategies.
- **Insure Collaboration/Coordination.** Involvement of many sectors of the community is needed for effective methamphetamine prevention. Multidisciplinary, coordinated strategies involving the criminal justice and health sectors are particularly critical. It is also important to involve youth, parents, educators, media, social service, community and faith-based organizations in prevention strategies.
- **Conduct Data Collection/Surveillance.** Target populations and risk factors must be identified so that prevention and education strategies can be designed to address specific needs of local communities. Multi-system data collection and monitoring should be ongoing and used to select priority prevention approaches.
- **Build Integrated Prevention and Treatment Programs.** Targeted prevention education and outreach for high-risk populations should be linked to treatment and should explore pathways to recovery other than through the criminal justice system. An integrated health care continuum should combine comprehensive substance abuse and mental health services, as needed, with sexually transmitted disease treatment for populations at highest risk for methamphetamine-related communicable disease.

**Implementation of Evidence-based Strategies**

*Environmental and Public Policy Approaches.* Environmental policy approaches, which are aimed at reducing methamphetamine availability, as opposed to education directed to individuals, have generally proven to have the greatest impact over time on
methamphetamine-related problems. For example, training for property owners and landlords on environmental design and management techniques has been shown to dramatically decrease criminal activity around apartment buildings once dominated by methamphetamine problems.

The Department of Health Services does not currently operate any methamphetamine-specific prevention programs. However, DHS does conduct environmental policy efforts to reduce tobacco use and alcohol-related problems and is currently implementing a 3-year environmental prevention program, funded by the California Department of Alcohol and Drug Programs, to reduce high-risk drinking behaviors among youth and young adults in the south county. Environmental approaches to target methamphetamine can build on this experience.

**Law Enforcement.** Supply-side strategies to reduce the production, distribution and sale of methamphetamine are important components of the overall prevention continuum. Community-oriented policing measures and targeted enforcement efforts can be effectively combined with other prevention efforts such as community organizing, health education, and media advocacy.

Current County-sponsored law enforcement initiatives to reduce the availability and use of methamphetamine include: community-oriented policing, school resource officers, neighborhood watch groups, and more targeted methamphetamine enforcement efforts, such as the Sheriff’s Narcotics Task Force and targeted monitoring of probation clients with methamphetamine history.

**Early Intervention with High-Risk Populations.** Early intervention and support services are targeted to high-risk populations and sometimes include families or other support networks. Examples of early intervention services include assessment, individual or group education, skill-building, and other types of support to prevent or intervene with drug using behaviors.

The Probation Department administers currently two early intervention programs. The Juvenile Probation Camp Fund provides $310,000 yearly for community contracts to deliver substance abuse counseling and family support to delinquent offenders. The Juvenile Justice Crime Prevention Act provides $1.3 million yearly to fund school and gang probation officers and support innovative community programs working with high-risk children and families. During FY 06/07, Probation will initiate two new programs: a 5-day intervention program for high school students suspended from school for substance issues and a 30-day after-school program for minors involved in substance abuse. Both programs will emphasize prevention, appropriate interventions and treatment for minors involved in methamphetamine and other drug use.

The Department of Health Services contracts with five community-based agencies to provide early intervention services to at-risk youth and their families ($165,000). These services include: assessment and brief therapy for youth and families; school- or community-based group education; and diversion programming that makes use of service learning and employment training opportunities. The Department also utilizes $70,000 in Safe and Drug Free Schools and Communities funds to contract with one community-based provider to deliver parent education and support to Latino parents of at-risk adolescents through the Padres Unidos program. Padres Unidos is an intensive 16-week parent skill-building course designed to assist Latino parents of high-risk youth to prevent alcohol and other drug involvement and youth violence.
Prevention Education. Methamphetamine prevention education efforts should follow established prevention principles and be part of broader prevention education efforts that target all forms of drug use. Curricula should include factual information about the harms specifically related to methamphetamine use without resorting to counterproductive scare tactics.

The Department of Health Services utilizes approximately $550,000 in State and Federal block grant funds for general alcohol and other drug prevention education activities through contracts with a network of community-based agencies. Contractors operate a range of programs in school, community and family settings. Many school districts in Sonoma County also deliver evidence-based alcohol and other drug prevention curriculum in the classroom, although delivery of these programs has been inconsistent over time due to academic priorities and funding constraints.

Youth Development. This evidence-based strategy focuses on helping young people to increase personal resilience and achieve their full potential as the best way to prevent them from engaging in risky behaviors. The Health Services and Probation Departments incorporate youth development principles in their current youth prevention programming.

Table 2 provides summary information on the current application of evidence-based practice within the local prevention system.

<table>
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<tr>
<th>Environmental and Public Policy Approaches</th>
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<th>School System</th>
<th>Criminal Justice System</th>
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<td>Prevention Education</td>
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Better information on the local prevalence, impacts and costs of methamphetamine use is critical to future program planning.

As noted throughout this report, data on the specific costs and impacts of methamphetamine use are relatively unavailable. While alcohol and other drug client data are routinely collected through the health, human services and criminal justice systems, methamphetamine-specific data are far less commonly captured. This is true locally and at the state and national levels. Several factors make data collection challenging:
- Methamphetamine use is under-documented. For example, because most criminal justice data is self-reported, it is likely to be under-reported by individuals seeking to conceal illegal activities.
- Methamphetamine use is often obscured by other data. In health-related data systems, when methamphetamine use contributes to morbidity or mortality, its role is often obscured by a “primary” diagnosis such as trauma or suicide.
- Data systems are not configured to collect alcohol and other drug problem data. In Human Services, for example, the constraints of the State-mandated data collection system do not allow for the capture of methamphetamine use as a contributor to specific child welfare cases.
- Data on cost impacts is difficult to estimate. Methamphetamine use is often part of a larger “problem set”. Because most methamphetamine users are polydrug users, it is difficult to quantify the potential cost benefit to County systems of reducing methamphetamine use. For example, it is not likely that reducing methamphetamine use by 20% would reduce client treatment or incarceration costs by the same amount, given the likelihood that many of these clients would enter the system for other drug use.

Increasing interest in the scope and impact of methamphetamine problems is helping to focus attention on the need for more and better data at the local, state and national levels. With appropriate resources, sound methodology and collaboration among key systems, data on methamphetamine use and its impacts can be captured, analyzed and used to develop and improve programs to prevent and treat methamphetamine problems in our community.

Appendices

Appendix A: Sonoma County AOD Treatment Provider Program Descriptions
Appendix B: Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol Series

Acknowledgements

Methamphetamine Workgroup:
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Endnotes

1 A gram is roughly the size of a packet of sugar. A hit or line or dose of meth is generally about ½ gram.

2 Office of Applied Studies. Results from the 2004 National Survey on Drug Use and Health (NSDUH), Detailed Tables. See http://oas.samhsa.gov/nsduh/2k4nsduh/2k4tabs/Sect1peTabs1to66.htm#tab1.1a; California Department of Finance, Population Projections, Demographic Research Unit.

3 California Department of Finance, Population Projections, Demographic Research Unit.

4 California Department of Alcohol and Drug Programs, CADDS; Department of Finance, Population Estimates.


9 Office of Statewide Health Planning and Development, Patient Discharge Data.


11 Sonoma County Public Health Division, Department of Health Services.

12 The felony arrest category “dangerous drugs” offenses include possession, possession for sale, sale, and the use of minors in the sale of such drug categories as barbiturates, amphetamines, methamphetamines, PCP, preludin, quaaludes, ritalin and generally manufactured or prescription drugs.

13 California Department of Justice, Criminal Justice Statistics Center

14 Sonoma County Sheriff’s Department

15 Sonoma County Probation Department

16 Sonoma County Probation Department

17 California Department of Alcohol and Drug Programs, CADDS


20 California Department of Alcohol and Drug Programs, CADDS


23 Cited studies include: The California Drug and Alcohol Treatment Assessment (CALDATA, 1994); the 1999 LAO Report on Substance Abuse in California; UCLA Integrated Substance Abuse Programs SACPA First Year (2003) and SACPA Cost Analysis (2006); and a Columbia University study, Substance Abuse in America (2005).

24 The information in this section draws heavily from two sources: the Substance Abuse and Mental Health Administration (SAMHSA) TIP 33, “Treatment for Stimulant Use Disorders,”
and the National Institute on Drug Abuse (NIDA) publication “Principles of Drug Addiction Treatment.”


26 The information on prevention best practices in this section was compiled from several documents, including:


California Society of Addiction Medicine, *Recommendations to Improve California’s Response to Methamphetamine*.


Methamphetamine Focus Group Findings
February 26, 2008

Prepared By: Selena Polston Consulting
Introduction

During the months of January and February 2008, 10 focus groups were conducted with a diverse population of Sonoma County methamphetamine (“meth”) users and their families. The following report represents a summary of key findings that emerged from each of those groups.

The 10 methamphetamine focus groups included a total of 80 meth users and their families and were designed to provide a comprehensive view of how meth has impacted various high-risk populations within the County.

47.5% of focus group participants were male, and 52.5 % were female. The average age was between 31 and 35. Approximately 54% of participants identified themselves as White, 26% as Hispanic, 3% African-American, 16% of mixed race and less than 1% Native American and Asian/Pacific Islander. The majority of participants had been in recovery for less than one year.

Below is a table describing each of the 10 focus groups, its sponsoring organization, target population and total number of participants in attendance.

<table>
<thead>
<tr>
<th>#</th>
<th>Sponsoring Organization</th>
<th>Target Population</th>
<th>Total # Participants</th>
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<tbody>
<tr>
<td>1.</td>
<td>Sierra Youth Center</td>
<td>Adolescent girls in residential treatment</td>
<td>11</td>
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<tr>
<td>2.</td>
<td>Turning Point</td>
<td>Long-term adult users in residential treatment</td>
<td>11</td>
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<tr>
<td>3.</td>
<td>Drug Abuse Alternatives Center</td>
<td>Parenting women in outpatient treatment</td>
<td>8</td>
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<tr>
<td>4.</td>
<td>COTS</td>
<td>Homeless adults in various stages of recovery</td>
<td>12</td>
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<tr>
<td>5.</td>
<td>Vineyard Worker Services</td>
<td>Mono-lingual Spanish speakers/ immigrants</td>
<td>13</td>
</tr>
<tr>
<td>6.</td>
<td>Narcotics Anonymous</td>
<td>Adult users in recovery</td>
<td>14</td>
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<tr>
<td>7.</td>
<td>Clean and Sober School</td>
<td>Adolescents in recovery</td>
<td>3</td>
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<tr>
<td>8.</td>
<td>Our House</td>
<td>Adolescent males and females in residential treatment</td>
<td>8</td>
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<tr>
<td>9.</td>
<td>Drug Abuse Alternatives Center</td>
<td>Gay men in outpatient treatment</td>
<td>2</td>
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<tr>
<td>10.</td>
<td>Hall of Justice</td>
<td>Parents of meth users</td>
<td>7</td>
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</tbody>
</table>
Findings

Although the focus groups targeted distinct populations, the findings that resulted from each of the 10 groups shared a high degree of consistency. As a result, the findings are presented as a single group of cross-cutting themes, rather than by sub-group. To aid the Task Force in utilizing the findings, they are presented here according to the work group issue they most directly address. However, it should be noted that many of the findings raise issues that relate to several work groups. In addition, there are several findings which relate to access and enforcement issues. These are located in the final section under “Access and Enforcement.”

Each of the findings is followed by a brief description and illustrated by relevant quotes from focus group participants.

A. Findings Regarding Data Enhancement/Systems Integration

- **Lack of clean and sober living environments (SLE’s) and lack of job skills stymies many users’ long-term sobriety.**

The majority of focus group respondents stated that proximity to meth was a decisive factor in both their initiation and ongoing abuse of the drug:

“*If I didn’t put myself around those people doing it, I would have never done it.*”

“*If I wasn’t around it, I probably wouldn’t have done it.*”

“*If I am in the room with it, I am gone.*”

Many participants believe that they must maintain a physical distance from the drug and those using it in order to maintain their sobriety over the long term. However, maintaining a healthy distance is difficult due to a lack of affordable clean and sober housing:

“*They (drug court) told me I can go to prison or to a Sober Living Environment (SLE) but I couldn’t go home. I now call my sponsor every day and have been clean for 4.5 years. I always stay in a safe environment.*”

“*What helped me stay sober more than anything was that when I was released, I was let go into a safe environment.*”
According to respondents, those who have used meth for many years have failed to develop the job and basic living and coping skills necessary to negotiate day-to-day life effectively. Without the ongoing development and reinforcement of these skills, former addicts are destined to return to using:

“Guys are getting out of Turning Point and they don’t have any money or job skills. We need to help them to live in a safe, sober environment and put them in a job link to get them skills, and not just expect them to figure it out for themselves.”

“Not using drugs is only half the equation. I had to learn how to mourn properly and how to meet my daily obligations and responsibilities.”

- **Full recovery from meth is a long-term and resource intensive investment**

Focus group participants acknowledge that recovery from meth is a long-term process that requires ongoing support at many levels. Several addicts emphasized that it was only with the intensive support of their therapists, sponsors, and family members, together with an array of health, housing and other social service programs that enabled them to maintain their sobriety.

“CPS’ involvement was a great help to me because they gave me the resources to do the treatment program, like transportation, housing and taking care of all the physical needs I have. CPS even sent over a person to help me fill out the housing form.”

According to respondents, many treatment programs fall short in dosage levels to effectively address users’ substantial issues. Because of insurance constraints, many programs are structured to provide only 30, 60 or 90 days of treatment.

“Research shows that it takes 18 months of being clean to clear you head and get through it. Letting them out after 30 days is the worst time to let them out and sets them up for failure.”

Several users expressed the desperate need for continuous support in order to maintain sobriety:

“You can’t give up on us. Users need people to stick with them for their recovery.”

- **Meth is often used in combination with alcohol and other drugs to extend or enhance their effects.**
Several focus group respondents described how they or their family members used meth in order to increase the amount of alcohol or other drugs they were able to consume before passing out.

“My parents would use meth and then would go buy alcohol and drink all night. The first time I tried it, I used it to sober myself up and stay awake.”

“I was drinking and smoking weed before using meth. But to be cool, you had to maintain and meth helped you handle more.”

“I was raped by someone because I was so drunk, so meth became a way to extend my drinking and still drive home.”

- Changes in the chemical composition of meth have shortened its effects and spurred users to consume larger amounts more often to maintain their desired high.

According to several long-term users, the changes in the composition of meth have made it more toxic and less effective. According to these respondents, the advent of the “tweaker” personality and profile is a direct result of these changes:

“The quality of meth was better 20 years ago. Now it’s so bad, we have the tweaker. It doesn’t last long. It ruins your physically. When it was made out of P2P, I stayed up for 22 days. Now it is made with amphetamines that deplete your dopamine and you build up a resistance to it. Now, no matter how much you do, you still crash. The high isn’t as high and the crash is worse. It has much more junk in it.”

According to a handful of long-term users, their decision to stop using meth was determined the significant decrease in quality and the accompanying toxicity:

“The quality of it went down. It’s junk. Not worth it anymore.”

“Now you see all these tweaker kids with scabs all over their bodies from picking at themselves. The stuff is junk now. It ruins your body.”

- Meth is commonly used at some workplaces, often with the consent of employers and/or managers

Several focus group participants reported that they had used meth while on the job to either increase their productivity, stay awake through multiple shifts or to compensate for a night of binge drinking. The two trades most often associated with meth use were the hotel industry and the construction trades. Several focus group respondents reported that their employers and/or managers had either provided them with meth, or else had looked the other way while they used the drug during work hours.
“As a manager at a hotel, I would take meth to stay up 36 hours to cover people’s shifts.”

“I used it because I was going to school and working and needed to be up. My employers asked me to use it to be a more productive worker.”

According to focus group respondents, many employers, especially those requiring continuous heavy labor or contiguous shifts see meth use as a way to meet their business goals:

“I used to deal for 20 years and would go on (construction) job sites and people would recognize me and I would be hired because they knew that I would get everyone loaded and the work would get done.”

“At my construction job almost everyone uses it.”

According to some focus group participants, employers are not as tolerant of meth today as they were ten years ago and more employers are utilizing drug testing.

- **Individuals receiving SSI are often targeted by meth dealers**

According to homeless participants, individuals receiving SSI are targets for meth dealers because of their steady monthly income. According to one respondent who previously sold meth, he and other dealers would gain entry into apartment buildings that housed the elderly and disabled and attempt to generate new customers:

“I got into the Rosenberg building downtown and would give away the meth for free. After I just got one hooked, I would get a call every 20 minutes from someone in the building wanting some.”

**B. Findings Regarding Access to Treatment**
Focus group participants believe the only method for receiving affordable treatment is through the criminal justice system

Most focus group participants and their families received treatment following their involvement with the criminal justice system. Only a handful of participants reported being able to secure treatment for themselves or their families outside the system. These individuals tended to be either very young, suffer from severe physical or mental disabilities or else come from families with financial means.

“If you are destitute or rich you can get it, but if you have a modest income and are working its hard to afford.”

For those families with financial means, paying for comprehensive services still proved daunting:

“We went to the Henry Olaf structured treatment program because there was nothing available in Sonoma County. It cost us almost 100K.”

“The first program we had to pay for ourselves and we had to sell most of our belongings. It was crushing.”

“It cost our family $4,500 per month for counseling and other services.”

“I spent every penny I had to help my son and it still didn’t help.”

Only a handful of users reported trying to get help before becoming involved in the criminal justice system. According to these individuals, NA was the only program free and open to them:

“People I know want to get help but get denied from programs and feel helpless.”

“I had to go to jail to get a court order to go to a program. Otherwise I would have to pay $3,000 out of my pocket.”

“There are only a limited number of community beds. If someone is ready to enter treatment they can’t wait until a community bed becomes available.”

“In reality there is no free long-term treatment for meth on demand except at Saint Anthony’s. But you have to sign up in San Francisco to get it.”

Many respondents expressed their belief that overall, there were not enough treatment beds in the county, especially beds for youth:
“There are no adolescent programs in Sonoma County except for Our House. “

“There are not nearly enough programs available for youth in need. Most kids have to go to jail to get treatment.”

Even when the criminal justice system does becomes involved, focus group participants believe it is not responding adequately to address meth issues among youth:

“When I called my son’s probation officer and told her he needed treatment, she told me that he would have to get arrested again to get it. I was disgusted.”

“The probation system is not giving swift enough consequences so that kids see that there are consequences for using meth.”

- The threat of jail/prison is effective at helping some users accept treatment

While each focus group respondent described a unique set of experiences which preceded their “hitting bottom” and making the decision to stop using, the majority of focus group participants indicated they were heavily influenced by their involvement or threat of involvement with the criminal justice system. The threat of prison convinced many participants to enter treatment programs they had previously shunned.

“I didn’t want to go to jail for no alcohol or drugs. So I stopped everything. …..My friend was killed by the cops because he pulled a gun on the cops. He was tweaking. He wouldn’t ever have done that if he wasn’t tweaking.”

“I am 54 and have already had two prison terms….I don’t want a third.”

“The prison system is fun and games until you get to a high level. Do you really want to spend 10-20 years behind bars and come out to see that your friends have homes and cars and lives and you have nothing.”

“I want to live life outside of prison walls. I don’t want to die in prison, but that’s where I keep finding myself.”

For many participants, spending modest amounts of time in jail enabled them to rid their body of the drug long enough to begin treatment.

When asked if they would return to meth use if there would be no criminal justice consequences, the majority of long-term users admitted that “yes” they would.
While participants stressed the importance of the criminal justice system in influencing their decision to remain sober, many users stated that viewing programs as “punishment” made it much less likely that they would successfully complete the program and more likely they would return to using. However, mandatory programs that are able to communicate a strong belief in the individual user’s worth and that generated hope among users were viewed as more meaningful, and hence more successful.

“The last trouble I had the judge wanted to put me in for 30 years. I had been in jail 10 times and finally was sent to a program. What turned the key was when I changed my attitude and looked at the program not as a punishment, but as an opportunity to become the person I wanted to be in the community in touch with my higher power. When I was first sentenced to go to the program and it was a punishment – that’s when I kept getting in trouble.

Several participants attributed their decision to finally “sober up” to a judge who “believed in them” and allowed them to go into a treatment program rather than sending them to jail:

“The judge looked at me and said he knew I was better than that and gave me the chance to go to treatment rather than jail. I owe my sobriety to him.”

- The threat of homelessness is effective at helping some users accept treatment.

Many focus group respondents (particularly those in the homeless community) stated that they had to decided to remain clean in order to maintain their subsidized housing:

“I lost my apartment and was back on the streets again. I’m 50 and can’t do the streets again.”

“The biggest motivator for me to stop using was getting housing.”

- When confronted with pregnancy and/or child custody issues, some meth-addicted women will accept treatment

According to several parenting women, the realization that they were newly pregnant or that their living children would be taken away from them, provided them sufficient incentive for accepting treatment:

“When I was pregnant I couldn’t stop. I wanted to, but I couldn’t. The night my baby was taken, was my clean date.”
“I was tired of how my life was. I was homeless, couch-surfing. It was not me. When I found out I was pregnant, I thought of the women who have done things to their kids. I wanted a clean and sober baby.”

“I was afraid of losing my child for a second time so I went to the treatment program.”

When loss of custody was combined with the threat of prison, the incentive for entering treatment appeared to increase:

“Going to jail and having my kids taken away from me made me crazy. I was so worried about their safety that I stopped.”

“I was so tired of the insanity but I couldn’t stop on my own. I had to be put in jail for two weeks.”

A handful of parenting women credited Sharon Uni (sp?), a staff member at Drug Free Babies for successfully bringing them into recovery. According to these respondents, Sharon’s unconditional support and one-on-one counseling, provided the women what they needed to start their recovery process:

“Sharon treated me with respect. She wanted to hear about my experience. She was real.”

- **Parents of meth users believe that they must receive parallel treatment to effectively support the sobriety of their children.**

The family members who had received parallel counseling and education services as their children were in treatment, insisted that the skills they gained were essential in supporting the long-term sobriety of their children:

“I don’t think a person has a chance without their whole family doing it.”

“The education starts when you get into recovery. The person and the family are both in denial. It’s a family disease.”

Many of the parents described their development of a “tough love” approach that enabled them to provide much-needed support while removing the tendency to “enable” their child’s addiction:

“As a parent, I felt it was my responsibility to pull up the bottom so that my child didn’t have to go to jail or be homeless. I was a tough love mom. We did an intervention and she was in an out-patient program in 5 days. We did it as a family.”
“The tough love was important to her success because she knew that I was dead serious that if she was not clean she could not stay at home. I knew I had the strength to tell her to go and she saw there was something to lose.”

“The greatest gift my son and we gave him was the clear boundaries and the continual love and support.”

A few parents stressed the importance of the Nar-Anon meetings for parents and family members as they dealt specifically with the issue of meth and the shame many families have around it.

- The majority of meth users believe that prevention activities will have little to no impact on those individuals with an addictive predisposition

While most participants supported meth prevention activities such as real-world testimonies, mentoring, youth development, and individual and family counseling, they expressed their belief that the majority of those individuals with a predisposition for meth use would ultimately try it and become addicted:

“My son saw me almost die, go through recovery and was proud of me, and he still got addicted to meth….If you are born an addict, then you will be an addict and the only thing a person can do is to have the window to fall, see your disease and get help.”

C. Findings Regarding School-Based Prevention

- According to respondents, meth is available for sale at the majority of area high schools and at several middle schools

Several youth reported that they had either bought meth at school or else had used meth in and around school grounds. When asked to identify which area high schools meth is available at, respondents replied “all of them.” When asked to identify which middle schools meth is available at, respondents replied “almost all of them.”

“I would go to school and have it offered to me four times.”

“You can get weed and meth even in grade school. Kids are taking it from their parents.”

“The first time I used it was in the bathroom at school. Some girls were using it and asked me if I wanted to do a line.”
Participants in the mono-lingual Spanish-speaking focus group expressed their belief that meth use among Mexican immigrants began in the high schools and that area high schools provided the easiest access to the drug:

"It's easier and more common to get it in the high school than on the street. It's about connections. Someone always knows who to call if they want it. Word gets out."

A handful of respondents stated that while they were using meth they would either skip school or else walk out of their classroom to smoke in cars or outside in the parking lot.

- **According to youth focus group participants, schools appear to be ‘out of the loop’ in terms of prevention and intervention.**

Of the approximately 25 youth interviewed in the focus groups, not one identified school teachers, counselors or other staff as being involved in the prevention or intervention of their meth use. According to focus group participants, schools and school counselors are over-burdened and wary to get involved in potentially litigious conflicts with families:

"The school didn’t call because they said that most parents don’t want to hear it and get mad at the school for butting into their business."

"Schools are not tracking and following up on absences and other behaviors that should key them off."

"The teachers that want to help the kids are hamstrung by the system. Everyone is gun-shy of lawsuits."

"I went to the school-site council and told them what was happening to my child, what we were going about it and my goals to bring education and support to the school. I was well-received by the parents and teachers, but the teachers were afraid to advocate for the program for fear of getting sued or their credential’s revoked."

- **Petaluma’s City School’s ‘Project Success’ is attempting to integrate school, police and treatment services to better identify and treat high-risk youth**

According to one focus group participant working in the Petaluma City School District, that district is attempting to develop an integrated program to intervene early in the lives of youth. The program is described as similar to an employee assistance program, but one that supports students through confidential group and individual counseling and referrals to treatment:
“We are working closely with law enforcement, treatment, referrals, counselor support etc. I get referrals from school counselors telling me about kids in trouble and from the police department – which is huge.”

D. Findings Regarding Strategies For Working With High Risk Populations

- Meth-addicted youth and adults view meth as a powerfully effective tool for coping with depression and other emotional disturbance.

The majority of youth and adults respondents stated that they were dealing with depression at the time of first use and believed that meth effectively and immediately reversed their painful feelings in the short term.

“When I took meth I could set aside any problems in my head. Things that were bothering me didn’t have a chance in the face of speed.”

“You don’t have to deal with yourself and think about your insecurities. When you use meth, your forget your sadness and mask your feelings.”

“Meth gets you out of your depression without the sexual side effects.”

Depression was identified as a key motivating factor for meth use among immigrant Spanish-speakers:

“The lack of family around makes people depressed. I’ve seen folks from my state of Guerrero become addicts. They can forget their troubles.”

“Using it has a lot to do with depression and the friends you hang out with. If you don’t have family here, you get depressed.”

Many youth respondents grew up in homes where they saw their parents use meth to decrease stress and other negative emotions.

“In my family it was considered normal to do drugs. There was nothing strange about it.”

According to these respondents, children of meth-addicted parents must be provided with alternative models for coping with their own negative feelings:

“We have to help kids whose parents use reflect on their experiences and give them coping skills so they can deal with their own anger and feelings.”
• Several youth and adult focus group respondents reported that they had received a diagnosis of ADD prior to the onset of meth addiction

Approximately 25% of all focus group respondents indicated that they had received a diagnosis of ADD or ADHD as a child or young adult. Many of these respondents reported receiving Ritalin or other prescription drugs to manage their ADD symptoms. When asked if they connected their ADD to later meth use, every respondent stated “yes”. Respondents reported that they enjoyed meth in large part because it helped them “calm down”, “focus”, and “get their work done”, three behaviors that were otherwise very difficult for them to achieve.

“If you are hyper, it helps you focus and gives you a sense of calm.”

A handful of respondents stated that their use of Ritalin set the stage for their addiction to meth and other forms of speed:

“The Ritalin given to kids is a form of speed. Some kids are developing addictions to prescription drugs before ever doing illegal drugs.”

• Many young people and gay men are introduced to meth through sexual partners and use meth to enhance their sexual experience

Across the board, all focus group respondents – whether they were male, female, youth, adult, gay or straight – were emphatic in their belief that meth significantly enhanced their sexual experience. Meth was attributed to increasing libido, to increasing responsiveness, stamina and decreasing any emotional trauma previously associated with sexual activity.

“It helped me separate myself from my feelings around sex and escape. I definitely want to do sexual things when I’m on it.”

Several young women and gay men reported that they were introduced to meth by a current or potential lover and were supplied with the drug on a regular basis by those or other sexual partners. A handful of women reported using meth to enable themselves to work in prostitution and several women reported having sex with partners they would have never considered had they not been using the drug.

“I had a boyfriend selling and then I just started using and that was the end of me.”

“I was in a sexual situation with a partner and he pressured me to try it.”

Focus group respondents identified young gay men in particular as particularly vulnerable to abusing meth:
“There are so many predators waiting for fresh faces to pull into their party scene. I don’t see how young gay men with their huge sex drive can avoid getting caught in it. I saw over and over young gay guys who were picked up on the streets, used for a few months and then literally thrown back on the streets as skin and bone and mentally disturbed.”

- The majority of youth using meth were introduced to it either by family members, or adult friends/neighbors

The majority of youth participants stated that they came from homes in which a parent or close family relative had a history of using meth:

“Meth was one of the biggest things in my household. I forgot which uncle gave it to me first.”

“When I was 14 years old my mom gave it to me and my older brother. She said, ‘do it with me, not on the street.’ “

“It was around my family constantly. I couldn’t hate my mom for something I had never tried.’

Even when meth-using parents did not condone the use of meth, youth viewed the drug as a “natural part of life.”:

“I got it from my parents. It was okay when I was being raised.”

“In my family it was normal to do drugs. There was nothing strange about it.”

“I thought drugs were a normal part of teen behavior.”

- Youth whose parents use meth express a simultaneous deep-seated repulsion as well as powerful attraction to the drug.

While the majority of focus group youth expressed deep anger and sadness regarding the damage meth had wrought upon their families, they also described an overpowering curiosity about the drug prior to their initiation:

“I grew up with it. My mom was a tweaker and I was curious about how she felt. I always hated it because my mom’s brain was ruined from it. But I just had to try it.”

“I was against it because my mom and dad did it. They got taken away on my fifth birthday for robbing a store. They were never around. But I just got so curious that I did it.”
“My mom had always done it and I had a hateful nature about it. But then I got curious about it. My mom always told me that it was a horrible thing to do. I got a contact high and got curious. I just wanted to know what it was like.

“I wanted to see for myself. I had to find out for myself. I was a crank baby.”

- Participant’s view meth’s greatest benefit is the sense of “invincibility” it provides users

In every focus group, participants reported that the “number one” benefit afforded them by meth was their sense of “invincibility.” Youth and adult, male and female, all users described a deep sense of satisfaction from their belief that they could conquer any school, job, social, sexual, criminal or other challenge while using meth.

“Everything came out perfect when I was on meth. I used to think I could kick anybody’s butt.”

Several participants reported using meth to put them at ease in social situations:

“All of a sudden I felt beautiful, confident, life of the party.”

“It gave me something to do – an identity. It connected me with people. Like asking a person for a lighter instead of saying ‘do you want to hang out.’”

Other users reported using meth to deal with stressful situations:

“I would use meth when I needed courage. When I was losing my kids or getting a summons. I would do a line before opening mail or opening the door. Being a single mom, it helped me not to worry so much. When I lost my husband, it helped me deal with the grief.”

“I took crystal when I crossed the border (with Mexico) to overcome my nerves.”

A handful of male participants reported using meth to summon courage for committing gang-related and other crimes.

“When I was in a gang and would commit a crime, it would give me more courage. It didn’t bother me if I killed someone. I didn’t mind.”

“I shot up right in one of the aisles of the market before robbing it.”
“My friends and I would use it to get up the courage to deal with problems we had with other people – like other gang members.”

- **According to participants, the majority of parents who do not use meth are unaware of the problem and ill-prepared to confront it**

Participants stated that parents not involved in the drug culture are woefully ignorant about the scope and danger of meth as it relates to their children.

“Parents are the ones who need drug education more than the kids”

Several youth participants described abusing meth under the nose of their unsuspecting parents:

“I was put on house arrest but was still using and my parents didn’t know what it was so I could use it when they were there.”

Participants insisted that parents must learn about the signs and symptoms of meth and how to effectively intervene if they suspect their children are using.

**E. Strategies Regarding Media/Public Education**

- **The majority of users described maintaining a highly negative view of meth and meth users both prior to and following their own use.**

In general, focus group respondents held a very negative view of meth and meth users that did not appear to change once they themselves became users. Across the board, meth was associated with “low class” and “dirty” people who are socially unacceptable.

“My dad was in and out of prison due to meth use and I had a bad connotation of it. The ‘dirty people’ was my thought about it.”

“I saw a movie about tweakers and thought they were so gross and putting themselves in situations that I would never want to be in.”

“My association with dopers wasn’t good. I thought of homeless people – not people like me.”

“I thought of bad stories. People who get real skinny, crazy, and become homeless after a while.”

Among the majority of focus group respondents, meth is considered the most serious and dangerous drug:
“People wanted to ‘straighten me out’ by giving me LSD or heroin.”

In general, respondents expressed a strong repulsion to meth even as they gave up their family, possessions and health in order to access it. They described a cognitive dissonance in which they held deeply negative associations with meth, even as they strived to gain access to the drug:

“I had bad such bad associations with meth – fighting parents, being a bad mother – But then I took the drug and felt beautiful and confident and life of the party.”

“I always knew it was wrong but I couldn’t stop doing it.”

- Among users, there is a strong association between the use of meth and the loss of physical attractiveness.

When asked to identify the “negative” results of meth use, the majority of focus group participants (many of them female) emphasized the loss of physical attractiveness. In general, respondents viewed “tweakers” as a highly unattractive sub-culture. They were repeatedly described by respondents as “scary-looking”, “gross”, “dirty”, and “unhealthy”:

“Whenever I think of meth I think of really gross skin and really messed up teeth. Just watching people around me, makes me not want to do it ever again.”

According to a handful of participants, recognizing how their face and body had changed as a result of meth use was so disturbing that it proved to be a powerful catalyst in helping them to reach the decision to stop using. Sometimes this recognition came after viewing “before and after” photographs, other times it happened during an unusual moment of clarity:

“One day I looked in the mirror and I got so pissed off I broke the mirror. I was white as paper. My skin was totally broken out. My lips were completely chapped. I had rubbed all the skin off my eyelid trying to get my makeup perfect. I couldn’t believe that I looked so much like a tweaker. I couldn’t believe it. I stayed with my mom until I could stay off of it.”

“I was coming down and thought I was dying. When I came up here and I saw my before and after pictures, I started crying. I was just bones.”

“I guess I looked tore up really bad. This guy pulled up and offered me $20. I wasn’t like that but I guess I looked so bad they thought I was something that I wasn’t.”
Among users there is also a strong association between meth use and the destruction of physical health.

“I almost had pulmonary failure from doing it. The drug creates health issues and you don’t take care of yourself.”

“Meth caused irreparable damage to my body”

The health issues caused by meth appeared to be critical for those infected with HIV:

“I would stop eating and lose weight. I wouldn’t drink water because it would interfere with my high. I stopped taking all my HIV meds.”

The biggest complaint surrounding meth for the general population is the loss of appetite and rapid weight loss and malnutrition which follows it:

“It is an appetite suppressant robbing you of your nutrients. You are not eating or sleeping.”

“I lost 30 pounds in three weeks. I was a living skeleton

According to one youth counselor, the message sent to boys and girls should be different to have the greatest impact:

“In my groups, I try to stress to the girls the damage meth does to your body and skin and face, and to the boys I stress how it will make you lose your job, your car, your apartment and your ability to be the provider of a family. There was a 20/20 special that showed successful people going bad due to meth. This really impacted my kids”

Among users there is concurrence that meth robs them of their physical, spiritual, intellectual and moral resources.

According to focus group participants, the devastation caused by meth in the lives of users and their families is so complete, it is almost incomprehensible:

“I have destroyed people. It is the most horrible thing I have done.”

“I lost my judgment, my teeth, my honesty, my integrity…I sold my soul.”

“I was just a little kid. By the time I stopped, I was gone. I had no love in my life from me or anyone else. I was an empty shell.”
Many users expressed a deep sense of guilt for the problems they had caused their family and friends. They struggled against viewing themselves as “the lowest of the low”.

“We are not the people who put pennies in our kids’ banks, we take them out.”

The worst things are what I put others through. I even dumped chemicals in the fields.”

“I lost the trust and respect of my family and my daughter. I lost everything I had – my car, my home, my family, my children”

F. **Access and Enforcement**

- Meth is “bought” and “sold” through bartering transactions almost as often as it is paid for in cash

Focus group participants described a world in which meth is regularly used in place of traditional currency. When meth users are experiencing a drug high, they will trade the drug for whatever real or perceived needs they have in the moment. Because meth often causes mania and impulsiveness, users will often trade the drug for low-price items such as clothing or alcohol. Conversely, if users are in withdrawl from the drug, they will often trade or barter expensive items such as watches, bicycles, jewelry or even cars for small amounts of the drug without the ability to weigh the cost/benefit to themselves. According to focus group participants, the meth barter system is one of the key reasons, meth addicts lose all their possessions:

“Many tweakers will have a small stash – maybe $100-$200 worth of it. They trade it and have a trader system. People who use also sell and trade. When they are high, they don’t crave anything and will trade it for a beer.

“Tweakers often give away $100 worth of possessions for just $10 worth of the drug”

- The majority of focus group participants are both meth users and meth dealers

Focus group respondents were unanimous in their agreement that dealing meth is the most affordable way to ensure access to it over the long-term.

“In order to supply yourself, you have to deal.”
“If you are selling, it’s cheaper. If you have a heavy habit, it’s a big motivation to sell.”

Respondents described a drug trade in Sonoma County in which thousands of individual dealers either dealt or bartered small to medium amounts of meth to themselves, their friends, family and associates.

“I had a large amount fronted to me and then I would sell it.”

“It was $80 an 8-ball. Then I never paid for it after that.”

“The drug culture here is still a pretty tight knit group. If you don’t know someone, then your friends do.”

The reason most respondents were dealing meth was that dealing it is considered to be “easy money”:

“As long as there are tweakers, there will be people who will sell drugs. It is easy money. A guy gave ma a big long speech about wasting my time working at Safeway when I could be making real money.”

“I stopped selling guns and switched to selling meth because I could make ten times as much selling meth.”

Many respondents described cutting the drug with unknown or toxic agents in order to reserve more of the drug for themselves. The majority of respondents dealing the drug stated that they made very little profit in the end because they consumed most of the drugs in their possession:

“The plan is to make money from dealing but then they just use it all.”

- The price of meth is determined by the quality of user’s contacts and their ability to ‘work the system’

While focus group respondents did not view meth as an inexpensive drug, as was previously anticipated, they did feel that both the cost and quality depended on one’s contacts and one’s ability to “work the system”. Respondents insisted that they either knew who to go in order to get the drug for a reasonable amount of money or else who to go to in order to get the drug for free. However, the view was that the price as well as the quality of the drug varied greatly.

“It depends on who you are. When I was using, I would show up and would just start using it.”

My best friend was my dealer. I didn't really buy it that much.”
“I got it from family members so it was cheap”

Respondents expressed a degree of pride for their ability to purchase meth for little or no money and a degree of scorn for those who couldn’t figure out how to do the same. There was consensus among the group,

- The manner in which meth is consumed determines where and with whom it is generally used.

While the majority of focus group participants began their meth use by inhaling it, the majority of addicts reported either smoking it (approx 60%) or injecting it (approx 25%) as their addiction deepened.

According to respondents, the methods in which individuals use the drug determine where they will consume it and with whom they will consume it.

According to focus group participants, those that inhale the drug tend to use it most openly and with the largest amount of people present. Inhalation of meth is regularly practiced at bars and restaurant tables, at private parties, in breakrooms and in other public settings where medium to large groups of people are gathering.

To smoke meth requires little to no wind, so the majority of smoking takes place indoors or in protected settings. Because smoking meth creates a noticeable odor, smokers tend to smoke in more private and semi-private settings such as private parties, motel rooms, cars, gas station and casino bathrooms, or behind dumpsters behind big-box retail establishments. According to focus group respondents, smoking of meth continues to be a highly social event which usually includes small to medium sized groups (very often in motels).

“We used to sit around in groups and smoke it on the bleachers I public. When slamming it we had to go in small groups in the bathroom.”

Shooting or “slamming” of meth tends to be the most highly-individual activity according to focus group respondents. Slammers reported being cautious to shoot up alone or with few others due to needle-sharing concerns, the preparation time required, and fear of law enforcement observation.

“People who are shooting are more secretive.”

“When people are slamming they are more intense and on a different high.”

In general, most respondents stated that they had minimal or no fear of police observation when they were doing meth and that as their addiction progressed they “were doing it everywhere all the time.”
“We would do it anywhere – hotel rooms, living rooms, parking lots – anywhere you get the urge.”

“At a hotel party, they were doing it everywhere. No one cares. If security rolls up, they would just put it in their pockets. No one was worried about it.”

“People do it everywhere once they are hooked. – at work, at school, at home. People are cautious at first then become less cautious.”

“I learned to drive with my knees so that I could smoke and drive.”

- **There are several “tweaker hot spots” in Sonoma County**

While focus group respondents insisted that meth addicts “will use the drug “anywhere, anytime”, they also acknowledged that “tweakers” felt more comfortable when they were amongst their own. According to respondents, there are several “hot spots” where meth users congregate to buy, sell, barter and use meth. These spots include: downtown Santa Rosa, Santa Rosa motels, Santa Rosa parks, the area surrounding Coddington mall, along Dutton avenue near Highway 12, along train tracks and throughout downtown Guerneville. Almost all focus group respondents identified motels and hotels as the most common destinations for selling and using meth.

“**They are doing it in hotels and motels all around Santa Rosa. There’s always a party.”**
Summary of Findings
Key Stakeholder Interviews

School-based Prevention

- Some school administrators/teachers believe the community’s expectation that schools be relied upon as the primary source of substance use prevention/early intervention services is unrealistic in today’s environment, citing lack of instructional time, teacher expertise/training and resources. Commitment remains strong to be part of a system-wide coalition.
- Schools, PTAs, social organizations and parents need to work together to create school and after school prevention activities/programs.
- Development/expansion of existing school based prevention/intervention programs should be a key strategy in the methamphetamine prevention plan.
- Parent awareness/involvement is crucial to preventing methamphetamine use among youth.
- Improved utilization of best practices and existing community resources was stressed. Need to create or expand community based interagency groups (schools, police, probation, and community based organizations providing mental health/treatment/social services) to coordinate prevention, intervention and treatment services.

Data Collection and System Integration

- Sonoma County Criminal Justice, Health and Human Services Departments expressed interest in exploring the creation of a standardized intake/assessment tool. Confidentiality and cost barriers exist. Potential benefits: earlier identification and assessment of client needs and delivery of services to high risk populations and improved system coordination/efficiencies.
- Health Care: Hospitals and community clinics report increased numbers of methamphetamine involved patients seeking care across all medical services. Underreporting is not uncommon due to training and protocol issues. Kaiser’s Behavioral Health system is an outstanding model. Mental health and substance abuse privacy rights/ laws restrict the sharing of data.
- Criminal justice, health and human services agencies share common interest in the development of automated data collection, analysis and sharing. Current data collection methods: limit ability to inform community of full scope of methamphetamine problem; limit ability to gather profile data on clients to determine needs/shape program design and services; limited cross system collaboration/integration for improved client services and system efficiencies; limit ability to track workload changes/trends over
time and modify practices and practices in response to changing needs; limit program evaluation/cost analysis.

- Some improvements include: AODS - Sonoma Web Interface Technology System; District Attorney - Tracking of methamphetamine cases; CPS case review to establish methamphetamine impact on child welfare system; Sonoma County Corrections Master Plan.

**Access to Treatment**

- Community stakeholders report cost is a barrier to receiving substance abuse treatment services for all but the upper middle class/wealthy.
- Insufficient treatment capacity reported for outpatient services, residential care, post treatment services; long waiting lists exist for intake screening and program/bed availability.
- Service delivery system is fragmented; there is a “silo mentality” in which providers often compete for the same funding, collaboration and integration is lacking. Treatment is under-funded (rates lower than actual costs). Funding has been flat for more than 5 years, future funding likely to remain flat or reduced. Stakeholders recommend improved coordination of existing resources (especially AOD and Mental Health linkages and expanded Perinatal services), introduction/deployment of best practices to improve system wide outcomes/efficiencies and offset anticipated future funding reductions.
- Hispanic, Native Americans and other minority and immigrant populations have language, cultural and other access issues as additional barriers to seeking and participating in prevention and treatment programs.
- Community Health Centers are primary source of affordable healthcare in the West County/River Area and Cloverdale/North County but are not set up to do AOD treatment. Clients often lack money, stable housing and transportation to obtain services in the greater Santa Rosa area. The need for expanded clean and sober housing, particularly in outlying rural areas of Sonoma County, was also identified.
- Custodial staff, Jail Medical and Mental Health staff as well as public and private service providers that interact with the jail system report ongoing improvement in custodial treatment. Starting Point is praised. However, many inmates are released from custody without a continuum of treatment plan in place. Significant cost barriers are acknowledged. Strengthening discharge planning/creating multidisciplinary community re-entry services are recommended.
- Locating treatment services can be frustrating and time consuming. Stakeholders suggest the creation of a resource center (storefront or website) that provides up to date information on community resources and services. Additionally, recommended is the establishment of one stop resource centers (requires high level of system wide coordination), ideally in more communities than just Santa Rosa, where at risk and drug/methamphetamine involved youth, adults and families can receive
services, including but not limited to: substance abuse treatment, mental health services, GED, literacy, and employment assistance, life skills, parenting and child care, transportation and housing assistance.


### High Risk Populations

- Recovery from methamphetamine addiction is a complicated and difficult journey.
- Criminal Justice, Health and Human Service Agencies report coming into contact with and providing services to multi-generational families in which methamphetamine is entrenched in the family system.
- Based on 2005-2006 Sonoma County Healthy Kids Survey findings, methamphetamine use in past 30 days among comprehensive high school students, 5%, and 10% among non-traditional high school students. Many community stakeholders identified school drop-outs as another high risk youth population, unfortunately prevalence data is limited for this population.
- In the general population, methamphetamine use is fairly equal among men and women. Among women, high risk sub groups include: women in the criminal justice system, women who have experienced physical or sexual abuse, women who are living with a methamphetamine involved partner.
- Jail inmates have multiple risk factors: Jail records reveal 10% of misdemeanants and 32% of felons were arrested for a narcotics offense; 20% have mental health issues of which 8% are identified as seriously mentally ill; 53% are unemployed. Custodial staff report 65% to 75% of inmates self acknowledge methamphetamine use at the time of booking and follow-up 14 day jail health survey.
- Interviews with staff associated with Psychiatric Emergency Services, Community Support Services, COTS (Committee on the Shelterless) and Catholic Charities reveal that a subset of clients receiving services from these agencies are homeless, addicted to methamphetamine, suffer from co-occurring mental health disorders and have chronic health issues. These clients are extremely challenging to serve due to their multiple problems and lack of social supports.
- Community stakeholders report that methamphetamine is known as a party drug across all social groups. Some individuals appear to be able to use methamphetamine recreationally without succumbing to addiction. Prevention messages will need to address this risky behavior.
- Law Enforcement officials report that methamphetamine use, sales, and trafficking among gangs has increased in recent years and is a significant community safety issue. To deal with this issue, new strategies will have
to be developed between law enforcement, treatment and social service providers and the community at large.

- Community stakeholders report anecdotally that methamphetamine use is more common among workers in physically demanding jobs, low-skilled construction work, production or assembly work, the hospitality industry, and among workers who work long hours or multiple jobs to make ends meet. Prevalence data is lacking. Health professionals and HR managers interviewed indicate there is a lack of training and protocols to identify methamphetamine involved workers and refer them to appropriate treatment.
Methamphetamine Use and Child Welfare in Sonoma County

FINAL REPORT
August 14, 2008

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EXECUTIVE SUMMARY

“Lily grew up in Sonoma County in a family where both her mother and step-father were addicted to methamphetamine. There were reports of both physical and sexual abuse. Lily began using methamphetamine when she was nine years old. Her parents gave it to her. Lily is now 21 years old. She has been diagnosed with poly-substance addiction and depression. She had had, and has lost to CPS, four children.”

KJ, Social Worker

- Approximately 49% of open child welfare cases in Sonoma County are impacted by methamphetamine.
- Parent methamphetamine use is correlated with three types of child abuse: caretaker absence or incapacitation, general neglect, and severe neglect.
- Methamphetamine-impacted child welfare cases are more likely to be court cases and less likely to be voluntary cases.
- Methamphetamine involvement is correlated to higher rates of domestic violence and child medical issues.

Sonoma County Human Services Department
Areas Where Methamphetamine Significantly Impacts Child Welfare
January, 2008

- Percent of Open Cases

<table>
<thead>
<tr>
<th>Category</th>
<th>No Meth</th>
<th>Meth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caretaker absence or incapacitation</td>
<td>22</td>
<td>41</td>
</tr>
<tr>
<td>General neglect</td>
<td>59</td>
<td>74</td>
</tr>
<tr>
<td>Severe neglect</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Always voluntary</td>
<td>37</td>
<td>17</td>
</tr>
<tr>
<td>Other substance use by parents</td>
<td>51</td>
<td>80</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>53</td>
<td>71</td>
</tr>
<tr>
<td>Child meth use</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Child medical issues</td>
<td>17</td>
<td>27</td>
</tr>
</tbody>
</table>

- No Meth
- Meth
“I first met Daisy eight years ago. She spent much of her youth in the juvenile justice system and the majority of her adult life in prison. Daisy started using methamphetamine when she was 14 years old. When I met Daisy, she was 35 and in prison on charges stemming from drug based crimes. She had been clean for two years because she was in prison. She told me that more than anything in the world she wanted to stay clean and eventually be able to care for her two children.”

FJ, Social Worker

AGENCY DESCRIPTION

The Sonoma County, Human Services Department, Family, Youth and Children's Services Division (HSD FYC) works with individuals and the community to ensure the safety and well-being of children under 18. With an annual budget of approximately $43 million and 170 professional and support staff, HSD FYC provides protective and supportive social services with the belief that children and their families deserve stable nurturing homes, a supportive environment, and a sense of personal empowerment and hope.

In 2007, HSD FYC received approximately 10,020 phone calls. 2,772 of these calls resulted in an investigation. If a referral is found to be unsubstantiated, the referral is closed. If the abuse allegation is substantiated, the referral usually becomes an Open Case. In November 2007, HSD FYC had 886 Open Cases. Each month, approximately 565 children are living in an out-of-home placement (for instance, relative, guardian, foster home, or group home). The number of Open Cases and children in out-of-home placement fluctuates as cases move through the system. In 2006, HSD FYC closed 239 Open Cases. 41% (98 children) were reunified with their parents, 39% (94 children) were placed in another permanent placement (adoption or permanent guardianship), and 17% (40 teens) emancipated (turned 18 and became independent). The remaining 3% (7 children) ran away or were incarcerated. HSD FYC services include:

- **Child Protective Services and Child Welfare Services (CPS and CWS)**
  CPS/CWS responds to allegations of abuse and neglect, intervenes in child abuse and neglect situations and provides services to and referrals for families in which children are at risk. CPS/CWS includes the following services:

  - **Emergency Response (ER):** All reports of child abuse and neglect are received by ER. Social workers conduct field visits and may interview families and children to determine the validity of the allegation of child abuse. If the risk of abuse or neglect is severe, ER social workers coordinate with law enforcement to have the child(ren) removed from the home
- **Family Maintenance (FM):** The purpose of Family Maintenance is to prevent the separation of children from their families by providing time-limited protective services to families to prevent or remedy abuse, neglect, or exploitation of children. Family Maintenance services can include but are not limited to counseling, parenting classes, family resource workers, and transportation.

- **Court Services:** If a child is removed from his/her home, the social workers in Court Services review the circumstances that resulted in the removal to determine if it is safe to return the child home or if it is necessary to file a petition to remove the child from parental care.

- **Family Reunification (FR):** In some cases, the risk to children is severe enough that they cannot return home. The children are made dependents of the court and placed in foster care. The purpose of Family Reunification is to provide appropriate services to the family so that the child can be reunified with his/her parents. FR social workers make regular reports to the Juvenile Court regarding the progress of the family.

- **Permanent Placement (PP):** When children cannot be reunified with their family because the risk of continued abuse or neglect is too great, an alternative family structure must be developed. PP social workers develop permanent living arrangements for children, including adoption, legal guardianship, emancipation, or long-term foster care. PP social workers make regular reports to the Juvenile Court on the progress plan for the child.

- **Adoptions:** The adoptions workers work with California State Adoptions making suitable matches between potential adoptive families and children. The two agencies work together to assess needs and deliver services to support the creation of forever families.

- **Foster Care**
The foster care program provides cash assistance for children who have been removed from their home and have been made dependents of the juvenile court. These funds can be paid to relatives, foster family homes, group homes or other approved placements.

- **Foster Care Licensing/Recruitment**
The foster care licensing and recruitment program ensure safe homes for children removed from their family by recruiting and training new foster parents. Staff issue licenses for and regularly inspects foster homes.

- **Redwood Children's Center**
This multi-disciplinary program provides a child-friendly environment where victims of child sexual abuse can be interviewed and observed by a team of professionals eliminating the need for multiple, separate interviews.

- **Valley Of The Moon Children's Home**
This emergency shelter provides a stable, supportive and nurturing environment to children removed from their homes due to abuse or neglect until a suitable foster home or other appropriate placement is arranged.
REVIEW OF THE LITERATURE

Abstract
To better understand the impact of methamphetamine use on child welfare in Sonoma County, the authors conducted a review of the literature to provide an overview of the issues related to parental use of methamphetamine and the risks to children’s safety and wellbeing. There is a paucity of quantitative research on the subject. Much of the available evidence on which this review has been based is of limited scope and variable quality in terms of gold-standard research. In practice, this review identified no population-based studies or large trials providing insight into methamphetamine use specifically and its association with child abuse. The literature does, however, illuminate potential issues related to parental use of methamphetamine and child safety and wellbeing worthy of additional study.

Introduction
Methamphetamine is a central nervous system stimulant with a high potential for abuse and dependence. A synthetic drug, methamphetamine is closely related chemically to amphetamine, but produces greater effects on the central nervous system. The drug’s euphoric effects are similar to, but longer lasting than those of cocaine. Methamphetamine causes the body to release large amounts of dopamine, a neurotransmitter, resulting in a prolonged sense of pleasure or euphoria for the user; however, over time, this causes severe side effects.

The World Health Organization estimates that there are more than 35 million regular users of amphetamine/methamphetamine worldwide. In 2004, 1.4 million people in the U.S. ages 12 and older had used methamphetamine in the past year. California leads the nation in methamphetamine output: 28% of the country’s methamphetamine production capacity is found in California. In 2003, 45% of the individuals admitted to treatment for methamphetamine were women. From 2002 to 2004, the number of individuals who met the DSM IV criteria for dependence on (addiction to) methamphetamine increased by 31.8%.

The relationship between substance abuse and child abuse and neglect has been studied and documented. Parents who abuse substances are known to pose a potential danger to their

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children. Under the influence, parents may demonstrate “poor judgment, confusion, irritability, paranoia, and increased violence; they may fail to provide adequate supervision.” The environment may be unsafe and the family functioning at a very low level. While parental use of methamphetamine, specifically, and child abuse has not been rigorously studied, it can reasonably be deduced that research findings related to substance abuse, in general, and child welfare apply to methamphetamine and perhaps, given its propensity for addiction, more intensely so.

Methamphetamine and Child Welfare

The literature on this topic can be broken down into specific categories:

1. Child safety
2. Child neglect
3. Physical abuse
4. Sexual abuse or exploitation
5. Behavioral/developmental issues
6. Health issues
7. Death
8. Educational backlash
9. Children’s addiction to methamphetamines
10. Likelihood to reunify with parents

This review summarizes the literature on the first six categories (child safety, child neglect, physical abuse, sexual abuse, behavioral/developmental issues, and health issues). These categories are most closely related to the working hypotheses of this study. The literature for the final four categories is not reviewed here.

Child Safety

Children with parents who use or abuse methamphetamine face risks to their safety and wellbeing from the following causes:

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

---

When methamphetamine is produced in a home where children reside, the dangers posed to children is increased due to the risk of toxic exposure or accidental poisoning from consuming a chemical used in methamphetamine production. However, the number of children removed from their parents due to having a methamphetamine lab in the home is very small compared to the total number of removals. There is no data available on the number of children in Sonoma County removed from their parents due to having a methamphetamine lab in the home.

Child Neglect

Children with methamphetamine-abusing parents are at a high risk for neglect. “Chronic drug users live in their own world and are rarely able to respond appropriately to their children’s needs. [They live in] households… characterized as poor, chronically unstable, and often chaotic places where drug and criminal activity might occur.” Furthermore, children with drug-abusing parents “often do not have enough food, are not adequately groomed, do not have appropriate sleeping conditions, and usually have not had adequate medical or dental care.”

Neglect is often the allegation that is substantiated in opening a child welfare case and possibly removing a child from his/her parents. In July, 2005 the National Association of Counties published a survey of 500 counties from 45 states where methamphetamine was believed to be a major cause of child abuse and neglect. Eight California counties estimated the number of child welfare cases where methamphetamine is a known factor (see Table 1). Child welfare cases involving Native American children are also reflecting a surge in methamphetamine-related neglect allegations. There are currently no data on the number of children in Sonoma County whose CPS cases were opened in response to substantiated allegations of neglect due to parents’ use of methamphetamine.

“Daisy was released from prison approximately one month after I met her. I wanted Daisy to succeed. I arranged for her to be admitted to a local drug treatment program for women. The afternoon of her release date I drove to the Greyhound Bus Station to take her straight into treatment. I waited in vain as the bus disgorged its passengers without Daisy. Later, I learned she had gotten off the bus in San Francisco. My heart felt broken for Daisy and her children.”

FJ, Social Worker

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Table 1: California Counties Estimation of Prevalence of Methamphetamine in opening CPS Case

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>Estimation Of # Of CPS Cases Where Methamphetamine was a Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butte</td>
<td>It is believed that 95% of children detained by CPS are from methamphetamine-using families.</td>
</tr>
<tr>
<td>Calaveras</td>
<td>63% of children had one or more parents with a history of using methamphetamine.</td>
</tr>
<tr>
<td>Mariposa</td>
<td>75% of families on child welfare services caseloads have used methamphetamine to some degree.</td>
</tr>
<tr>
<td>Merced</td>
<td>Estimated that 67 – 75% of current child welfare cases are methamphetamine related.</td>
</tr>
<tr>
<td>San Benito</td>
<td>Of active cases, 72% have methamphetamine as a known factor.</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>In a sample of Family Maintenance and Family Reunification cases that had a parent ordered to participate in substance abuse services, 62.5% of mothers reported methamphetamine as the drug of choice.</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>25% of all referrals to Child Protective Services involve substance abuse. For cases requiring juvenile court intervention, 80% are children who have substance abusing parents. Methamphetamine represents 90% of these cases.</td>
</tr>
<tr>
<td>Shasta</td>
<td>70 – 80% of families in child welfare system have methamphetamine as a known factor.</td>
</tr>
</tbody>
</table>

Physical Abuse

Although this review revealed no quantitative research on the association between parental methamphetamine abuse specifically and physical abuse of children, anecdotal reports of parents physically abusing children while abusing methamphetamine abound. Newspaper articles have appeared across the state and country reporting extreme cases of physical abuse to children involving parents in methamphetamine-induced psychoses. For example, in a special Modesto Bee report,

“a terrified and confused 13-year old said nothing for months until one fall morning when she appeared at school with chemical burns on her arms, back and hips. She had been doused with bleach by her stepfather in an attempt to rid her of her demons. This followed her parents attempting to rid her 5-year old sister of demons, in much the same way, ultimately leading to her sister’s death after 8 days of torture, including meals consisting of Clorox bleach, vanilla ice cream, garlic and other spices. Her sister died, was dismembered with a pruning saw and burned. The teen was told what to say if anyone asked where her sister was.”

The Sacramento County prosecutor, Marv Stern, who helped send the teen’s parents to prison, said, “If you have a child death case and there’s a drug involved, it’s more likely to be meth than any other drug. I don’t know why, but I can tell you there is a clear link between parents who abuse meth and physical abuse.”

---

18 Ibid.
Sexual Abuse

Methamphetamine use is believed to be associated with increased incidents of sexual abuse due to the following reasons:\textsuperscript{19}

- Methamphetamine increases sexual arousal in adults
- Methamphetamine lab homes have been observed to “be littered with pornography”
- Children in homes where adults abuse methamphetamine are often left unsupervised amidst many adults (drug buyers and associates)
- Children with parents who abuse methamphetamine may be prostituted for drugs or forced to view sexual acts or pornography

Further, there is data to support the assertion that children who are sexually abused grow up to use and abuse substances, including methamphetamine, contributing to multi-generational dysfunction and dependence. Substance abuse and child welfare experts have recommended targeting substance abuse prevention programming to children in the child welfare system.\textsuperscript{20}

Behavioral/Developmental Issues

According to the California Society of Addiction Medicine, “methamphetamine has been shown to lead to… lowered visual recognition memory similar to cocaine in infants, poor social adjustment, and increased aggressive behavior in 4 and 8 year olds despite normal psychometrics. Deficits in delayed verbal memory and sustained attention were… in a cohort of children aged 6.9 (+/- 3.5 years) with prenatal methamphetamine exposure.”\textsuperscript{21} These findings have been replicated in other studies.\textsuperscript{22,23}

Aside from behavioral effects related to prenatal exposure to methamphetamine, this review did not locate literature on the effect of parental methamphetamine use on children who were not prenatally exposed but who nonetheless have been abused and are in the child welfare system.

Health Issues

Methamphetamine exposure in utero is known to cause serious, adverse effects to infants including premature delivery, brain damage, low birth weight, abnormal feeding patterns, poor feeding, tremors and excessive muscle tension (hypertonia).\textsuperscript{24}

There are documented health risks to children living in a home that also has a methamphetamine lab including methamphetamine ingestion, exposure to chemicals used in its manufacture, and

\begin{itemize}
\end{itemize}
respiratory, dermatological, and dental problems.\textsuperscript{25,26} According to Nancy Young, an expert on substance abuse and child welfare, “children are more likely than adults to suffer health effects from exposure to chemicals. They have higher metabolic rates; their skeletal systems and nervous systems are developing; their skin is not as thick as an adult’s skin, which means they absorb chemicals; and children tend to put things in their mouths and use touch to explore the world. Some fumes or gases are heavier than air, and will sink down to the child’s level, increasing their exposure.”\textsuperscript{27}

Aside from health effects related to prenatal exposure to methamphetamine and health effects observed in children living in a home with a methamphetamine lab, this review did not locate literature on the effect of parental methamphetamine use on children for whom these two conditions are not present but who nonetheless have been abused and are in the child welfare system. Additional examination is needed on this topic.

**PURPOSE OF THIS STUDY**

This HSD FYC project, to identify the impact of methamphetamines on child welfare in Sonoma County, was implemented to inform the work of the Sonoma County Methamphetamine Task Force. The Task Force, coordinated by the Sonoma County Health Department, convened in November, 2007 and is charged with examining the impact of methamphetamine in Sonoma County and developing a comprehensive countywide methamphetamine prevention plan. The 35 Task Force members include representatives from government, the private sector, prevention and treatment providers, and concerned community members.

A one-year planning grant from the California Endowment supports the group’s activities. In summer 2008, the Task Force will propose a plan focusing on all aspects of the local methamphetamine problem including strategies to prevent the manufacture, sale and distribution of methamphetamines in Sonoma County, specific interventions for groups at especially high risk for use, expanded treatment availability, and increasing public education on the community problems caused by methamphetamines.

**DESIGN**

On November 20, 2007 the study authors met with the HSD FYC managers and supervisors (a group of 23 individuals) to discuss the purpose of the study and possible approaches. The meeting resulted in a list of possible approaches and the establishment of a short-term workgroup to guide the process. The Workgroup met on November 26 and December 6, 2007 to develop the study design and selected the following research questions and hypotheses.


\textsuperscript{26} Messina, N., Marinelli-Casey, P., and Rawson, R. (2005) *Children exposed to methamphetamine use and manufacture*. UCLA Integrated Substance Abuse Programs (August 1, 2005).

### TABLE 1: Research Questions and Hypothesis

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Hypotheses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many cases in the Sonoma County child welfare system are impacted by methamphetamine?</td>
<td>- Anecdotally, the members of the Methamphetamine Workgroup believed that approximately 50% of child welfare cases and referrals involve parents who use methamphetamine.</td>
</tr>
<tr>
<td>2. Are there demographic differences between Sonoma County child welfare cases impacted or not impacted by methamphetamine?</td>
<td>- This analysis was exploratory in nature. The members of the work group did not propose any hypotheses related to child demographics.</td>
</tr>
</tbody>
</table>
| 3. How are methamphetamine-impacted Sonoma County cases similar or different in terms of severity from cases not impacted by methamphetamine? | - Families impacted by methamphetamine will have higher rates of domestic violence.  
- Children impacted by parent methamphetamine use will have higher rates of medical issues and behavioral issues. |

HSD FYC social workers enter information about cases and referrals into a state-wide, internet-based database called Child Welfare Services/Case Management System (CWS/CMS). While this database captures hundreds of pieces of information about each case and referral, it does not record whether or not a family is impacted by methamphetamine. Furthermore, other information in the database is not amenable for easy data abstraction. Child’s race is not uniformly entered by the social worker. And child’s medical problems, behavioral issues, and family domestic violence are only entered in the form of case notes. To capture the information needed to answer the questions of this study, the workgroup designed a data collection instrument to be completed by social workers (Appendix A).

The data collection instrument was reviewed by the HSD FYC Managers at a meeting on December 4, 2007. Based on this discussion, the instrument was modified and plans were finalized by the Methamphetamine Workgroup.
SAMPLING METHODOLOGY

The population selected for this study consisted of children involved in an open child welfare case and children with an open referral on November 22, 2007. The 891 open cases and 618 open referrals constituted the population (N=1,509) from which a random sample of 40% (n=604) was selected for the study. The size of the sample provided low probability of response bias with a 95% confidence level and a confidence interval of +/-4 percentage points.

A stratified random sample was used for open cases (N=891 x 40% = 356 rounded up to 360) with stratification based on the type of involvement in the child welfare system at the time of the sampling (November 22, 2007): voluntary family maintenance, court investigations, family reunification/court-ordered family maintenance, and permanent placement. A simple random sample was employed to select 40% of the referral population (N=618 x 40% = 247). A random number generator was used to select the children to be included in the study.

<table>
<thead>
<tr>
<th>Unit</th>
<th># cases</th>
<th>% of total open case population</th>
<th>(Total Sample Size) x (% of total)</th>
<th>Planned Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Services</td>
<td>44</td>
<td>4.9%</td>
<td>360 x 4.9%</td>
<td>18</td>
</tr>
<tr>
<td>Family Maintenance</td>
<td>220</td>
<td>24.7%</td>
<td>360 x 24.7%</td>
<td>89</td>
</tr>
<tr>
<td>Family Reunification</td>
<td>236</td>
<td>26.5%</td>
<td>360 x 26.5%</td>
<td>95</td>
</tr>
<tr>
<td>Permanent Placement</td>
<td>391</td>
<td>43.9%</td>
<td>360 x 43.9%</td>
<td>158</td>
</tr>
<tr>
<td><strong>Total Open Cases</strong></td>
<td><strong>891</strong></td>
<td><strong>100%</strong></td>
<td></td>
<td><strong>360</strong></td>
</tr>
</tbody>
</table>
RESPONSE RATE

The response rate for information abstracted from CWS/CMS was 100%. The response rate for the data collection instrument was dependent on social worker participation.

Socials workers returned the data collection instrument for 324 open cases and 150 referrals for an overall response rate of 79%.

TABLE 3: Response Rate

<table>
<thead>
<tr>
<th>Unit</th>
<th>Planned Sample Size</th>
<th>Actual Sample Size$^{2 \text{ and } 3}$</th>
<th># of Responses</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court Services</td>
<td>18</td>
<td>21</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>Family Maintenance</td>
<td>89</td>
<td>96</td>
<td>74</td>
<td>77%</td>
</tr>
<tr>
<td>Family Reunification</td>
<td>95</td>
<td>76</td>
<td>76</td>
<td>100%</td>
</tr>
<tr>
<td>Permanent Placement</td>
<td>158</td>
<td>180</td>
<td>162</td>
<td>90%</td>
</tr>
<tr>
<td>Total Open Cases</td>
<td>360</td>
<td>373</td>
<td>333</td>
<td>89%</td>
</tr>
<tr>
<td>Referrals</td>
<td>247</td>
<td>236</td>
<td>150</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Total Sample</strong></td>
<td><strong>609</strong></td>
<td><strong>483</strong></td>
<td></td>
<td><strong>79%</strong></td>
</tr>
</tbody>
</table>

Rubin and Babbie (1993, Research Methods for Social Work) suggest a general rule for response rates. “A response rate of at least 50 percent is usually considered adequate for analysis and reporting. A response of at least 60 percent is good. And a response rate of 70 percent is very good… These are only rough guides … and a demonstrated lack of response bias is far more important than a high response rate” (p. 340). There are no statistically significant differences between the sample of open cases and the open cases not included in the sample (see Appendix B for this analysis). Based on the excellent response rate of 89% for Open Cases and in relation to the demographics tested, there is no reason to believe that the findings of the sample do not accurately reflect all open Sonoma County child welfare cases.

“We recently had four babies born with methamphetamine in their bloodstreams. All four babies went through withdrawal from the effect of having a toxic drug in their system. Often, the babies have to be given a tincture of opium to ease the symptoms. Seeing a baby in such great distress is always emotionally terribly disturbing. The good news in this story is that with early intervention, our babies get better. Three of these babies have been adopted in loving, forever families. Unfortunately, their parents were not able to emerge from the imprisonment that is addiction to methamphetamine.”

FJ, Social Worker
“About two years ago I got a call. ‘Hi, this is Daisy. Do you remember me?’ Daisy told me she was about to graduate from a recovery program in San Francisco. She had been clean and sober for 14 months – her longest period of sobriety (outside prison time) since she was 14 years old.”

FJ, Social Worker

RESULTS

Research Question 1: How many cases in the Sonoma County child welfare system are impacted by methamphetamine?

49.4% of Sonoma County child welfare Open Cases have one or both parents that have ever used methamphetamine (95% Confidence Interval = 44% < P < 55%). Approximately 487 children in Sonoma County and currently served by the child welfare system are impacted by the methamphetamine use of their parents.

16.5% of active referrals are reported by the referral social worker as having methamphetamine involvement. Fully understanding why this rate is so much lower than the Open Case rate requires further analysis. One hypothesis is that the methamphetamine rate in active referrals is lower because not all referrals become Open Cases. Only the referrals deemed by the social worker to be of sufficient severity to warrant long-term HSD FYC intervention become Open Cases. If all methamphetamine referrals become Open Cases, the rate in Open Cases would be greater than the rate in active referrals because the denominator in Open Cases is lower than the denominator in active referrals. Information about active referrals is not included in this analysis because of this unanswered question and because the response rate for active referrals was less than 70%.

Research Question 2: Are there demographic differences between Sonoma County child welfare cases impacted or not impacted by methamphetamine?

Yes, methamphetamine use by parents is associated with child’s age at first referral, child’s current age, length of time since first referral, number of years since first referral, number of different types of abuse allegations, type of abuse allegations, and ethnicity.
TABLE 4: Association Between Parent Methamphetamine Use and Child Demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Parent Methamphetamine Use⁵</th>
<th>Statistic⁶</th>
<th>p⁷</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Child’s Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>57%</td>
<td>51%</td>
<td>r=1.36</td>
</tr>
<tr>
<td>Male</td>
<td>43%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Child’s current age (average)</td>
<td>9.5</td>
<td>8.8</td>
<td>t=1.11</td>
</tr>
<tr>
<td>Child age at first referral (average)</td>
<td>5.43</td>
<td>3.95</td>
<td>t=3.19</td>
</tr>
<tr>
<td>Years since first referral</td>
<td>3.52</td>
<td>4.55</td>
<td>t=2.30</td>
</tr>
<tr>
<td>Number of different types of abuse allegations</td>
<td>2.66</td>
<td>3.11</td>
<td>t=2.75</td>
</tr>
<tr>
<td>Type of Abuse Allegation⁸</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caretaker Absence or Incapacitation</td>
<td>22%</td>
<td>41%</td>
<td>r=12.43</td>
</tr>
<tr>
<td>General Neglect</td>
<td>59%</td>
<td>74%</td>
<td>r=7.15</td>
</tr>
<tr>
<td>Severe Neglect</td>
<td>11%</td>
<td>23%</td>
<td>r=7.24</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>37%</td>
<td>40%</td>
<td>r=.25</td>
</tr>
<tr>
<td>Exploitation</td>
<td>2%</td>
<td>1%</td>
<td>r=.52</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>54%</td>
<td>51%</td>
<td>r=.29</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>22%</td>
<td>20%</td>
<td>r=.18</td>
</tr>
<tr>
<td>Sibling at Risk</td>
<td>18%</td>
<td>14%</td>
<td>r=.86</td>
</tr>
<tr>
<td>Substantial Risk</td>
<td>47%</td>
<td>54%</td>
<td>r=1.70</td>
</tr>
<tr>
<td>Family ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>47%</td>
<td>53%</td>
<td>X²=44.57</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>71%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>5%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>44%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>44%</td>
<td>56%</td>
<td></td>
</tr>
</tbody>
</table>
Sonoma County Human Services Department

Methamphetamine and Abuse Allegations

January, 2008

* = a statistically significant difference between the two groups.
Parent Methamphetamine Use by Ethnicity
January, 2008

Percent of Open Cases

- Caucasian/White (n=239): 47% No Meth, 53% Meth
- Hispanic/Mexican/Latino (n=160): 71% No Meth, 29% Meth
- Other (n=41): 44% No Meth, 56% Meth
- Native American (n=21): 5% No Meth, 95% Meth
- African American/Black (n=18): 44% No Meth, 56% Meth
Research Question 3: How are methamphetamine-impacted Sonoma County cases similar or different in terms of severity from cases not impacted by methamphetamine?

Child welfare cases impacted by methamphetamine are more complex and more severe. They are more likely to have current and past court involvement. Conversely, they are less likely than non-methamphetamine cases to have always been a voluntary case. There is an association between parent methamphetamine use and parent use of other substances, domestic violence, child medical issues, and child behavioral issues.

TABLE 5: Association Between Parent Methamphetamine use and Factors Affecting Case Severity

<table>
<thead>
<tr>
<th>Parent Methamphetamine Use&lt;sup&gt;5&lt;/sup&gt;</th>
<th>No</th>
<th>Yes</th>
<th>Statistic&lt;sup&gt;6&lt;/sup&gt;</th>
<th>p&lt;sup&gt;7&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always Voluntary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Court Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past Court Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent(s) other substance(s) use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child methamphetamine use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child substance use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child medical issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child behavioral issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

```
We recently did an extended interview of a young boy named Robbie. The initial referral was for sexual abuse. Robbie had a very primitive presentation (crab walking) and was very evasive behaviorally and verbally. We could not substantiate sexual abuse. About two months later I saw him at Valley of the Moon Children’s Home. He had been brought in on a methamphetamine bust.”
```

SL, Social Worker
Sonoma County Human Services Department

Methamphetamine and Case Severity
January, 2008

* = a statistically significant difference between the two groups.

Percent of Open Cases

- Always Voluntary
- Current Court Involvement
- Past Court Involvement
- Parent(s) other substance(s) use
- Domestic Violence
- Child methamphetamine use
- Child substance use
- Child medical issues
- Child behavioral issues

No Meth | Meth
--- | ---
37 | 17
61 | 82
63 | 83
51 | 80
54 | 71
1 | 7
10 | 10
17 | 27
44 | 44
Sonoma County Human Services Department
Parent Abuse of Other Substances
January, 2008

* = a statistically significant difference between the two groups
“Daisy has returned to Sonoma County. She has wisely stayed away from her old friends. She has wisely chosen a living situation that supports her sobriety. She has been clean now for over three years. Daisy works with youth, especially girls, who are at risk for gang involvement. Her children, who are now young teens, are in a guardianship with other relatives. She is going slow and steady with her relationship with her children. She calls me about once a month ‘just to check in.’ A couple of months ago she talked about visiting with her children and her voice broke as she said, ‘You know what? Both of my kids looked at me and said, Mom, we are really proud of you.’”

FJ, Social Worker

**CONCLUSIONS**

1. The percent of open cases affected by parental methamphetamine abuse (49.4%) is almost exactly what the HSD FYC managers and supervisors hypothesized (50%) based on their experience.

2. The abuse allegations for methamphetamine-impacted cases are more likely to involve the different types of neglect. While this was expected, the fact that there is no association between parent methamphetamine use and physical abuse or sexual abuse was a surprise.

3. Virtually all Native American cases are methamphetamine impacted. This finding was vetted through and confirmed by the Sonoma County Indian Child Welfare Act (ICWA) Roundtable on April 8, 2008.

4. Worker experience suggested that methamphetamine-impacted cases are more likely to be court involved and this was confirmed with these findings.

5. As expected, these cases are more complex, as illustrated by greater rates of family domestic violence, and greater rates of child medical issues.

6. Unexpectedly, child behavioral issues are not more common in methamphetamine-impacted families.

7. Child behavioral issues seem to be high (44%) in all child welfare families.

8. Finally, and perhaps most tragically, parent methamphetamine use is associated with child methamphetamine use.

The abuse of methamphetamine is a major factor affecting child welfare services in Sonoma County. The cases of children from methamphetamine-impacted families are more complex and require greater resources from HSD FYC. It is reasonable to conclude that these complex cases also require greater resources from parents, foster parents, and community service providers.
“Lily’s first, second and fourth children were removed from her custody in their infancy. Somehow, Lily stayed under the radar until her third child, Joseph, was almost three years old at which point he was taken into protective custody during a drug raid. Joseph had rotten teeth and eroded gums as a result of bad nutrition and dental neglect. He had lice and was underweight. In foster care, Joseph was very sad, cried a lot, and worried about his mother. He was hyper-vigilant, startled easily, and was constantly monitoring the environment for danger. Joseph has been adopted. But he is still mourning the loss of his mother and is difficult in creative ways, for instance peeing into the heating vents. His adoptive parents are not sure they can keep him.”

KJ, Social Worker

RECOMMENDATIONS

(These recommendations are numbered for ease of discussion. The numbering does not reflect prioritization.)

1. Information regarding parental methamphetamine use is not routinely collected in the HSD FYC electronic database (CWS/CMS). Collecting the information for this study required case review by social workers. HSD FYC should implement a standardized and electronic method of capturing parental methamphetamine use to facilitate ongoing analysis and evaluation of the effectiveness of different interventions.

2. This information suggests the need for a comprehensive analysis of the adequacy and effectiveness of the range of available community resources for methamphetamine-affected families and a discussion of resources that may need to be enhanced to fully meet these families’ needs and adequately protect children. Adequate resources include appropriate court programs and readily available treatment programs.

3. To most effectively protect children and strengthen families, interventions for methamphetamine using individuals should start as soon as a problem is identified, and, if possible, before legal outcomes have been determined.

4. Recovery from methamphetamine use appears to take longer than recovery from other substances. Mandated permanency timeframes may not recognize this difference and may be too short for adequate recovery – even if a parent begins recovery immediately upon removal of his or her child. The possibilities for reunification, even if it takes longer than currently mandated time frames, may warrant exploration.

5. Members of the ICWA Roundtable were not surprised by the finding that virtually all Native American cases are impacted by methamphetamines. And, Tribes have implemented varied efforts to respond to the methamphetamine crisis they are experiencing. This information is valuable for Tribes as a quantification of the problem and will be used by Tribes to further conversations about and funding and planning for increased and improved culturally appropriate interventions.
ENDNOTES

1. All photographs are from the public domain and are property of their owners. All rights are reserved for the owner.

2. In this table, “case” refers to any Open Case or Active Referral currently in the HSD FYC child welfare system.

2. In practice, some Family Reunification social workers manage some Permanency Placement cases. The CWS/CMS field for unit does not reflect this variation in business practice. A case may be assigned to a FR worker and be coded as FR unit but actually be a PP case. For this analysis, the case was assigned the unit that most accurately reflects the type of service provided. Therefore, the number of open cases in each service component was ultimately slightly different than expected when the sample was selected.

3. At the time of the study (and unidentified at the time of the sampling), 40 children had both an open case and an active referral. 22 of these children were selected to be in the sample. For this analysis, these children have been included with Open Cases. Social workers returned a data collection instrument for 21 of the 22 sample cases that were both an Open Case and an active referral. In some instances, both the Open Case social worker and the Referral social worker returned the data collection instrument. Of these, there were four cases where the responses on the data collection instrument differed slightly between the case and the referral due to having been completed by different social workers. In these instances, preference was given to the Open Case worker’s response considering the greater degree of familiarity he/she was likely to have with the family.

4. Parent Methamphetamine use is yes if either the mother or father is currently using or has ever used methamphetamine (according to the social worker).

5. Two statistical tests are reflected in this table. The Pearson’s Correlation (r), also known as Chi-Square ($X^2$), is the appropriate statistic test for examining the association between two categorical variables. The T-Test (t) is the appropriate statistical test for examining the different between two means.

6. The $p$ value ($p$) represents the probability that a conclusion that there is an association between parental methamphetamine use and the demographic/factor affecting severity is the wrong conclusion. If the $p$ value is less than .05, the association is considered statistically significant. In this case, there is less than a 5% chance that concluding there is an association between parental methamphetamine use and the demographic or factor affecting severity is wrong. Items that show a statistically significant association are shaded.

8. Type of abuse allegation reflects the percent of children who have ever had an allegation of each type of abuse. This does not reflect substantiated claims of abuse.
## APPENDIX A

### METH CASE or REFERRAL WORKSHEET

#### CONFIDENTIAL CLIENT INFORMATION

<table>
<thead>
<tr>
<th>1. Is the mother a meth user?</th>
<th>2. Is the father a meth user?</th>
<th>3. Is the child a meth user?</th>
<th>4. Which of these other substances has the mother ever abused?</th>
<th>5. Which of these other substances has the father ever abused?</th>
<th>6. Which of these other substances has the child ever abused?</th>
<th>7. Has this case included allegations of domestic violence?</th>
<th>8. Does this child have medical issues?</th>
<th>9. Does this child have behavioral health or developmental issues?</th>
<th>10. How does the family self identify ethnically?</th>
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<tbody>
<tr>
<td>Choices for 1-3 (select all that apply)</td>
<td>Choices for 4-6 (select all that apply)</td>
<td>Choices for 7-9 (select all that apply)</td>
<td>Choices for 10 (select all that apply)</td>
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### Unit:

### Worker:

### Child Name

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## APPENDIX B: Difference between open cases not in sample and open cases in sample

<table>
<thead>
<tr>
<th></th>
<th>All open cases</th>
<th>Not in Sample</th>
<th>In Sample</th>
<th>Test</th>
<th>P</th>
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<tbody>
<tr>
<td>Child Gender</td>
<td></td>
<td></td>
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<tr>
<td>Female</td>
<td>51%</td>
<td>48%</td>
<td>54%</td>
<td>X²=3.11</td>
<td>.08</td>
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<tr>
<td>Male</td>
<td>49%</td>
<td>52%</td>
<td>46%</td>
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<tr>
<td>ALWAYS VOLUNTARY</td>
<td></td>
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<tr>
<td>Current court involvement</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>X²=.01</td>
<td>.92</td>
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<tr>
<td>Past court involvement</td>
<td>71%</td>
<td>71%</td>
<td>72%</td>
<td>X²=.01</td>
<td>.94</td>
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<tr>
<td>Child’s age (years) at first referral (average)</td>
<td>5.20</td>
<td>4.70</td>
<td>t=1.60</td>
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<tr>
<td>Years since first referral (average)</td>
<td>3.56</td>
<td>4.02</td>
<td>t=1.64</td>
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<tr>
<td>Current child age (average)</td>
<td>9.26</td>
<td>9.20</td>
<td>t=.17</td>
<td>.87</td>
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<tr>
<td>Number of different types of abuse allegations (average)</td>
<td>2.77</td>
<td>2.89</td>
<td>t=1.04</td>
<td>.30</td>
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<tr>
<td>Percent of children experiencing each type of abuse allegation</td>
<td></td>
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<tr>
<td>Caregiver absence or incapacitation</td>
<td>29%</td>
<td>27%</td>
<td>31%</td>
<td>X²=1.75</td>
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<tr>
<td>Emotional abuse</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
<td>X²=.00</td>
<td>.98</td>
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<tr>
<td>Exploitation</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>X²=.30</td>
<td>.58</td>
</tr>
<tr>
<td>General neglect</td>
<td>64%</td>
<td>64%</td>
<td>64%</td>
<td>X²=.00</td>
<td>.95</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>49%</td>
<td>48%</td>
<td>52%</td>
<td>X²=1.40</td>
<td>.24</td>
</tr>
<tr>
<td>Severe Neglect</td>
<td>15%</td>
<td>14%</td>
<td>17%</td>
<td>X²=1.44</td>
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</tr>
<tr>
<td>Sexual Abuse</td>
<td>20%</td>
<td>19%</td>
<td>21%</td>
<td>X²=.17</td>
<td>.68</td>
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<tr>
<td>Sibling at Risk</td>
<td>16%</td>
<td>16%</td>
<td>15%</td>
<td>X²=1.16</td>
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<tr>
<td>Substantial Risk</td>
<td>51%</td>
<td>51%</td>
<td>51%</td>
<td>X²=1.16</td>
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<tr>
<td>Unit</td>
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<tr>
<td>Family Maintenance</td>
<td>25%</td>
<td>25%</td>
<td>22%</td>
<td>X²=1.16</td>
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<tr>
<td>Court</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
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<tr>
<td>Permanency Placement</td>
<td>49%</td>
<td>49%</td>
<td>49%</td>
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<tr>
<td>Family Reunification (including court ordered family maintenance)</td>
<td>23%</td>
<td>23%</td>
<td>21%</td>
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</table>
**Guide to Acronyms and Abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADD</td>
<td>Attention Deficit Disorder</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<tr>
<td>ADP</td>
<td>Alcohol and Drug Programs</td>
</tr>
<tr>
<td>BOS</td>
<td>Board of Supervisors</td>
</tr>
<tr>
<td>CADPAAC</td>
<td>County Alcohol and Drug Programs Administrators Association of California</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CHD</td>
<td>California Human Development</td>
</tr>
<tr>
<td>CHIS</td>
<td>California Health Interview Survey</td>
</tr>
<tr>
<td>CHKS</td>
<td>California Healthy Kids Survey</td>
</tr>
<tr>
<td>CCLHO</td>
<td>California Council of Local Health Officers</td>
</tr>
<tr>
<td>CMI</td>
<td>California Methamphetamine Initiative</td>
</tr>
<tr>
<td>COTS</td>
<td>Committee on the Shelterless</td>
</tr>
<tr>
<td>CPS</td>
<td>Child Protective Services</td>
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<tr>
<td>DAAC</td>
<td>Drug Abuse Alternatives Center</td>
</tr>
<tr>
<td>DHS, AODS</td>
<td>Department of Health Services, Alcohol and Other Drug Services</td>
</tr>
<tr>
<td>DHS, P&amp;P</td>
<td>Department of Health Services, Prevention and Planning Division</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information Specialist</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HSD FYC</td>
<td>Human Services Department, Family, Youth and Children’s Services Division</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MHSA</td>
<td>Mental Health Services Act</td>
</tr>
<tr>
<td>NACo</td>
<td>National Association of Counties</td>
</tr>
<tr>
<td>NCSACW</td>
<td>National Center for Substance Abuse and Child Welfare</td>
</tr>
<tr>
<td>NIATx</td>
<td>Network for the Improvement of Addiction Treatment</td>
</tr>
<tr>
<td>NORA</td>
<td>Nonviolent Offender Rehabilitation Act</td>
</tr>
<tr>
<td>NSDUH</td>
<td>National Survey on Drug Use and Health</td>
</tr>
<tr>
<td>OJJDP</td>
<td>Office of Juvenile Justice Delinquency Prevention</td>
</tr>
<tr>
<td>PPA</td>
<td>Program Planning Analyst</td>
</tr>
<tr>
<td>SACPA</td>
<td>Substance Abuse and Crime Prevention Act</td>
</tr>
<tr>
<td>SAFERR</td>
<td>Screening and Assessment for Family Engagement, Retention, and Recovery</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SAP</td>
<td>Student Assistance Program</td>
</tr>
<tr>
<td>SAY</td>
<td>Social Advocates for Youth</td>
</tr>
<tr>
<td>SBIRT</td>
<td>Screening, Brief Intervention and Referral to Treatment</td>
</tr>
<tr>
<td>SCOE</td>
<td>Sonoma County Office of Education</td>
</tr>
<tr>
<td>SLE</td>
<td>Sober Living Environment</td>
</tr>
<tr>
<td>STEP</td>
<td>Solutions for Treatment Expansion Project</td>
</tr>
<tr>
<td>SWITS</td>
<td>Sonoma Web Infrastructure for Treatment Services</td>
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</table>
My Name is METH

I destroy homes, I tear families apart,
I'm more costly than diamonds, more precious than gold,
The sorrow I bring is a sight to behold.
If you need me, remember I'm easily found,
I live all around you, in schools and in town
I live with the rich; I live with the poor,
I live down the street, and maybe next door.
I'm made in a lab, but not like you think,
I can be made under the kitchen sink.
In your child's closet, and even in the woods,
If this scares you to death, well it certainly should.
I have many names but there's one you know best,
I'm sure you've heard of me, my name is crystal meth.
My power is awesome; try me you'll see.
But if you do, you may never break free.
Just try me once and I might let you go,
But try me twice, and I'll own your soul.
When I possess you, you'll steal and you'll lie,
You'll do what you have to, just to get high.
The crimes you'll commit for my narcotic charms,
Will be work the pleasure you'll feel in your arms.
You'll lie to your loved ones; steal from them too.
When you see their tears, it should make you sad.
But you'll forget your morals and how it should be,
I'll be your conscience, I'll teach you my ways.
I take kids from parents, and parents from kids,
I turn people from God, and separate friends.
I’ll take everything for you, your looks and your pride,
   I’ll be with you always, right by your side.
You’ll give up everything, your family, your home,
   Your friends, your money, then you’ll be alone
I’ll take and take, ’til you have nothing more to give,
When I’m finished with you, you’ll be lucky to live.
   If you try me be warned, this no game.
   If given a chance, I’ll drive you insane.
I’ll ravish your body, I’ll control your mind.
   I’ll own you completely, your soul will be mine.
The nightmares I’ll give you while lying in bed,
   The voices you’ll hear from inside your head.
The sweats, the shakes, the visions you’ll see,
   I want you to know, these are all gift from me.
But then it’s too late, and you’ll know in your heart,
   That you are mine, and we shall not part.
You’ll regret that you tried me, they always do,
   But you came to me, not I to you.
You knew this would happen, many times you were told
   But challenge my poser, and chose to be bold.
You could have said no and just walked away
   If you could live that day over, now what would you say?
I’ll be your master, you’ll be my slave.
   I’ll even go with you, when you go to your grave.
Now that you have met me, what will you do?
   Will you try me or not? It’s all up to you.
I can bring you more misery than words can describe,
   Come take my hand, let me lead you to hell.

- Anonymous