MODULE ONE
INTRODUCTION

WELCOME

Welcome to *Working With Families: A Substance Abuse Curriculum*. This three-day training focuses on substance abuse issues specifically related to the responsibilities associated with the case managers in DFCS who have contact with families experiencing substance abuse problems. The training has been developed to expand on learning you received in the DFCS *Core* curriculum. This Participant Guide and the accompanying PowerPoint Presentation support the instruction.

The training is meant to be interactive and your participation is important to the over all instruction provided. You will be asked to respond to general questions, work in small group activities, and share your experiences as part of the learning experience.

Please let the trainer know if you have any special needs or concerns. It is great to have you joining this training experience.

PURPOSE OF THE TRAINING

The purpose of this training is to advance your skills in working with families where substance abuse problems exist. It is not intended to make you a substance abuse expert or teach you to perform substance abuse assessments.

STRUCTURE OF THE CLASS

The materials used in the training presentation include presentations through instructor led training, PowerPoint and CD presentations; small and large group activities.

This three day class begins promptly at 8:30 AM each day and concludes by 4:30 PM. We will have two fifteen minute breaks and an hour long lunch break. Actual class instruction time covers six and a half hours per day.

You will also have an opportunity to complete a course evaluation at the close of the training. Your comments about the course design, the course instruction, and the information provided is important for DFCS to consider as we strive to provide quality-learning experiences for the field.

EDUCATION AND TRAINING SERVICES SECTION

DIVISION OF FAMILY AND CHILDREN SERVICES TRAINING PROGRAMS

CLASSROOM STANDARDS, EXPECTATIONS AND ATTENDANCE POLICY

As professional employees with the Department of Human Resources (DHR), Division of Family and Children Services (DFCS), all participants in any DFCS training programs must abide by the DHR Standards of Conduct, which set forth acceptable and unacceptable conduct toward peers, supervisors, managers, and clients. Trainees are encouraged to review the DHR Standards of Conduct found at:

http://www2.state.ga.us/departments/dhr/ohrmd/Policies/1201.pdf

The standards and expectations for the professional behavior of trainees in the classroom are as follows:

When Division employees are in training, their conduct must reflect their commitment and service to DHR and DFCS. Time spent in the classroom and in field practice is a normal workday.

Trainers serve in a supervisory role in the classroom. Responding to the trainer in accordance with the DHR Standards of Conduct is standard operating procedure.

Trainees are expected to complete written tests that cover material presented in class.

Trainees are expected to behave in a respectful manner. Examples of behaviors that are unacceptable and will not be tolerated include the following:

- inattentiveness during classroom time as exhibited by holding side conversations, conducting personal business, reading outside material or sleeping
- personal attacks, use of offensive language, argumentativeness, or excessive talking
- use of the Internet for reasons other than classroom activity
- eating food while in the computer lab
- use of cell phones, radios or beepers during class. All such devices must be turned off during class and replies to calls must be made during official breaks.

Engaging in these behaviors or in any behavior deemed disruptive or inappropriate by the trainer may result in an immediate conference with the trainer, notification to the trainee's immediate supervisor, administrator or director, or expulsion from class. The trainer will confer with the appropriate authority prior to expelling a trainee from class.

Trainees are expected to dress in accordance with Personal Appearance During Work Hours per section IV of the DHR Employee Handbook as follows:

> *While the Department does not specify a Department-wide dress code, employees are expected to be clean and neat in appearance during work hours. As representatives of the State, employees should present a business-like professional image. Dress code policies may be established by DHR organizational units. In certain types of jobs, employees may be required to wear uniforms.*
>
> *DHR organizations units may designate specific days as "casual days". Dress on casual days may be less formal, but should always be clean, neat and suitable for the work place.*
>
> *If lettered or illustrated clothing is worn, it should not promote a particular political, moral, religious, personal or other opinion. Clothing which is obscene, vulgar, offensive or inflammatory is prohibited. Employees may be required to change inappropriate dress or instructed not to wear the same or similar clothing in the future. Employees who do not comply with established dress code standards may be subject to disciplinary action, up to and including separation.*

Trainees are encouraged to review the DHR Employees Handbook at:

> http://www2.state.ga.us/departments/dhr/ohrmd/Publications/index.html

In addition to adhering to the Classroom Standards and Expectations, the following attendance policies apply to all staff while engaged in any training:

Trainees are expected to arrive on time and adhere to the time allotted for breaks and lunch. If an emergency arises that warrants arriving late or leaving early, the trainee must address the emergency with the trainer in concert with approval from the supervisor.

Annual leave should not be requested and cannot be approved during training. Any exceptions must be discussed with the appropriate authority prior to training. The only acceptable excuses for being absent from classroom training are the following:

Sick leave (e.g. emergency illness or medical appointments for acute illnesses). In the case of sick leave, trainees must notify their immediate supervisor in the county office as soon as possible to report their absence from classroom training.

OR

Court leave (e.g. subpoena to court, unexcused jury duty). In the case of court leave, trainees must obtain prior approval from their immediate supervisor in the county office as soon as possible in order to be absent from classroom training.

The county supervisor or administrator is the only employee who can approve a trainee's leave request. For Centralized Hire trainees, the administrative supervisor is the only employee authorized to approve a trainee's leave request. The trainer/facilitator **will NOT** approve any leave.

The county supervisor must notify the appropriate authority as soon as possible that a trainee will be absent from class due to sick or court leave. The appropriate authority will notify the trainer of the absence.

Trainees absent from class due to approved sick or court leave may be required to make up all or part of the course depending on the length of the absence and the length of the course. This may affect time frames for their completion of training. The appropriate authority will determine with the trainer whether a trainee will continue a course, after consultation with the trainee's supervisor.

For the purposes of determining expulsion from a class, notification regarding leave or continuation in a class, the appropriate contact via an e-mail is:

- For attendance at any Office of Financial Independence training e-mail: OFItraining@dhr.state.ga.us
- For attendance at any Social Services training e-mail: SStraining@dhr.state.ga.us

I _____ have read and understand the Classroom Standards, Expectations and Attendance Policy for DFCS training programs.

Signature _____ Date _____

AGENDA

DAY ONE AGENDA

1. Introduction

Module includes: Expectations, Housekeeping Issues, Introduction to Content, Examining Perceptions of Substance Abuse

2. The Language of Substance Abuse

Module includes: Review of Terminology, Policy, Facts and Figures

3. Methamphetamine: The Newest Threat

Module includes: Signs of Use, Georgia's Epidemic, DFCS draft Protocol

DAY TWO AGENDA

4. Addiction: A Brain Disease

Module includes: The Disease Model

5. Behavioral Characteristics of Substance Abusers

Module includes: Denial, Recovery, and Relapse

6. A Family Disease

Module includes: Effects on Family Systems, Enabling and Rescuing Behaviors, Power and Control Issues, Impact on Children

DAY THREE AGENDA

7. Treatment

Module includes: Treatment Options, ASAM Treatment Levels)

8. Moving the Family towards Change

Module includes: Five Principles, Seven Ways to React Appropriately to Individual Resistance, Five Useful Strategies Used in MI, Positive Reframing and Joining Skills, and Practicing Non-Judgment

9. Conclusion

Module includes: Closing Activity, Wrap-Up, and Evaluation

LEARNING OBJECTIVES FOR THE COURSE

The following Learning Objectives have formed the bases for course development:

1. Recognize and identify substance abuse terms and relevant policy references.

2. Promote changes in family functioning through the recognition and acknowledgement of addiction as a disease.

3. Describe the effects of methamphetamine manufacturing and use on families, children and others associated with the case.

4. Complete casework activities that foster safety, risk reduction and permanency in families exposed to substance abuse.

5. Assist the family in recognizing that addiction is a family disease.

6. Identify different treatment strategies substance abuse professionals utilize in treating substance abusers and their relevance to casework practice.

7. Describe and utilize the five principles in Motivational Interviewing when promoting changes in the family.

8. Use positive reframing and joining skills in engaging families.

9. Recognize behaviors and conditions consistent with denial, recovery, and relapse, and their impact on the development of safety plans and case management.

10. Strengthen planning with families and case management skills that promote healthy family functioning with families in recovery while reducing risk, assessing safety and achieving permanency. Enhance skills in facilitating Family Team Conferencing.

NOTES

MODULE TWO
THE LANGUAGE OF SUBSTANCE ABUSE

PURPOSE: To provide a review of substance abuse terminology and DFCS policy and to introduce current facts and figures relevant to drug abuse in Georgia.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Identify and link substance abuse terms within the context of policy and child welfare practice.
- Apply new information regarding terms and facts in relation to substance abuse.

ACTIVITY

Activity

Miss-Matched Worksheet
Substance Abuse Terms

TIME: 10 Minutes

PURPOSE: To recall substance abuse terms and their meaning

INSTRUCTIONAL METHOD: Individual Review
Large Group discussion

MATERIALS: *Miss-Matched* Worksheet

INSTRUCTIONS:

1. Complete the worksheet by matching the word with the correct meaning.
2. Be prepared to share responses in large group discussion.

Miss- Matched Worksheet

Match the correct term listed below with the description by inserting the correct letter with matching number

Substance Abuse Terminology

Term	Matched Letter	Description
1. Addiction		**a. a phenomenon whereby a drug user becomes physically accustomed to a particular dose of a substance and requires ever-increasing dosages in order to obtain the same effects**
2. Dependence		**b. co-existence of any psychiatric disorder and substance use disorder**
3. Detoxification		**c. side effects experienced by a person who has become physically dependent on a substance, upon decreasing the substance's dosage, or discontinuing its use**
4. High		**d. the state of being both physically and psychologically dependent on a substance**
5. Street Drug		**e. a naturally occurring neurotransmitter in the brain that is associated with feelings of pleasure**
6. Tolerance		**f. a process whereby an addict is withdrawn from a substance**
7. Withdrawal		**g. a state in which a person requires a steady concentration of a particular substance in order to avoid experiencing withdrawal symptoms**
8. Opioids		**h. a substance purchased from a drug dealer**
9. Benzodiazepines		**i. cocaine that has not been neutralized by an acid to make the hydrochloride salt; comes in a rock crystal that can be heated and its vapors smoked; "crack" refers to the crackling sound heard when heated**

Substance Abuse Terminology (continued)

Term	Matched Letter	Description
10. Sedatives or "downers"		j. a synthetic stimulant commonly used as a recreational drug; legally prescribed as a treatment for ADD under the brand named of Desoxyn, for both children and adults; on the street, generally found as an odorless, white or off-white, bitter-tasting powder; can be found in pills, capsules and larger crystals; frequently snorted, but also used orally, smoked, and injected
11. Cannabinoid		k. potent psychomotor stimulants; generally cause strong physical and mental stimulation, keeping users awake and alert for many hours, and can cause mood swings/euphoria
12. Hallucinogenic or "psychedelic"		l. a powerfully addictive stimulant drug; the powered hydrochloride salt form of cocaine can be snorted or dissolved in water and injected
13. Inhalants		m. facility capable of producing more than 10 pounds of meth a day
14. Dopamine		n. prescription barbiturate drugs commonly referred to as tranquilizers
15. Cocaine		o. prescription painkillers such as morphine and Demerol as well as illegal substances such as heroin
16. Crack		p. gaseous drugs used in the medical practice of anesthesia, as well as such common substances as paint thinner, gasoline, glue
17. Methamphetamine		q. prescription drugs used for treating anxiety, such as valium
18. Super Lab		r. drugs-obtained from the hemp plant (marijuana "pot" and hashish)
19. Amphetamines		s. drugs-LSD, PCP or angel dust
20. Dual Diagnosis		t. the altered state of consciousness that a person seeks when abusing a substance

ACTIVITY

Activity Test your Policy Knowledge

TIME: 20 Minutes

PURPOSE: To identify specific policy requirements for cases with substance abuse allegations.

INSTRUCTIONAL METHOD: Individual Response

MATERIALS: ***Test your Policy Knowledge Worksheet***
Writing instrument

INSTRUCTIONS:

1. Read and answer the following 6 questions.
2. Work independently of your classmates to test your knowledge of policy requirements.
3. Indicate when you have completed the questions to the trainer and then wait quietly while everyone completes the assignment.
4. Record the policy reference provided by the trainer for each question for future reference when you return to your office.

Test your Policy Knowledge Worksheet

1. What four questions must be asked once a referral indicates that either a newborn infant **and/or** the infant's mother tests positive for illegal drugs?

2. When the answer to any one of these questions is "**no**," what action must the department take immediately?

3. When the answer to all of the above questions is "**yes**," what action must the department take immediately?

4. If a parent refuses to voluntarily submit to a drug screen, what action must the case manager take immediately?

5. What are the drug screen requirements on an on-going CPS case where drugs are part of the case plan?

6. What are the two special provisions that must take place before reunification may occur in cases when substance abuse is part of the case plans?

The Adoption and Safe Families Act (ASFA)

The Adoption and Safe Families Act (ASFA) includes a number of provisions that are intended to move children more quickly through the foster care system into safe, permanent families. These are:

- A time frame of **12 months to have a permanency plan in place** for every child in care;

- A **permanency hearing** within 12 months of the child's removal (and every 12 months thereafter as long as the child remains in care);

- A judicial determination regarding "***reasonable efforts to finalize the permanency plan***" within 12 months of the child's removal (and every 12 months thereafter);

- Case Plan documentation of a "**compelling reason**" whenever the agency recommends in its Case Plan a permanency plan other than reunification, adoption, guardianship or permanent placement with a fit and willing relative;

- The **mandatory filing of a petition to terminate parental rights** whenever the court has determined the child to be abandoned or the parent has been convicted of certain felony offenses or the child has been in care for 15 of the most recent 22 months. (The only exception to filing occurs when a "**compelling reason**" is documented in the Case Plan, reviewed by the court and determined to be in the child's best interest); and

- **Concurrent planning** with respect to two practices: (1) the selection of dual permanency plans; and (2) the concurrent efforts to identify, recruit and approve a qualified family for a child at the same time that the county department files a petition to terminate parental rights.

Criteria for Use, Abuse and Addiction*

USE	ABUSE	ADDICTION
1. No Problems	1. Problems	1. Problems
2. Control (choice)	2. Control (choice)	2. Less than 100 percent control (choice)
	3. Non-progressive	3. Progressive continued use despite adverse consequences

Joseph Terhaar and Keetjie Ramo, Working with Addictions: A Trainer's Manual of the Washington State Department of Social and Health Services

ACTIVITY

Activity

What Do You Spy?

TIME: 20 Minutes

PURPOSE: For trainees to see if they can identify drugs or drug paraphernalia.

INSTRUCTIONAL METHOD: Individual Review
Large Group discussion

MATERIALS: *What Do You Spy?* Worksheet

INSTRUCTIONS:

- Watch each slide and indicate what you think the slide is representing and share with class as directed by the trainer.

What Do You Spy? Worksheet

Write down the name of the drug or paraphernalia next to the appropriate slide number.

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LINKING SUBSTANCE ABUSE AND MALTREATMENT

Reports of Parental Alcohol and Other Substance Abuse
Adapted from CPS 2103.8

Question for Reporter/Others	Evident in the information	Gap in Information
1. What has happened that prompted you to call at this time?		
2. Tell me about the living environment?		
3. Any evidence of the following signs: ✓ **Windows left covered for complete privacy** ✓ **Lights left on for long periods** ✓ **Activities at all hours of the night/continuous for days** ✓ **Roach clips, rolling papers, pipes, blunts** ✓ **Multi doctors seen, multiple pharmacies used** ✓ **Treatment for pain where prescription pain killers are used** ✓ **Body building supplements** ✓ **Clubbing and Rave activities** ✓ **Other concern?**		
4. Have you ever seen the parents use drugs?		
5. What are you seeing that leads you to believe that he/she is using drugs?		

LINKING SUBSTANCE ABUSE AND MALTREATMENT

(page 2)

Question for Reporter/Others	Evident in the information	Gap in Information
6. What behaviors or conditions in the children have you observed that concern you?		
7. Is the behavior or situation occurring now?		
8. Are the children with the parent now?		
9. Are the children under the age of 13 years?		
10. Do you know if the children are missing school regularly?		
11. Are the children left unsupervised? Are they alone now? (Disposition as a neglect investigation)		
12. Have you ever seen the police at the home?		
13. Are you seeing the same people coming and going over and over again?		
14. Have you ever seen any drug paraphernalia?		
15. Have you ever known the parent to drive while under the influence of alcohol or other drugs?		
16. Have you know the caregivers to have legal problems related to drug use?		

STATE: Any gaps identified should be addressed in formal interviews, other direct contacts, and in general observations.

NOTES

MODULE Three
METHAMPHETAMINE: THE NEWEST THREAT

PURPOSE: To increase the knowledge of trainees about the development and use of methamphetamines.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Describe the effects of methamphetamine manufacturing and use on families, children, and others associated with the case.
- Identify potential signs of methamphetamine use with a family.
- Develop a plan to ensure to the greatest extent possible the safety of the child and the case manager in settings where meth is being used or developed.

METHAMPHETAMINE

Definition of Methamphetamine

- An addictive stimulant drug that strongly activates certain systems in the brain

Street Names

- Speed
- Meth
- Chalk

In its smoked form, it is often referred to as:

- Ice
- Crystal
- Crank
- Glass

Methamphetamine is a white, odorless, bitter-tasting crystalline powder easily dissolved in water or alcohol.

Its chemical structure is similar to amphetamines but….
It has a more pronounced effect on the central Nervous system. It causes increased activity, decreased appetite and a general sense of well-being.

Its effects can last 6-8 hours.

After the initial "rush," there is typically a state of high agitation that can lead to violent behavior.

Guidelines for Managing Children Found at Clandestine Methamphetamine Laboratory Sites

A collaboration of
the Georgia Bureau of Investigation,
the Georgia Department of Human Resources, and
the Georgia Poison Center

June, 2005

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Particip

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ACKNOWLEDGEMENTS

The recommendations presented in this collaborative document are intended to serve as guidelines. It is impossible to anticipate all combinations of circumstance that may occur. The individuals at the scene should use their best judgment. At times this may require the use of a different approach than listed below. It is appropriate for those using a different approach to clearly document why they chose to follow the path they did, in the event that questions arise at

a later date.

We acknowledge the leadership and expertise of Robert Geller, M.D. in launching these guidelines. We would also like to acknowledge the contributions of Rosalyn K. Bacon M.P.H., Claudia Barthold M.D., Consuelo Campbell M.S.P.H., Wilfred Hamm M.S.S.W., Janet Oliva Ph.D., Phil Price, Janice Saturday, and Carla Simms M.S.W., as well as many other members of the Georgia Department of Human Resources, Division of Public Health, Meth Workgroup too numerous to mention.

I GLOSSARY OF TERMS

Airborne Chemical Exposure: Contact in the air with one or more chemicals in either gas or droplet form.

Clandestine Drug Lab/Laboratory: Facilities equipped and used in the production of illegal drugs. For the manufacture of methamphetamines, these can be located in a variety of locations such as homes, hotel rooms, fields, abandoned buildings, and even automobiles.

Cook/Cooking: The process of preparing individual chemicals to react with other substances to produce a new product with the ultimate goal of producing an illicit drug. A cook is “active” when chemicals are in the process of being heated or mixed or are otherwise in use.

Entry Team: The individuals, most often public safety or hazardous material technicians, who are designated to make the first entrance into a suspected meth lab.

Gross Contamination: Clearly visible evidence of chemicals on an individual or item. Examples include but are not limited to, large fresh stains or obvious odor. Since there is a wide variety of substances and chemicals used in the production of methamphetamine, there is no single type of odor or stain that implies contamination. An odor is not always detectible. Gross contamination should be clear to an untrained observer in close proximity to an individual or item.

Personal Protective Equipment (PPE): Items of clothing or tools that may be used to insulate a worker from chemical, thermal or other hazards encountered while he or she is working. PPE commonly includes goggles, masks, gloves, suits, hoods, respirators or boots. The type of equipment used depends on the suspected hazards to be encountered.

Reasonable Observation Period: A span of time deemed by a medical professional to be adequate to see signs or symptoms of a toxic exposure. This decision can be made based on a medical professional’s personal knowledge or in concert with a medical toxicologist or the Georgia Poison Center. Knowledge of the type and amount of potentially toxic exposure is helpful in determining an adequate amount of time needed for this purpose.

Visible Contamination: Clearly apparent evidence of the presence of chemicals on an individual or item. (see Gross Contamination).

ITEMS LISTED IN THIS GLOSSARY ARE MARKED IN BOLD

IN THE FOLLOWING GUIDELINES

Georgia Guidelines for Managing Children Found at Clandestine Methamphetamine Laboratory Sites

II INTRODUCTION

Methamphetamine production and use appear to be growing problems in the state of Georgia. The manufacture of methamphetamine and related compounds may occur in hidden or clandestine laboratories. These can be located in virtually any location including houses, trailers, cars, or hotels. There are a variety of methods used to make methamphetamine, each utilizing different chemicals. Many of the chemicals used are potentially hazardous, not only to those directly involved in the manufacture of the drugs, but also to those who live in or around the laboratories. The desired final methamphetamine product is potentially dangerous as well. Children living in or around such laboratories are at risk of exposure to hazardous chemicals by inhalation, ingestion and/or direct skin contact.

This document presents guidelines for the handling of children found in and around **clandestine drug laboratories** after law enforcement entry into these facilities. The overriding goals of these guidelines are:

1. To assure the safety of the children found at meth laboratories;
2. To assure the safety of law enforcement, health care providers, state agency personnel and the general public interacting with and caring for children found at meth laboratories; and
3. To minimize the psychosocial trauma to the children while protecting their health and safety.

These guidelines address the situation where children have been found at a site believed to be a **clandestine drug laboratory** and where concern exists that the children may have been exposed to the chemicals used in that process. It is recommended that law enforcement personnel contact the Division of Family and Children Services (DFCS) and obtain their assistance either prior to entering a site if it is known that children are present or once children have been found at a site. These guidelines do not address the long-term management of children found in or around **clandestine drug laboratories**, lab site remediation, recommendations for **PPE** (personal protective equipment) for law enforcement, or specific

hazardous-materials protocols for decontamination, though they are important issues.

Published data, as well as peer comments reviewed up to April 1, 2005, demonstrates a general lack of data on which informed decisions can be made. The available data does show clear risk of gradual pulmonary injury to individuals recurrently involved in entry, seizure and processing of methamphetamine laboratories, but provides little evidence of injury to occasional responders to sites contaminated by lab activity. There are no data available at this time that specifically address the acute injury to children at the time of their removal from **a clandestine drug lab**. It is unclear what long term effects might ensue for children residing in a methamphetamine lab. Concerns exist that neglect and/or chemical exposure may impact physical and neurodevelopmental health.

For information about the toxicology of chemicals encountered at a scene, the Georgia Poison Center may be contacted 24 hours a day, 7 days a week at 1-800-222-1222 within Georgia, or at 404-616-9000 from outside Georgia.

III PROTOCOLS FOR HIGH RISK SITUATIONS

1. Definition of a High Risk Situation:

a. Lab entered while drug **cooking** in progress, AND/ OR

b. Lab found with evidence of recent **cooking** (e.g. warm vessels or odor present) in an area with shared ventilation (The area in which the child is residing.).

2. Initial Encounter

a. Police or other members of **entry team** in appropriate **PPE** (personal protective equipment) bring children to the Division of Family and Children Services (DFCS) or Emergency Medical Services (EMS) staff waiting at a safe distance outside the house.

b. Unless **grossly contaminated**, possessions immediately brought with the child should include:

i. Eyeglasses

ii. Hearing aids

iii. Durable medical equipment attached to the child (such as feeding tubes or IV access ports entering the skin)

iv. Prescription medications

(1) It may be appropriate to validate that contents are compatible with

the label. This can be done by comparing the contents with those expected. The Georgia Poison Center will assist in deciphering the codes imprinted on tablets or capsules, if contacted.

c. No cloth or paper possessions should be brought with the child at the time of the evacuation from the site.

i. It may be appropriate to claim items important to the child at a later time once re-entry into the home is deemed safe. See “Moderate Risk Situation” section on possessions (Section 12, a through e) for guidance.

3. Decontamination

a. If the patient is **visibly contaminated**, remove clothes immediately and decontaminate as appropriate for specific chemicals in use at that site.

b. Decontamination should be performed by the agency responsible for this task at the scene and should follow appropriate procedures as defined by that agency.

c. With issues of gender sensitivity, appropriate attention should be given to changing, and related issues. Maintenance of appropriate protection from cold weather should be taken into account as well, especially when decontaminating infants and small children. Infants and small children are at increased risk of cold stress due to their smaller size and disproportionately large body surface area. Care must be taken not to wash infants or young children with cold water. Even when washed with warm water, care should be taken to promptly dress them after washing.

d. If the patient is not visibly contaminated, have the patient change into clean clothes and leave contaminated clothing behind at the site. Additional steps may be necessary, depending on the specific chemicals in use at that site. This decision should be made by the agency or team members tasked with decontamination decisions.

e. Eye glasses, hearing aids or durable medical equipment attached to the child who was evacuated should be cleansed or wiped down thoroughly (i.e. every surface needs to be cleaned). Items in this category that have no visible contamination can generally be cleaned by use of typically available household multi-surface cleaners (such as Fantastik™, Formula 409™, or similar agents) while wearing household rubber gloves. However, best practices should be determined in consultation with decontamination staff, hazardous materials experts and/or the Georgia Poison Center.

f. Children should be bathed at the earliest possible opportunity that protects their privacy and health, unless on-scene decontamination was necessary as per section 3.a. above.

4. Clothes

a. Change the child's clothes on scene. Given that prompt clothing change is in the best interest of the child, this should be done as soon as is feasible.

b. If the child is able to independently undress and dress without assistance, the child should be offered an appropriate area to do so.

c. In the event that the child requires assistance, DFCS or any other agency's staff capable of doing so should assist the child.

d. Consultation with hazardous materials/decontamination staff is encouraged in case of questions regarding proper procedures and disposition of the removed clothing.

e. It is preferable to use clean clothes from outside the home (e.g. newly purchased items or items from neighbors or family).

   i. If not available, use paper scrubs,

   ii. If none of the above are available wrap child in a clean blanket from outside the home after decontamination,

f. Do not dress the children in clothing from inside the home in which a **cook** is active at the time of evacuation until they have been laundered. Clothing from inside the home should be laundered before children wear them. Rationale: The concern is that any cloth material taken from the home during a "cook" or shortly after a "cook" may expose clothing to airborne chemicals, which would contaminate previously clean porous items.

5. Medical Evaluation

a. If possible, initial evaluation should take place on scene to identify immediate threats to life. If there are any questions regarding the presence of such threats, rapid consultation with EMS or other medical personnel should be performed.

b. Even if an on-scene examination takes place, the child should be taken to the most appropriate emergency department for evaluation prior to placement. Rationale: The medical examination in the emergency department should be geared to

find and treat acute toxicity, and rule out delayed toxicity during a **reasonable observation period** from exposure to **airborne** chemicals from the **cook**. It is neither intended to be a comprehensive physical or neurodevelopmental examination nor is it intended to diagnose chronic condition that pose no acute danger to the health or well being of the child.

i. The emergency department physician should be informed of what chemicals were at the scene (if known) and be informed that a **cook** was apparently in progress or apparently had recently been in progress prior to the evacuation of the child. (see also the GBI Clandestine Laboratory Guideline document for cross referencing and coordination, section 4.B.8)

ii. While the extent of evaluation and disposition is the choice of the treating physician, it is recommended that the emergency department (ED) evaluation include at least the following:

    (1) Measurement of vital signs including heart rate, blood pressure, respiratory rate, oxygen saturation and temperature;

    (2) Physical examination with specific attention paid to the cardio-pulmonary systems and skin examinations; and

    (3) Observation for development of delayed toxicity for approximately 6 hours.

iii. No specific laboratory or radiological testing is recommended to be performed at the time of the ED evaluation unless medically indicated.

    (1) Urine or blood toxicological testing does not need to be sent unless the clinician feels it is medically indicated. In general urine toxicology screens do not add much clinical information in this setting.

iv. If a forensic sample is desired by law enforcement agencies, standard forensic sample handling, including chain of custody procedures, should be followed.

c. Once released from the initial evaluation, follow-up of the child should be arranged by DFCS for full medical examination including laboratory work and neurodevelopmental evaluation.

   i. The first choice should be to arrange follow-up with the child's own pediatrician, possibly in through referral to with a neurodevelopmental specialist.

   ii. If the child's pediatrician or neurodevelopment specialist is not available, a clinic or hospital practice should evaluate the child within 72-96 hours for follow-up examination and laboratory testing to assess for chronic toxicity.

      (1) Laboratory evaluation should generally include a Complete Metabolic Panel, including sodium, potassium, chloride, CO_2, BUN, creatinine, and liver function tests.

   iii. Given the child's toxicological exposure, it may be beneficial to consider the following tests as the clinician deems them to be indicated:

      (1) Complete Blood Count

      (2) Chest Radiograph

      (3) Pulmonary Function Tests as appropriate for age

6. Possessions

a. During evacuation from a site in which a **cook** is in progress or believed to be recently completed, no items should be removed from the home, except for those items in section 2.b. above in compliance with forensic protocols.

b. Consideration should be given to claiming items potentially important to the child once investigation of or evaluation of the scene has been processed and is deemed safe. This decision should be made by those local officials responsible for scene clean-up.

IV PROTOCOLS FOR MODERATE RISK SITUATIONS

1. Definition of Moderate Risk Situation:

a. No **cook** in progress and no evidence of recent **cook**, BUT chemicals and **cook** apparatus were found in an area where children share ventilation (area in which child resides).

2. Initial Encounter

a. Police or other members of **entry team,** in appropriate **PPE,** bring children to DFCS or EMS staff waiting at a safe distance outside the house.

b. Unless **grossly contaminated**, possessions immediately brought with child should include:

   i. Eyeglasses

   ii. Hearing aids

   iii. Durable medical equipment attached to the child (such as feeding tubes or IV access ports entering the skin)

   iv. Prescription medications

      (1) It may be appropriate to validate that contents are compatible with the label. This can be done by comparing the contents with those expected. The Georgia Poison Center will assist in deciphering the codes imprinted on tablets or capsules, if contacted.

3. Decontamination

a. If the patient is **visibly contaminated**, remove clothes immediately and decontaminate as appropriate for specific chemicals in use at that site.

b. Decontamination should be performed by the agency responsible for this task at the scene and should follow appropriate procedures as defined by that agency.

c. Appropriate attention should be given to issues of gender sensitivity, including appropriate cover while changing and related issues. Maintenance of appropriate protection from cold weather should be taken into account as well, especially when decontaminating infants and small children. Infants and small children are at increased risk of cold stress due to their smaller size and disproportionately large body surface area. Care must be taken not to wash infants or young children with cold water. Even when washed with warm water, care should be taken to promptly dress them after washing.

d. Eyeglasses, hearing aids or durable medical equipment attached to the child who was evacuated should be wiped down thoroughly (i.e. every surface needs to be cleaned). Items in this category that have no visible contamination can generally be cleaned by use of typically available household multi-surface cleaners (such as Fantastik™, Formula 409™, or similar agents) while wearing household rubber gloves. However, best practices should be determined in consultation with decontamination staff, hazardous materials experts and/or the Georgia Poison Center.

e. Children should be bathed at the earliest possible opportunity that protects their privacy and health, unless on-scene decontamination was necessary as per section (3.a) above.

Clothes

a. Change the child's clothes on scene. Given that prompt clothing change is in the best interest of the child, this should be done as soon as is feasible.

b. If the child is able to independently undress and dress without assistance, the child should be offered an appropriate area to do so.

c. In the event that the child requires assistance, DFCS or any other agency's staff capable of doing so should assist the child.

d. Consultation with hazardous materials/decontamination staff is encouraged in case of questions regarding proper procedures and disposition of the removed clothing.

e. It is preferable to use clean clothes from outside the home (e.g. newly purchased items or items from neighbors or family).
    i. If not available, use paper scrubs,
    ii. If none of the above are available wrap child in a clean blanket from outside the home after decontamination,
f. Do not dress the children in clothing from inside the home in which a **cook** is active at the time of evacuation until they have been laundered. Clothing from inside the home should be laundered before children wear them. Rationale: The concern is that any cloth material taken from the home during a "cook" or shortly after a "cook" may expose clothing to airborne chemicals, which would contaminate previously clean porous items.

4. Medical Evaluation

a. If the child has ANY acute health complaints or there are concerns regarding the child's acute health, or if the child was rescued from a burning structure, the child should be evaluated before placement.
    i. If possible initial evaluation should take place on scene to identify immediate threats to life. If there are any questions regarding the presence of such threats, rapid consultation with EMS or other medical personnel should be performed.
    ii. Even if an on-scene examination takes place, the child should be taken to the most appropriate emergency department for evaluation prior to placement. Rationale: The medical examination in the emergency department should be geared to find and treat acute toxicity and rule out delayed toxicity during a **reasonable observation** period in the symptomatic child. It is neither intended to be a comprehensive physical or neurodevelopmental examination nor is it intended to diagnose chronic condition that pose no acute danger to the health or well being of the child.

iii. The emergency department physician should be informed of what chemicals were at the scene (if known) and be informed that no evidence of a recent cook, but chemicals and cook apparatus were found during evacuation of the child (see the GBI Clandestine Lab Guidelines 4.B.8.).

iv. While the extent of evaluation and disposition is the choice of the treating physician, it is recommended that the ED evaluation of the symptomatic child include at least the following:

(1) Measurement of vital signs including heart rate, blood pressure, respiratory rate, oxygen saturation and temperature;

(2) Physical examination with specific attention paid to the cardiac, pulmonary and skin examinations; and

(3) Observation for development of delayed toxicity for approximately 6 hours.

v. No specific laboratory or radiological testing is recommended to be performed at the time of the ED evaluation unless medically indicated.

(1) Urine or blood toxicological testing does not need to be sent unless the clinician feels it is medically indicated. In general urine toxicology screens do not add much clinical information in this setting.

vi. If a forensic sample is desired by law enforcement agencies, standard forensic sample handling including chain of custody procedures should be followed.

b. If the child does NOT have any acute health complaints and there are NO concerns regarding the child's acute health DFCS should follow the standard procedure for any child taken into DFCS custody. The temporary custodian should be given a written and verbal explanation of any warning signs, and when to call the physician.

c. Follow up should be arranged for all children in coordination with DFCS for full medical examination, including laboratory work and neurodevelopmental evaluation.

   i. The first choice should be to arrange follow up with the child's own pediatrician, possibly through referral to a neurodevelopmental specialist.

   ii. If the child's pediatrician or neurodevelopment specialist is not available, a clinic or hospital practice should evaluate the child within 72-96 hours for follow-up examination and laboratory testing to assess for chronic toxicity.

      (1) Laboratory evaluation should generally include a Complete Metabolic Panel, including sodium, potassium, chloride, CO_2, BUN, creatinine, and liver function tests.

   iii. Given the child's toxicological exposure, it may be beneficial to consider the following tests as the clinician deems them to be indicated:

      (1) Complete Blood Count

      (2) Chest Radiograph

      (3) Pulmonary Function Tests as appropriate for age

5. Possessions

a. Items can be removed:

   i. At the time of the child's removal from site, AND/OR

   ii. Once the site has been processed and deemed safe for entry by law enforcement personnel in compliance with forensic protocols.

b. Items that are **grossly contaminated** should be left at the scene for later assessment and possible handling as contaminated goods.

c. Unless **grossly contaminated**, solid surface items should be thoroughly cleansed or wiped down (i.e. each side of the object should be cleaned) after which the item may be given to the child (e.g. plastic toys, Nintendo™ type game systems, computers and other electronics). Items in this category that

have no visible contamination can generally be cleaned by use of typically available household multi-surface cleaners (such as Fantastik™, Formula 409™, or similar agents) while wearing household rubber gloves. However, best practices should be determined in consultation with decontamination staff, hazardous materials experts and/or the Georgia Poison Center.

d. Clothes or stuffed items housed in covered or enclosed areas (i.e. dresser drawers or boxes) that do not have visible contamination can be sent with the child to the foster family, where they can be washed safely using the following guidelines:
    i. Items should be transported in plastic bags that can be tied closed in transit.
    ii. Each bag should contain no more than several items (about 3 to 5 pounds per bag maximum).
    iii. The foster family should be notified that each bag of clothes should be washed alone as a single wash load, using hot water and warm rinse, and generous amounts of detergent.
e. If there is uncertainty as to whether an item is contaminated or not, leave it at the scene for later assessment.

V PROTOCOLS FOR MINOR RISK SITUATIONS

1. Definition of Minor Risk:

a. No **cook** in progress and no evidence of recent **cook**.

b. No chemicals or **cook** apparatus or evidence of contamination found in an area with shared ventilation with the area in which the children were residing (e.g., children are found in a house without any immediately evident contamination *and* the house does not share any ventilation [i.e. ducts or doors or windows] with a trailer in which chemicals and cooking vessels were housed.).

2. Initial Encounter

a. Police or other members of **entry team** in appropriate **PPE** bring children to DFCS or EMS.

b. Possessions immediately brought with child should include:

i. Glasses

ii. Hearing aids

iii. Durable medical equipment attached to the child (such as feeding tubes or IV access ports entering the skin).

(1) If any of these possessions are **visibly contaminated** the “moderate risk” guidelines should be followed (Section 3.d).

iv. Prescription medications

(1) It may be appropriate to validate that contents are compatible with the label. This can be done by comparing the contents with those expected. The Georgia Poison Center will assist in deciphering the codes imprinted on tablets or capsules, if contacted.

3. Decontamination

a. If the patient is **visibly contaminated,** the “moderate risk” guidelines should be followed (see Moderate Risk Guidelines in Section 4).

b. The child does not need decontamination at the scene.

c. Children should be bathed at the earliest possible opportunity that protects their privacy and health. This should occur in a setting that is appropriately heated, in order to minimize the risk of cold stress.

d. Eyeglasses, hearing aids or durable medical equipment attached to the child who was evacuated should be wiped down to remove household dirt and other potential debris. Items in this category that have no visible contamination can generally be cleaned by use of typically available household multi-surface cleaners (such as Fantastik™, Formula 409™, or similar agents) while wearing household rubber gloves. However, best practices should be determined in consultation with decontamination staff, hazardous materials experts and/or the Georgia Poison Center.

4. Clothes

a. The child should change clothes in this situation, as follows:

   i. Clothing from outside the home (e.g. newly purchased items or items from neighbors or family), or paper scrubs can be used.

   ii. Clothes from inside the site can be used as long as the clothes are not **visibly contaminated** (by visual inspection or smell).

5. Medical Evaluation

a. If the child has ANY acute health complaints, or there are ANY concerns regarding the child's acute health, or if the child was rescued from a burning structure, the child should be evaluated by a physician before placement.

b. If the child does NOT have any acute health complaints and there are NO concerns regarding the child's acute health, DFCS should follow the standard procedure for any child taken into DFCS.

c. Once released from the initial evaluation, follow up of the child should be arranged by DFCS for full medical examination including laboratory work and neurodevelopmental evaluation.

   i. The first choice should be to arrange follow up with the child's own pediatrician, possibly in conjunction with a neurodevelopmental specialist.

   ii. If the child's pediatrician or neurodevelopment specialist is not available, a clinic or hospital practice should evaluate the child within 72-96 hours for follow-up examination and laboratory testing to assess for chronic toxicity.

      (2) Laboratory evaluation should generally include a Complete Metabolic Panel (including sodium, potassium, chloride, CO_2, BUN, creatinine, liver function tests).

   iii. Given the child's toxicological exposure it may be beneficial to consider the following tests as the clinician deems them to be indicated:

      (3) Complete Blood Count

      (4) Chest Radiograph

      (5) Pulmonary Function Tests as appropriate for age

6. Possessions

a. Items can be removed at the time of the child's removal from the site AND/ OR once the site has been processed and deemed safe for entry by law enforcement personnel in compliance with forensic protocols.

b. Items that are **grossly contaminated** should be left at the scene for later assessment and possible handling as contaminated goods.

c. Unless **grossly contaminated**, solid surface items should be thoroughly be cleansed or wiped down (i.e. each side of the object should be cleaned), after which the item may be given to the child (e.g. plastic toys, Nintendo™ type game systems, computers and other electronics). Items in this category that have no visible contamination can generally be cleaned by

use of typically available household multi-surface cleaners (such as Fantastik™, Formula 409™, or similar agents) while wearing household rubber gloves. However, best practices should be determined in consultation with decontamination staff, hazardous materials experts and/or the Georgia Poison Center.

d. Clothes or stuffed items that do not have visible contamination can be sent to the foster family to be washed.
    v. Items should be transported in plastic bags that can be tied closed in transit.
    vi. The foster family should be notified that clothes should be washed, using hot water and warm rinse, and generous amounts of detergent, prior to wearing.
e. If there is uncertainty as to whether an item is contaminated or not, leave it at the scene for later assessment.

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Georgia Guidelines for Handling Children Found at Clandestine Methamphetamine Laboratory Sites

Levels of Risks Comparisons

	HIGH RISK	**MODERATE RISK**	**MINOR RISK**
Definition	Lab entered while cook in progress AND/OR Lab found with evidence of recent cook	No cook in progress and no evidence of recent cooking, **But** chemicals and cook apparatus found	No cook in progress and no evidence of recent cooking No chemicals or cook apparatus or evidence of contamination found
Initial Encounter	Police or other **entry team** members bring children to DFCS or EMS away from site No cloth or paper possessions should be brought with the child	Police or other **entry team** members bring children to DFCS or EMS away from site	Police or other members bring children to DFCS or EMS away from site
Decontamination	If visible contamination, remove clothes immediately and decontaminate If no visible contamination, change clothes and leave original clothes behind Glasses, hearing aids or durable medical equipment attached to child should be cleansed Bathe child at earliest opportunity	If visible contamination, remove clothes immediately and decontaminate If no visible contamination, change clothes and leave original clothes behind Glasses, hearing aids or durable medical equipment attached to child should be cleansed Bathe child at earliest opportunity	If no contamination, bathe the child at earliest opportunity Wipe down glasses, hearing aid or durable medical equipment attached to the child

	HIGH RISK	MODERATE RISK	MINOR RISK
Clothes	Don't put clothes on child from inside site Change child clothes on scene If no clothes are available, use paper scrubs If none of above are available, wrap child in blanket after decontamination	Change child's clothes on scene with newly purchased clothes If new clothing is not available, use paper scrubs If none of above are available, wrap child in blanket after decontamination	Child should have a change of clothes from outside home Clothes from inside the site used as long as clothes are not visibly contaminated
	HIGH RISK	**MODERATE RISK**	**MINOR RISK**
Medical Evaluation	If possible, initial evaluation should take place at site Even if on-scene exam is done, take child to most appropriate emergency room for evaluation Inform emergency room MD of what chemicals were at the scene and that cook was in progress or had recently been in progress The emergency MD should measure vital signs; complete a physical exam with particular attention to the cardiac, pulmonary and skin examinations	If child has acute health complaints or there are concerns regarding the health state of the child, evaluate the child before placement Even if on-scene exam is done, take child to most appropriate emergency room for evaluation Inform emergency room MD of what chemicals were at the scene and that cook was in progress or had recently been in progress The emergency MD should measure vital signs; complete a physical exam with particular	If child has acute health complaints or there are concerns regarding the health state of the child, evaluate the child before placement Follow standard procedures for placement

	HIGH RISK	MODERATE RISK	MINOR RISK
	The child should be observed for the development of delayed toxicity for 6 hours No specific laboratory or radiological testing is recommended unless medically indicated Once released, follow up should be arranged for full medical exam Laboratory evaluation should include a Complete Metabolic Panel Considering the child's toxicological exposure, carrying out a complete blood count, chest radiograph, and pulmonary function test appropriate for age	attention to the cardiac, pulmonary and skin examinations No specific laboratory or radiological testing is recommended unless medically indicated Follow standard procedures for placement Make arrangement for full medical exam Laboratory evaluation should include a Complete Metabolic Panel If child does NOT have any acute health complaints and there are NO concerns regarding the child's acute health, DFCS should follow the standard procedure for any child taken into custody.	**(continued)**
Possessions	No items removed from home except for glasses, hearing aid, or medical equipment attached to child Claim items important to child once scene has	Items can be removed from site once site has been deemed safe Items contaminated should be left at the site Solid surface items	Items can be removed from site once site has been deemed safe Items contaminated should be left at the site Solid surface items

	HIGH RISK	MODERATE RISK	MINOR RISK
	been processed and deemed safe	should be thoroughly cleansed or wiped down Clothes or stuffed items housed in covered area can be taken to placement and then washed Transport items in plastic bags containing no more than 3 to 5 items The placement family should be notified that all possessions should be washed If there is uncertainty whether an item is contaminated or not-leave at the scene for assessment	should be thoroughly cleansed or wiped down Clothes or stuffed items housed in covered area can be taken to placement and then washed If there is uncertainty whether an item is contaminated or not-leave at the scene for assessment

Risks Associated Methamphetamine the Use and Manufacturing of Methamphetamine

(From Signs of Client Methamphetamine Use and Caseworker Safety Procedures; Illinois State University School of Social Work)

Risk with use:

1. Cardiovascular emergencies (heart attack, coronary artery spasm)
2. Cerebrovascular accident (stroke)
3. Seizures
4. Hyperthermia
5. Depression (following use)
6. Stimulant psychosis/paranoia
7. Spontaneous recurrences of methamphetamine (induced paranoid-hallucinatory state-flashbacks
8. Memory impairment
9. Damage to serotonin neurons

Risk with Manufacturing

1. Explosion
2. Fire
3. Respiratory problems, up to and including permanent damage
4. Chemical burns
5. Contact with potentially violent chemist/illegal subculture
6. Stimulant psychosis associated with chemist's use of meth

Risks Associated Methamphetamine the Use and Manufacturing of Methamphetamine

Signs of Use

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech
- Euphoria
- Hyperactivity
- Dry mouth
- Tremor (shaking hands)
- Dilated pupils
- Lack of appetite
- Insomnia/lack of sleep
- Bruxism (teeth-grinding)
- Depression (crash when drug wears off
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Formication (feeling of insects crawling on body)
- Presence of white powder, straws, injection

Signs of Manufacturing

- Laboratory equipment
- Large quantity of pills containing ephedrine or pseudoephedrine (example, Sudafed®)
- Chemical odor
- Chemicals not commonly found in home (red phosphorus, acetone, liquid ephedrine, ether, iodine, P2P (propanone)
- Usually high quantities of household chemicals (lye, Drano®, paint thinner)

Risks Associated Methamphetamine the Use and Manufacturing of Methamphetamine

Indications of potential/impending client violence toward case manager:

- Signs of meth use
- Client extremely irritable and /or argumentative
- Escalation of client irritability, anger
- Regular client does not appear to know who you are
- Evidence of client paranoid thinking, delusions
- Client verbalizes implicit or explicit threat against caseworker
- Presence of knife, firearm or other weapon in the immediate vicinity

Recommendations for ensuring safety:

- Inform supervisor/co-worker that you will be visiting a client with a history of making/using meth
- Arrange for some to check on you if you do not call in by established time
- If you feel unsure of your safety, leave
- Do not let client get between you and an exit
- Park your car so that you can not be boxed in
- Do not argue with or antagonize client
- Do not position yourself in the client's peripheral vision area or where the client can not see you
- Do not move suddenly
- Tell the client what you are doing and why
- Ask permission if you want to go to another area of the dwelling
- Watch for:
    - Symptoms of stimulant use
    - Methamphetamine paraphernalia
    - Signs that client is becoming upset, angry or suspicious'
    - Scratch marks or scabs, particularly on client's hands and arms
    - Evidence of hallucinations
    - Strong chemical odor

ARTICLE

Behind the Drug: The Child Victims of Meth Labs
November 2, 2002

By Mark Ells, JD, Barbara Sturgis, PhD, Gregg Wright, MD1

Introduction:

Suspected meth lab found in bathroom of motel room" "Two meth labs found in county" "The remains of meth lab were found near cornfield" "Fertilizer thieves risk eyes, lungs and lives by illegally tapping into the highly unstable contents of anhydrous ammonia tanks." "Meth-suing mother sleeps while her 17-month-old son has his genitalia bitten off and eaten by a pit bull" "A drug-dealing mother uses her 1-year-old child as collateral for meth." These are representative headlines describing what officials are calling an epidemic of illegal methamphetamine manufacturing and use. While these headlines are from a single Nebraska paper, they could be from almost any newspaper in any state. It is important to note, however, that rural areas are seeing unprecedented levels of illicit manufacturing operations. This article describes the unique dangers to children and to those investigating reports of child abuse and neglect, which are presented by meth use and production.

Meth's Effects on Users

Methamphetamine (meth), also known as "crank," "crystal-meth," "glass," "ice," "speed," "zip" and "quartz", is an increasingly common addictive and mood altering drug that is smoked, snorted, orally ingested, or injected. Users who snort or orally ingest the drug experience a "high" of euphoric feelings, increased wakefulness and activity, and decreased appetite. This state lasts for several hours. Users who smoke or inject the drug experience an extremely intense, pleasurable "rush" lasting for several minutes that can be followed by a high lasting for several hours. Methamphetamine has a high potential for tolerance: each time the drug is used, more meth is required to achieve the same effect.

Binge abusers maintain the high by smoking or injecting more of the meth with decreasing effectiveness until, eventually, there is no more rush or high. "Tweaking" describes an extremely unpleasant state at the end of a binge. The abuser may take other drugs, often alcohol, to ease these feelings. The "crash" occurs after the abuser stops taking the drug and sleeps, often for several days at a time. The crash becomes more severe

as increasing amounts of meth are ingested.

Addicts are chronic meth abusers completely focused on preventing the crash. They continue to seek the pleasurable rush, but with reduced success. Each successive rush becomes less euphoric and takes more meth to accomplish. It is a very short step from binging to high intensity use. Long-term meth abuse results in many damaging effects: violent behavior, anxiety, confusion, paranoia, depression, suicidal thinking and behavior, insomnia, hallucinations, delusions, and rages.

Meth's Effects on Children

Use during pregnancy presents stark risks. The effects of methamphetamine on the developing fetus can be severe and life threatening. In addition to direct drug effects, prenatal nutrition and prenatal care may be seriously neglected and the fetus may be exposed to alcohol and other damaging substances. Premature delivery, with all of its complications, is more common with prenatal meth use. After delivery, the infant may show abnormal reflexes and extreme irritability.

Each level of meth use has an impact on the user's ability to care for children. Low-intensity abusers can continue to function, but experience mood swings. When high, abusers feel good, are active and can get a lot accomplished. They are also irritable and impatient, increasing the possibility of abusive behavior. When the effects of the drug wear off, even low-level abusers are likely to feel an increased need to sleep, which can interfere with care giving.

Binging has significant adverse effects on care giving because the binger is preoccupied with the rush and maintaining the high. Irritability increases and the abuser can become argumentative, assaultive and threatening. Children are often left to fend for themselves. Tweaking increases the risk because the abuser hasn't slept in several days and is likely using other drugs or alcohol. The tweaker is often paranoid and can experience delusions and hallucinations. Violent reactions to otherwise innocent stimuli are common.

After a binge, abusers can sleep for days, leaving their children unsupervised. They often miss school and older children are put in the position of caring for younger children.

When crashing, the abuser experiences increasing feelings of depression, lethargy and loss of energy. These symptoms impair the abusers' interest in caring for their children, depriving them of basic physical and emotional needs. Abusers often experience suicidal feelings. This period

can last for months during which the probability of reuse is high.

Long-term, chronic meth abuse can lead to psychotic behavior characterized by intense paranoia, delusions, hallucinations and extreme violence. The delusions can involve the children. For example, a parent "overheard" conversations about people plotting to steal his children and feared that the babysitter was poisoning him. He kidnapped the children from their mother. Another abuser believed that the FBI was jolting him by projecting electric charges through the walls of his house.

Chronic abusers also suffer impaired cognitive functioning, are often sexually promiscuous, volatile and impulsive, and frequently are hospitalized. Domestic violence and other criminal behaviors are common. Chronic meth abuse can also increase the likelihood of other psychological disorders, such as psychosis and serious mood disorders. Because chronic abusers are preoccupied with obtaining and using meth, they expose the children to other users. The risk of abuse and neglect is high. Investigators are confronted with volatile and unpredictable caregivers, and can be incorporated into the abusers' paranoid delusions. This increases the risk of violence towards workers and necessitates heightened precautions. When a chronic meth user stops using, eventually hallucinations disappear and paranoia decreases. However, the abuser may continue belief in his delusions and remain paranoid. Given the nature of the addiction, long-term treatment and follow-up will be required. During that time, the safety of the abuser's children must be constantly assessed and protected.

Risks Associated with the Manufacture of Meth

Methamphetamine is manufactured with readily available, but highly dangerous materials and equipment. Many of the raw materials involved in manufacturing methamphetamine are highly volatile, often resulting in explosion and fire. In fact, illicit laboratories are often discovered because they explode. Children also may be injured by direct contact with caustic materials used in the manufacture of meth, including hydrochloric acid and sodium hydroxide, and toxic solvents such as acetone, ether, and methyl alcohol. Anhydrous ammonia, stolen from an agricultural facility, is stored in propane tanks that are damaged by exposure to the ammonia. These tanks, in turn, can leak or explode, exposing children to toxic ammonia and ammonia vapors. Errors and accidents in the process of manufacturing meth generate a wide range of toxic substances. Phosphine gas, for example, has caused severe lung damage and death among several individuals involved in the manufacture of methamphetamine.

Perhaps as dangerous as the chemicals are the criminals involved in methamphetamine manufacture. Both the supplier and buyer may be meth users whose behavior can be, as noted above, unpredictable and dangerous. Children may be exposed to weapons and other forms of violence directly associated with high-stakes criminal commerce.

Investigators encountering methamphetamine laboratories are exposed to all of these risks, including explosion, fire and exposure to toxic and caustic chemicals and gasses. Awareness of the materials used in the manufacturing process will help workers reduce these risks.

Evidence of methamphetamine manufacture

The starting point for methamphetamine manufacture is often ephedrine or pseudoephedrine, found in over-the-counter cold and flu remedies. Unusual quantities of these preparations and their packaging should raise suspicion. The solvents used in manufacturing meth include acetone, alcohol, toluene, paint thinner, denatured alcohol, engine starter or brake cleaner. These materials are sold in hardware and auto supply stores. Sodium hydroxide is sold as lye and as drain cleaner; hydrochloric acid is sold as muriatic acid. Iodine, table matches, and lithium batteries are also frequently used and readily available. While all of these items may have legitimate purposes, unusual quantities or circumstances should raise suspicion. Some signs are suspicious regardless of quantity: Propane tanks used illegally to store anhydrous ammonia will show a blue corrosion of the brass valves; coffee filters may have tablet residue or red staining rather than coffee grounds.

Meth labs commonly have an unusually sweet or strong odor such as ether, ammonia, or auto parts cleaner. The windows of a building containing a meth lab may be covered, blackened or frosted to prevent anyone seeing inside the structure. Other common attributes of meth labs include sporadic traffic throughout the day and night, and unusual trash containing large amounts of empty anti-freeze containers, camping fuel cans, battery parts, stained coffee filters, drain cleaners, and glassware. Other items commonly found at meth labs include brake fluid, brake cleaner, iodine crystals and starter fluid.

Ensuring the safety of investigators, children and the public

Due to the danger of chemical contamination, fire or explosion, or harm from someone protecting an investment, law enforcement should always be present during an investigation of suspected child abuse or neglect at a meth lab. The team approach may never be more important for safety

reasons than during this type of investigation.

An investigator who suspects the presence of a methamphetamine laboratory should take steps to limit personal exposure to chemicals on the skin or in the air. Gasses from a methamphetamine laboratory, including phosphine, can be toxic at concentrations below what can be detected by smell. An investigator who suspects exposure to toxic chemicals should change clothes and shower as soon as possible. Medical care should be sought if symptoms appear, especially any respiratory symptoms.

Children at the scene of a methamphetamine laboratory should be considered potentially exposed and examined by medical personnel as quickly as possible. The child's personal things should be left at the scene to minimize the chance of contaminating other areas or people. If there is obvious contamination of the clothes a child is wearing, they should be changed and left at the site for evidence. It is imperative to remove children from the scene of a methamphetamine lab as soon as removal can be effected safely.

In addition to the personal dangers already described, there are critical environmental concerns. The chemicals and processes used in this risky industry can also easily contaminate drinking water supplies, soil and air, causing a great danger to nearby residences. Coordination with state or local agencies charged with protection of those resources is necessary.

Conclusion

Investigation of suspected child abuse or neglect is always potentially dangerous. For investigators who unexpectedly find themselves at the scene of a meth lab, the danger is real and immediate. Investigators must know how to protect themselves during the investigation—both from the toxic chemicals and from the toxic adults present at the scene. If children are present, their safety requires the investigator go in harm's way to remove them. The investigator must not leave until certain no children are present or until any children present are safely removed.

The current epidemic of meth abuse and illicit manufacture is creating new and substantial risks to children, law enforcement and child protection investigators, and the community. Investigators must be cognizant of the indications and clues often present where meth is being manufactured, and of the dangers associated with such activities. Training and education are important. Watchfulness and caution are essential.

ACTIVITY

Activity **Case Scenarios**

TIME: 30 Minutes

PURPOSE: To consider safety needs of children where methamphetamine is in use

INSTRUCTIONAL METHOD: Individual Review
Small Group Review
Large Group discussion

MATERIALS: *Case Scenarios*

INSTRUCTIONS:

3. Read Case Scenario
4. Meet with your assigned group
5. Select a group reporter/recorder
6. Answer the three discussion questions
7. Be prepared to discuss with the large group

Scenario: Dakota Patrone

CM got a referral 3/1/2005. The reporter indicated that neighbors had complained about “unusual activity” at 345 Calquit Road in the county. Reporter said there was a “strong chemical odor” as well as a single occupant who seemed to be “up all night.” Recently it appeared that two children (about ages 5 and 3 girls) moved into the home. They were described as malodorous, their clothes were dark grey from not being washed, and they “always seemed to have colds.”

The adult caregiver Ms Patrone (neighbor was unsure of the relationship) was observed on several occasions to “pick at sores on her hands” and would sometimes be “scratching at bugs that were not there.” The neighbor was concerned for the safety of the children as the Ms Patrone would appear suspicious and would not let the girls play with the other children, she was secretive about who they were and she would leave them for “long hours” by themselves. The neighbor reported, “I believe she must have been dead one day, because the girls were so very hungry and she would not get up to feed them. When I called out to her, and told the girls to go wake her we just couldn’t, it was almost six hours later when she came looking for the girls.”

The neighbor was calling now because she felt the girls were infested with lice and the other children would not play with them. In addition, the three year old seemed to “have a burn that was getting infected.” Neighbor says she has never and would never go into the house. “It smells like something died in there.”
Law enforcement was contacted and they reported the family was known to them.

The Lead detective told the CM that they had suspicions of possible methamphetamine use and or production at the residence and agreed to meet the worker at DFCS before proceeding to 345 Callquit Road in the county.

Scenario: Dakota Patrone

On reaching the residence the worker counted four empty bottles of Drano, six containers of paint thinner, and an empty container labeled lye thrown toward the back of the property. No one responded when they rapped on the door.

Questions

1. What are the indicators of methamphetamine use?

2. What needs to happen before, during and after an assessment of this situation?

3. What are the safety needs of the children?

Scenario: Paris Lewis

Referral Information:

Paris Lewis and Eddie Grassle had been known to the Department Family Children services for several months, due to repeated allegations of drug use, abuse and sale in the home. Those reports did not indicate maltreatment. After repeated reports of drug activity, and an isolated incident of the physical abuse of Amber Grassle, where she was beaten for waking her mom who was sleeping for 10 hours, the Department devised a safety plan with Mr. Grassle's mother, making her the physical custodian of Amber (10) and Amanda Lewis (12) while the investigation proceeded. Both Ms. Lewis and Mr. Grassle agreed to comply with the safety plan and awaited the ongoing worker.

Other Client Information

Ms. Lewis said that Amanda was a spoilt, selfish child. She does not understand I can't sleep well at all. She makes me so mad, sometimes I can't control my anger. "She about killed me during delivery, and my momma had to raise her the first year because I couldn't handle that. She met Mr. Grassle at a family reunion. She wanted to be sure the CM noted they were not related.

She admitted that Eddie introduced her to methamphetamines approximately 2 years ago and that he introduced her to the drug, shortly after he began using himself. They also admitted to sharing needles. To support their use she admitted that he sells meth and heroine but not crack, because "crack is nasty stuff." She indicated the sales were a way of increasing their financial base and providing for the family. They both work at fast food outlets. However Ms. Lewis does not eat there and appears anorexic.

Scenario: Paris Lewis

Questions

1. What are the indicators of methamphetamine use?

2. What other questions should be asked about the parents' involvement with drugs?

3. What needs to happen before, during and after an assessment of this situation?

4. What are the safety needs of the children?

Scenario: Christopher Cotton

Referral Information:

Kathy and Christopher Cotton, aged 39 and 41 respectively just moved to Georgia four weeks ago. There was a CPS alert on them originating in Birmingham Alabama. They had come in to request general assistance however the CM noted the children 8, 10 and 3 had an unusually foul odor and appeared hungry and emaciated. A new intake was taken and would have been referred for Differential Response (Diversion) when their past history was uncovered.

When contacted, Social Services in Birmingham indicated the family was transient and a definite flight risk. There was a significant drinking problem with alcoholism diagnosed for Mr. Cotton. Kathy Cotton though willing to comply with drug screens and encourage attendance in AA seemed the chief enabler at times and would divert household income to the purchase of alcohol. She claimed her husband was so amicable when under a “little influence.”

The CM in Alabama indicated that as soon as there were treatment options in place the family would disappear. In the past they moved after a drug screen came back “sample not human.” The CM also reported that she did not believe the Cotton’s were poly-drug users but admitted they were only screened for alcohol. After further investigation the county DFCS CM was told by the 10 year old that his mom “only used meth to try to lose weight. She worked at a restaurant sometimes and the boss made her work long hours. She didn’t want to be tired.”

Scenario: Christopher Cotton

Questions

1. What are the indicators of methamphetamine use?

2. What other questions should be asked about the parents' involvement with drugs?

3. What needs to happen before, during and after an assessment of this situation?

4. What are the safety needs of the children?

Jacked: Thirty Hours and Beyond

Methamphetamine
by Cynric

DOSE :		**insufflated**	**Methamphetamine**	**(powder / crystals)**

BODY WEIGHT :	**185 lb**

This report is about my first experience with the drug Crystal Methamphetamine. I had been a fan of ritalin, adorol, and dexadrine, which are some over the counter 'upper' type medications used to treat attention deficit disorder (ADD or ADHD)... They worked great for me when I snorted them; they sped me up, increased my concentration, and helped me through school... Well my dad was a fan of Crystal Methamphetamine, and had been for several years. It was my best friend at-the-time, Rob's, birthday, which falls in the spring. It was about 12 noon, and we were in my room watching TV trying to figure out how to get a bag of weed to smoke on his birthday, since we both had no money... My dad overheard us, and decided to give us our first try of crystal.

He gave us a bag with about 3/4 of a gram in it, and a bullet to snort with (for those of you who are unfamiliar with a bullet, it's a small device with a cylindrical container attached to it.. you fill the container with your powder substance, flip the chamber in the upper part down toward the powder, flip the bullet upside down and tap on it to fill the chamber, then flip the chamber up so it's facing the top of the device where there is an opening.. and then you put the opening to your nostril and inhale and it gives you a metered dose about the size of a flake of fishfood.. which may not seem much, but if you have good shit two bumps out of it is all you need to get going)... He showed us how to use it.. Rob went first, he took the first bump in his right nostril.. A split second after he breathed the powder in, his eyes erupted like a water faucet from the burn.. which only lasted about 20 seconds.. then he took one in the other nostril... and passed the bullet to me.. then it was my turn.. I took my first bump.. and a split second after it went up my nose, I got this unbelievable burn like I had never felt before.. and it made my eyes burn and water.. it felt kind of like when you cut really really strong onions... except there was the burning sensation in my nose with it... I have extremely bad sinus problems, but after that I noticed I was able to breathe easier (hey, it's a decongestant too! LOL).. I took a bump in each nostril.. the next thing I know I got this rush that felt like I was being given some kind of supernatural power.. and a slight tingling sensation 'below the belt'...

Rob and I proceeded to do 2 more bumps each out of the bullet. After those

kicked in (which took about 30 seconds to a minute after snorting it) I felt this incredible feeling.. like I was king of the world, and I could do anything I wanted.. I also noticed my jaw was clenching which started to make my teeth hurt after a while.. and my head would do these ticks almost like someone with turrets syndrome would do (but not quite as noticeable).. Then the overwhelming urge to smoke hit... We hung around my house for about a half an hour, in which time I managed to finish off about 4 cigarettes .. I noticed also that I was completely focused on everything I tried to do.. and I could move quicker than normal and I was more agile in my movements.. Everything around me seemed to slow down, like I was moving and talking faster than anything else.. except it seemed, of course, that Rob was on the same level as me hehe...

Anyway, after that, we decided to go out and do something because we couldn't sit still.. just sitting down for that half an hour felt like a week had passed... and we had gone through about a weeks worth of conversation, too :P It made both of us really agreeable, we just agreed with each other.. we didn't argue over anything or whatever.. we were just laid back as far as our attitudes.. but at the same time it felt like if anyone messed with me.. I could kill them without a second thought.. It also felt kind of like everything was coming toward me in a way, like I was the center of the universe... so we left my apartment.. And decided to go to a mountain near my place with lots of hiking trails... Rob let me drive his car, which was funny because I was only 15 at the time and had no drivers license.. On the way, we stopped and bought 2 cartons of cigarettes.. And of course took another couple bumps each..

When we got to the mountain, we decided to bypass the hiking trails and climb straight up the rock face with no safety harnesses.. which was also odd because I am afraid of heights.. but no, not when I'm on crystal :P... I still have a scar on my leg from where I slammed it into a rock.. and I didn't even feel it at the time, I just had this attitude like 'whatever, I have to get to the top.. I have to climb!'... Anyway, we finished the bag by 1 in the morning.. both of us had tried to eat, but the mere thought of food made us sick to our stomachs.. I managed to force down about half a hot dog, and almost had it returned to me via airmail :P.. We took the last of the crystal at about 1 in the morning... and we had finished both cartons of cigarettes by 10 in the morning.. and we were still wide awake.. we felt tired and drained physically.. but our minds were still racing on strong.. finally at 6 that night we were able to get to sleep.. 3/4 of a gram between two people had kept us awake for about 30 hours.. and we still had to force ourselves to sleep then.. We both felt like complete shit by the time we went to bed, but it was well worth the experience...

Suffice it to say.. After that, those little prescription drugs never felt the same.. Since then, I've become a hardcore speed freak.. My father quit

doing it because he was mainlining it (or shooting it up for those of you who don't know what that means)... And shooting it up caused him serious health problems.. And now I have to smoke crystal because I've burned a hole in my nose and I get nose bleeds all the time, even if I don't snort anything... So, those of you thinking of trying it.. if you like to fly and be sped up, and have an awesome time.. and you like a drug to last a long time.. crystal will probably be the best thing you can do and the longest lasting.. but keep in mind, it's got it's physical drawbacks with long term abuse... and also make sure you get the pure stuff.. it should be a sort of white powder.. or little white rocks that crush up very easily when touched.. and if you crush it with paper over top, it should leave a little bit of oily residue where it touched the paper.. not much, but a little bit [Erowid Note : Meth can be, but is not always oily].. and it's EXTREMELY bitter... more so than anything I've ever tasted in my life.. if someone is trying to sell you a tan colored or red colored or blue colored meth.. it's either not real shit, or it's been cut to hell and back.. the most common cut is baby laxative, which has no distinct smell or taste when mixed with crystal methamphetamine... And that's about all I can think to put in this report.. I'm jacked right now, so this is an example of how it makes you ramble on and on LOL... I hope I gave some insight to those of you who have been thinking about trying the drug.. and to those of you who have just gotten into it real bad and haven't learned of the consequences of it's abuse... take care, and be safe.

Exp Year: 1996

ID: 2053

Added: Jun 23, 2000

Views: 140035

NOTES

MODULE FOUR
ADDICTION: A BRAIN DISEASE

PURPOSE: To increase knowledge and awareness of the medical viewpoint of addiction as a disease.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Define and recognize addiction as a disease in order to more effectively promote needed changes in individual and family functioning
- Acknowledge and explain that the disease model has been adopted as the frame of reference that drives DFCS casework practice relating to chemical dependency.

ACTIVITY

Activity

National Institute of Drug Abuse Introduction

TIME: 10 Minutes

PURPOSE: To recognize addiction as a brain disease.

INSTRUCTIONAL METHOD: CD Presentation
Large Group Discussion

INSTRUCTIONS FOR THE ACTIVITY:

1. View segment of CD: *Neurobiology The Brain: Understanding Through the Study of Addiction* "NIDA Introduction."
2. Participate in large group discussion.

ACTIVITY

Activity

Drug Abuse and Addiction

TIME: 30 Minutes

PURPOSE: The trainee will be able to recognize addiction as a brain disease.

INSTRUCTIONAL METHODS: CD Presentation
Large Group Discussion

INSTRUCTIONS:

1. View segment of CD: *The Brain: Understanding Neurobiology Through the Study of Addiction*
   "*Drug Abuse and Addiction"*
2. Read "*Drug Abuse and Addiction"*
3. Participate in a large group discussion

DRUG ABUSE AND ADDICTION

1. Your brain is different every day. Certain synapses may become stronger or even disappear as a result of what was experienced and learned that day.
2. Drugs release dopamine. Drug users feel a "rush" and experience a "high" for a short time. However, the changes in the brain can last a long time…perhaps forever.
3. One change that occurs is the development of cravings; an uncontrollable urge for drugs. A craving can be stimulated by a simple memory such as an image or the mere mention of the drug.
4. Tolerance develops when a person needs increasing doses of a drug to achieve the same "rush" or "high" that previously resulted from a lower dosage of the drug. (Two primary mechanisms underlie the development of tolerance. First, the body may become more efficient at metabolizing the drug, thereby reducing the amount that enters the blood system. Second, the cells of the body and brain may become more resistant to the effect of the drug.)
5. Drugs affect many other parts of the brain too. Ex: THC was shown to change the way neurons function creating changes in many areas including movement, balance, coordination, memory and judgment.
6. Drinking alcohol can kill neurons that affect memory, mental and consciousness functions.
7. MDMA (also known as ecstasy) can also kill neurons. PET scan imaging shows changes in the brain 18 months after use.
8. Cocaine PET scans show a decrease in brain activity 100 days after use.

Conclusion: Scientists wonder if there are areas in the brain that never really recover from the effects of drugs. Scientific investigations reinforce the fact that drug addiction is a brain disease. Drugs really do change the way the neurons in the brain work.

ACTIVITY

Activity

Ruth's Story

TIME: 30 Minutes

PURPOSE: To illustrate the concept of addiction as a brain disease that impacts a person in three areas: biological, psychological and social.

INSTRUCTIONAL METHOD: CD Presentation
Small Group Activity
Large Group Discussion

MATERIALS: Participant's Guide:

- *The Brain: Understanding Neurobiology Through the Study of Addiction: "Ruth's Story"*

INSTRUCTIONS FOR THE ACTIVITY:

1. View segment of CD: *The Brain: Understanding Neurobiology Through the Study of Addiction: "Ruth's Story"*
2. Participate in a large group discussion: How does this picture of addiction relate to what we have been learning?
3. Participate in a small group discussion on the CD segment and complete "Ruth's Story" worksheet together.
4. Participate in a large group discussion and review worksheet together.

RUTH'S STORY

1. Discuss as a group what you saw that indicated that Ruth was dealing with a chronic disease. Write a few phrases with your response to demonstrate the progression of the disease.

_____
_____
_____
_____

2. Ruth's disease impacted all areas of her life: biological, psychological and social. Discuss the impact of these areas together and write your responses below.

   Biological Impact:

   _____
   _____
   _____
   _____

   Psychological Impact:

   _____
   _____
   _____
   _____

   Social Impact:

   _____
   _____
   _____
   _____

3. What was the impact on Ruth's family?

   _____
   _____
   _____
   _____

Addictive Disorder

“Among the social and medical ills of the 20th century, substance abuse -which includes drugs, marijuana, and alcohol- ranks as one of the most devastating and costly. (E.L. Gardner, 1992). An addictive disorder is defined as the preoccupation with acquiring and consuming alcohol or drugs, the compulsive use of alcohol and drugs despite adverse consequences, and includes a pattern of relapse to alcohol and drug use despite the recurrence of adverse consequences. Central to addiction is the concept of loss of control over alcohol and drug use which leads to consequences that are harmful to the individual and others associated with him or her. This loss of control is what makes an addiction a disease or disorder similar to other diseases or disorders, such as schizophrenia or diabetes (Miller 1994).”

Addiction's a Disease

A lot of misconceptions,
when it comes to drugs and drinking.
I'd like to set the record straight,
And help you in your thinking.

It's more than just some moron,
Who don't know enough to quit.
It's hard to understand it,
that is, 'til you have been bit.

Let me give a quick comparison,
To make you more aware.
Like gout or diabetes,
It requires certain care.

It's not a form of weakness.
Science, surely disagrees.
Addiction is genetic,
It's a chronic, real disease.

A lot of people have it,
What they really know for sure.
It doesn't ever go away,
It doesn't have a cure.

It's been around forever,
Since the early days of booze.
There's those who will defeat it.
The majority will lose.

It's lethal in the long run,
And it isn't going away.
For those who just ignore it,
There's a price, they'll someday pay.

Often death and institutions.
Broken families, screwed up lives.
There's abuse to little children.
Cheated husbands, battered wives.

These are symptoms, quite abundant,
that addiction tends to share.
Addiction's a disease,
Which many people aren't aware.

Author Unknown

NOTES

MODULE FIVE
BEHAVIORAL CHARACTERISTICS OF SUBSTANCE ABUSERS

PURPOSE: To demonstrate the effects denial has on substance abusers and to illustrate the recovery process.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Identify factors associated with denial, recovery, and relapse in working more effectively with cases where substance abuse disorders are present.

ACTIVITY

Activity

Dealing With Denial

TIME: 30 Minutes

PURPOSE: To brainstorm strategies for dealing with denial.

INSTRUCTIONAL METHODS: Small Group Discussion
Large Group Discussion

MATERIALS: *Dealing with Denial*
Case Scenario *The Haggis Family*

INSTRUCTIONS:

1. Get into your assigned group
2. Select a recorder and presenter (could be the same)
3. Read the Haggis Case Information and complete the worksheet Dealing with Denial Questions.
4. Be prepared to discuss with large group.

CASE SCENARIO: The Haggis Family

Patti Louise Haggis, age 19, delivered Gwida Molly Haggis on 12/29/03. She told CM she did not remember when she got pregnant and the entire pregnancy seemed a blur. She indicated that she loved Gwida but had complained bitterly to the hospital staff that *she could not stand it's high pitched crying and she really need some peace and quiet.*

When asked about the delivery she told the worker *it went very well and the baby was just fine except for a slight bleeding in her brain.* She explained that she was a drug user however, she had quit the habit since getting pregnant. She did admit that there was a time when she was pregnant when she was unsure whether she wanted to keep the baby. She remembered being asked by a *nice lady who could not have children whether I wanted to sell her the baby, but of course, I refused.*

She agreed with the CM that the best place for Gwida now would be foster care but *indicated she will do everything it takes to get her back.* The CM advised that the court would likely order her into drug treatment and submit to random drug screens.

Client admitted that was no problem for her as she really was not addicted to drugs or alcohol. Client expressed that her only crime was *loving a party too much.* She first used crack when she was 17 but implied it was a one-time incident.

Client says she will sign any case plan to get her child back. She has no other children and will be moving back to her mother's house as soon as she is released from the hospital.

Dealing with Denial Questions

1. What types of denial are evident in this case?

2. How could you help the family work through the denial?

3. How would confrontation, support or a combination of both be used to address the denial?

4. What other information do you need to address the behaviors indicated?

ACTIVITY

Activity

Portrait of Addiction/The Problem Was

TIME: 10 Minutes

PURPOSE: To brainstorm strategies for dealing with denial.

INSTRUCTIONAL METHODS:

Large Group Discussion

INSTRUCTIONS:

1. View the presentation
2. Refer to the *Portrait* of *Addiction/The Problem Was* Discussion Question and be prepared to share responses with the large group

Discussion Question:

What indications of denial did you hear stated by the individuals?

<u>Client</u> Based Checklist To Assess Recovery Efforts And Prevent Relapse.

✘ ***Please check the questions asked and indicate any comments applicable.. (page 1)***

✘	Question	Comments
	What changes have you made in your life? (Activities, church, friends, places you go or hang out?)	
	Have you been encountering triggers? Please explain.	
	What do you think about AA/NA?	
	Do you have a sponsor? Tell me about your sponsor.	
	When is your next A & D appointment?	
	Are you taking any medications? Prescription? Over the counter?	
	What is your normal daily schedule now?	
	How are you taking care of yourself?	
	What is your work schedule?	
	Have you been able to pay your bills this month? Please explain.	
	What do you do for fun?	
	What have you learned about how your drinking/drug use has affected your children? How do you feel about that?	
	Has anything happened lately that made you depressed/sad? Please explain. What did you do about it?	

<u>Client</u> Based Checklist To Assess Recovery Efforts And Prevent Relapse

- ***Please check the questions asked and indicate any comments applicable. (page 2)***

x	Question	Comments
	What do you consider triggers? How are you dealing with them?	
	When is the last time you attended AA/NA?	
	How do you feel about AA/NA?	
	Are you attending 12-step meetings? What step are you on now? How many chips have you gotten? (Praise the chip level when appropriate)	
	When is the last time you went to a doctor? What did he prescribe?	
	What is the most important thing you have learned in AA/NA?	
	Tell me about how you are eating and sleeping.	
	Who in your family is supporting/helping you? Who is helping/supporting you? How is your support system helping you?	
	Have you missed work lately? Please explain.	
	Have you made any new friends? Tell me about your friends.	
	What do you and your children do for fun?	
	Has anything happened lately that made your angry? Please explain. What did you do about it?	
	How has AA/NA helped you stay clean?	

<u>Child</u> Based Checklist To Assess Recovery Efforts And Prevent Relapse

x Please check the questions as they are asked and indicate any comments applicable. (page 1)

✖	Questions	Comments
	Where is your mom when you get home from school?	
	What do you do when you get home from school?	
	Is your mom home at night?	
	What does your mom fix for you to eat?	
	What did your mom cook for dinner last night?	
	How is it going since your mom quit drinking (using)?	
	What time do you go to bed? Where do you sleep?	
	What have you done for fun lately with your mom?	
	Where have you gone for fun lately with your mom?	
	What family/friends do you and your mom have contact with?	
	What does your mom do when you misbehave?	
	How does your mom discipline you now?	
	Tell me about school. Have you missed school lately? How many days?	
	Have you been offered drugs/alcohol by anyone? Please explain.	
	Has anything happened in the last week/month that made you afraid? Please explain.	
	Who stays with you when your mom goes to AA/NA meetings?	
	What do you do when your mom goes to AA/NA?	
	How is your mom different since she started getting help for her drinking/drugs?	
	Have you been worried that your mom might start drinking/using again? (Explore reasons)	
	Is anything worrying you now? (Explore)	

RELAPSE SYMTOMS LIST

(From Chemical Dependency/Codependency-David Hazen)

This is a checklist of warning signs, in order of increasing severity. Remember, relapse is a process which leads to the use of a chemical, not the final event. Experiencing any one of these symptoms could indicate a person is in relapse.

- I start doubting my ability to stay clean/sober.
- I deny my fears.
- I adamantly convince myself that "I'll never drink/use again."
- I decide being abstinent is all I need.
- I try to force sobriety upon others.
- I become overconfident about my recovery.
- I avoid talking about my problems and my recovery.
- I avoid my sponsor, or internally do the "yeah, but..." to what he/she says.
- I behave compulsively (overwork/under work, over talk/withdraw, etc.).
- I overreact to stressful situations.
- I start isolating myself.
- I become preoccupied with one area of my life.
- I start having minor depressions.
- I start unrealistic or haphazard planning.
- I live in the "there and then."
- I find my life plans begin to fail.
- I start idle daydreaming and wishful thinking.
- I view my problems as unsolvable.
- I long for happiness but don't know what it is.
- I avoid having fun.
- I overanalyze myself.
- I become irritated with friends/family.
- I experience periods of confusion.
- I am easily angered.
- I begin blaming people, places, things, and conditions for my problems.
- I begin doubting my disease.

RELAPSE SYMTOMS LIST **(continued)**

- I eat irregularly (over/under eating, snacking, etc.)
- I have listless periods.
- I sleep irregularly (over/under sleeping).
- I progressively lose my daily routine.
- I experience periods of deep depression.
- I sporadically attend 12-Step or Aftercare meetings.
- I develop an "I don't care" attitude.
- I hoard money, sex, or power.
- I openly reject help.
- I develop aches and pains.
- I rationalize that drinking/using can't make my life worse than it is now.
- I feel powerless and helpless.
- I feel sorry for myself.
- I have fantasies about social drinking/using.
- I begin to lie consciously.
- I increase my use of aspirin/nonprescription medications.
- I completely lose confidence in myself.
- I develop unreasonable resentments.
- I stop attending 12-Step or Aftercare meetings.
- I am overwhelmed with loneliness, frustration, anger, and tension.
- I begin visiting drinking/using "friends" and places.
- I convince myself I'm cured.
- I make or experience a major life change.
- I start drinking/using a chemical that is not my drug/drink of choice.
- I practice controlled drinking/using.
- I lose control.

ACTIVITY

Activity

Signs of Relapse

TIME: 15 Minutes

PURPOSE: This activity allows you to build your skills in identifying signs of relapse and subsequent actions to strengthen recovery.

INSTRUCTIONAL METHODS: Individual work
Large Group Discussion

MATERIALS:

- *The Don Figueroa Case 452 Contact Sheet*
- *Signs of Relapse Worksheet*
- *Child based checklist to assess recovery efforts /prevent relapse*
- *Client based checklist to assess recovery efforts /prevent relapse*

INSTRUCTIONS:

1. Divide the group into groups of 3 or 4
2. Identify a recorder and presenter (not necessarily the same person)
3. Individually read the assigned case. Complete the column for the signs in the *Signs of Relapse Worksheet*
4. Share your responses in your group
5. Review the Child based and Client based checklist and identify questions you would ask to gather more information about relapse in this case.
6. Identify next steps to take in addressing the behaviors observed.
7. Be prepared to share responses in large group discussion.

Georgia Department of Human Resources

CONTACT SHEET

PAGE NO. 13

CASE NAME: Figueroa, Don CASE ID NO.: 026-5678977-00

Date Staff Member Type Contact/Activity	Individual(s) Contacted, Purpose, Content, and/or Results of Contact
12/12/ 2004	CM arrived at the residence on County Line Road at 8:00a.m. and knocked on the door. Client came to the door in under pants holding 4 year old Katje in his arms. Client expressed alarm at seeing CM and was most reluctant to invite the CM to enter despite the 30degree weather. The living room was still barely furnished but the counter separating the kitchen and living room had several boxes of cold medicine, tincture of iodine (one bottle), one container of charcoal lighter fluid and a large metal can of paint thinner. The kitchen floor was brown from spills and the sink cluttered with unwashed dishes, chicken bones, ding dongs, and empty Mr. Wings containers.
Cantrell Ekeren	Melissa Sharpe stumbled into the room seeming to have difficulty in focussing and became very aggitated on recognizing the CM. CM reminded the family that he had told them he was required to make unannounced visits and inquired as to the reason Ms Sharpe had missed her drug screen the day before.
UHV	" I have told you so many times before, I'm not frigging doing meth, crack or any damn drugs. Why can't you just leave us the hell alone."
	She continued to bemoan her stinking "luck" and lashed out at Mr. Figueroa for letting CM into the house. CM asked Mr. Figueroa about the items on the counter and he explained they belonged to neighbor who was coming later to do repairs on the house. Cm explained he was there to see how they progressing on the case plan steps to remain in treatment in order to become drug free. Ms. Sharpe said that "her counselor did not like her because she was living with a hispanic man. She's racist." CM reminded her that at the last visit she had indicated they had a great relationship and she felt that the counselor (Laura Craft) really understood her problem. " I don't like her now she makes me mad. I have been feeling discouraged too, and don't just harp on me Don has not been going to NA either.

Signs of Relapse: Worksheet

Descriptions	Signs	Next Steps
Increasing lack of cooperation/avoiding behavior		
Deterioration in daily living activities		
Increasing self-pity		
Increasing depression		
Setting expectations that are too numerous or unrealistic		
Distancing from friends who are clean and sober		
Re-establishing old relationships with drug-using acquaintances		

2105.15 Relapse Issues in Substance Abuse Cases

Requirement

Evaluate each occurrence of relapse individually, on a case-by-case basis. File a deprivation complaint if safety of a child cannot be ensured in the home or through other controlling safety interventions. If a child is not at imminent risk and/or safety is controlled through other means, evaluate the existing evidence of substantiated maltreatment with the supervisor to determine whether court-ordered intervention is necessary for compliance with services. If the court is already involved, notify the court of any significant changes to the case plan resulting from the relapse.

Procedures/Practice Issues

Relapse is defined as a falling back or sliding into a former state. Within the context of substance abuse, relapse is marked by a subsequent occurrence of drug use following a period of abstinence/sobriety. Relapse occurs in varying degrees, ranging from a single instance of drug use to an extended episode of binging that lasts for several days. Relapse is most often triggered by physical, emotional and/or psychological cues in the environment (e.g., the smell and/or sight of the drug, a former hangout where the person used drugs, interaction with people with whom the person commonly used drugs, etc.).

Signs of relapse:

- increasing lack of cooperation/avoiding behavior;
- deterioration in daily living activities;
- increasing self-pity;
- increasing depression;
- setting expectations that are too numerous or unrealistic;
- distancing from friends who are clean and sober; and,
- re-establishing old relationships with drug-using acquaintances

Relapse planning involves the identification and development of a plan of action that the family agrees to follow in the event that relapse occurs. This may include outlining who will contact the DFCS case manager, participation in AA or NA, weekly telephone contact with an identified family member or friend, a temporary care giving resource for the children, etc. Discuss these plans with family members so that roles and responsibilities are clearly defined.

The best predictor of whether a person will recover from an instance of relapse is how much that person perceives he/she has to lose by continuing to use drugs. When there is no progress in other life areas (e.g., improved parenting competency, financial stability, positive relationships, etc.), there is also a lack of necessary motivation to regain control over the addiction. To prevent the risk of relapse, address all of these factors in case management.

NOTES

MODULE SIX
A FAMILY DISEASE

PURPOSE: To look at substance abuse from a systems perspective and therefore recognize addiction as a family issue.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Work with and encourage behavioral and situational changes through the recognition of the family as a comprehensive unit of connected parts.
- Involve the family in assessment, planning, case management and ongoing recovery.
- Demonstrate an understanding of the impact of substance abuse on children.

ACTIVITY

Activity

Help Me Please!

TIME: 15 Minutes

PURPOSE: To identify the pitfalls of enabling and rescuing behaviors.

INSTRUCTIONAL METHODS: Individual work
Large Group Discussion

MATERIALS:

- *Help Me Please!* Scenario and Discussion Questions

INSTRUCTIONS:

- Read the *Help Me Please!* Scenario and answer the Discussion Questions.
- Be prepared to share responses in large group discussion

Help Me Please!
Scenario and Discussion Questions

Crystal Lightman was assigned to work with Flo Drummond (referred for neglect) in CPS ongoing. Ms. Drummond has had an extensive history with the department spanning ten years, the underlying cause being her addiction to alcohol. Her children have flipped flopped between placement and ongoing CPS. She has become more stable over the past two years ever since Crystal's been working with her. Crystal tries to balance FCP and the risk and safety needs of the children and has done much in service provision. She has helped Ms. Drummond see the links between her abuse of alcohol and her need to utilize parenting practices that match her children's age and stage of development. However, the therapist reported that Ms. Drummond's choices were still being impaired by her use of alcohol. In response to this, the client told the worker that she was clean and she could search her house for booze anytime.

One of the major goals in her family plan was to find housing that would keep the children safe and stable. Her house was recently condemned and she was told to be out by May 31 when the wreckers would demolish the building. It was now May 15th. The worker asked Ms. Drummond to confirm her plans for moving. She told Crystal she had tried to find a place but couldn't. "They will just have to let me stay in my old house. Just un-condemn it." Crystal told her that was not an option and she would call her back later. The CM contacted low income housing and set up an appointment on May 23rd @ 2:30 for the client to inspect the townhouse and complete the paper work. Ms. Drummond who did not have transportation agreed to do this after her hair and nail appointment on the 23rd. She would have her girlfriend take her. At 2:20 Ms. Drummond called the worker to inform her that after the hair/nail appointment her girlfriend needed to go to the mall and could not take her. "I guess I can go another day," she told the CM. The CM went and picked up Ms. Drummond so she could secure the apartment. Before dropping the client off that

evening the CM was assured that Ms. Drummond had made all the plans for moving. The worker explained that if she did not move DFCS would have no choice but to place her children in foster care to assure they had adequate shelter. Ms. Drummond said she understood.

At 4:45 on May 29, Ms. Drummond called the worker to state that Bubba's Truck got "tore up" in a wreck and he was arrested for DUI last night. "Good thing the baby was sick and I had to stay home with her." Could she call the wrecking people and ask them to wait till the truck was fixed?

At 9:00 on Saturday, May 30, Crystal Lightman and her boyfriend rented a U-Haul and moved the client to her new residence.

Discussion Questions

1. What did the worker do well?

2. How was helping a hindrance?

3. How would you have managed this differently?

Substance Exposed Infants and Their Mother's Evaluation Guidelines

The Substance Use history taking should include legal and illegal drugs (prescription drugs, alcohol, and cigarettes), and should cover:	
Area Evaluated	**Observations/ Comments**
Duration of use, including age of first use	
Frequency, type, and amount of drugs used and periods of abstinence	
How taken	
Social context of use (with whom the patient uses, where and when she uses)	
Substance Use abuse treatment history	
Support group involvement	
Consequences of use (self-perceived and objective)	
Relapse factors	
Family history of use	
Motivation for treatment	
Motivation for continued use of drugs	
Urine toxicologies as needed: *A urine toxicology is indicated when an adequate drug history cannot be obtained from the mother and she is manifesting symptoms of possible addiction or withdrawal and when the child is showing signs or symptoms of withdrawal.*	
A psychosocial assessment should include:	
Support systems (role of the patient in her family support system and the stress created by that system)	
Patient's attitude toward the birth of this child and her perception of her ability to parent this child and any older children	
Role of the father, both in the mother's life and his potential role with the child	
Education and employment	
History of physical, sexual, and emotional abuse, both as a child and as an adult	
Current life situation, including housing, transportation, child care, monetary support, and legal considerations or problems.	
The mental health assessment should cover:	
Mental status examination	
Psychiatric symptomatology	
Psychiatric history and treatment	
Suicide risk	
Family psychiatric history	
DSM-V-R diagnosis	
Treatment recommendations.	
Standardized psychiatric evaluation Referral and ongoing assessment	

Early Interventions for Infants

Components - Because of their distinctive needs, drug-exposed infants should receive more than the standard medical follow-up. Such follow-up should preferably be carried out under the supervision of a specially trained pediatrician. Follow-up interventions include but are not limited to:	
Intervention	Observations/Comments
Nutrition (especially if inadequate sucking reflex is evident)	
Psychomotor assessment and monitoring of development	
Vision and hearing screening	
Speech and language assessments and therapy	
emotional development assessments and therapy	
Play therapy	
Early educational needs assessments	
Physical therapy	
Immunization (see Exhibits 6 and 7).	
Referrals - Stay abreast of available community services for drug-exposed infants and their families. Examples of routine health care referrals for drug-exposed infants and their families should include referrals to Federal programs such as:	
Early Periodic Screening, Diagnosis and Testing Program	
Maternal and child health services	
Community health centers	
Healthy Start Program.	

Adapted from U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information

NOTES

MODULE SEVEN
TREATMENT

PURPOSE: To advance the knowledge base of case managers in understanding the different treatment modalities and options used in treating substance-abusing clients.

LEARNING OBJECTIVES: After the completion of the Module, the trainee will be able to:

- Identify different treatment strategies substance abuse professionals utilize in treating substance abusers
- Demonstrate an understanding of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders
- Recognize the stages in the12 Step Recovery Program
- Identify and apply different approaches to treatment between women and men.

CAGE*

C Have you ever felt the need to ***C***ut down on your drinking or substance use?

A Have people ***A***nnoyed you by criticizing or complaining about your drinking or drug use?

G Have you ever felt bad or ***G***uilty about your drinking?

E Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover (***E***ye-opener)?

Getting a “yes” answer on two or more of these questions could suggest that a more thorough assessment should follow with referrals to other professionals dealing with substance abuse issues.

**Children's Services Practice Notes*; The N.C. Division of Social Services and the Family and Children's Response Program

Substance Abuse Questions for Family Members*

Let the parent(s) know that as part of your job, you must talk with all the children.

Establish rapport with each child by first socializing, talking about their interests, hobbies, school, friends.

When referring to the parent's substance use, do so calmly and as fact.

Talk with the parent about your child interviews in a caring, sensitive way that focuses on the children's feelings, fears and hopes for the family. Do not present information from the children about places, events, and times as this may cause the parent to be upset with the child for disclosing specific family information.

Use the Questions for Substance Abuse as a guide during the interview(s). What you are interested in is how each child experiences the parent's alcohol or drug use and what he or she thinks the family would be like to if alcohol or drug was not a problem in their family.

1. Are you afraid to be around your family member when he or she is drinking or using other drugs?

2. Do you worry about your family member's drinking or other drug use?

3. Does your family member refuse to talk about his or her drinking or other drug use?

4. Has your family member broken promises because of his or her drinking or drug use?

5. Has your family member ever lied about his or her drinking or using, or tried to hide it from you?

Substance Abuse Questions for Family Members

6. Have you ever been embarrassed or afraid by your family member's drinking or other drug use?

7. Does you family member's behavior change noticeable when he or she is drinking or using?

8. Has anyone else talked to you about your family member's drinking or drug use?

9. Do you know if your family member has tried to cut down on drug and/or alcohol use and could not?

Questions for School-Aged Children

1. Do other kids know about the alcohol/drug trouble in your family?

2. How does your mom/dad's drug use affect the way you have to act?

3. How does your mom/dad/s drinking/drug use affect the kind of person you are?

4. How does your mom/dad's drinking/drug use affect how other kids treat you?

5. Do you think your teacher knows about any of this?

*Adapted from Vernon E. Johnson, Everything You Need To Know About Chemical Dependence

What is Treatment?

Chemical dependence treatment is a structured, time-limited program of intervention that confronts the addiction process by addressing the chemically dependent person's:

- Physical aspects of the dependence through medically supervised withdrawal from the drug through a detoxification process

- Psychological aspects of the dependence, particularly the defense mechanism of denial, through individual, group and family therapy

- Emotional and social needs through the support and fellowship of other addicts (the chemically dependent person has been meeting these needs with the drug)

- Spiritual needs that have gone unmet and ignored throughout the person's drug involvement (this need is met by the introduction and beginning of involvement in a 12 Step program of recovery)

ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders Second Edition Revised

Adult

Level 0.5 Early Intervention

This treatment level is for the specific individual who, for a known reason, is at risk of developing substance abuse related problems or for those for whom there is not yet sufficient information to document a substance abuse disorder.

Early intervention could consist of one-on-one counseling by trained personnel offered in a clinical setting, school setting, work setting, or a community center.

Support systems would include ongoing treatment, referral for medical care if indicated, or referral for community services.

Interventions would include group and or/family therapy.

The assessment process would be completed to screen for and rule in/out a substance abuse disorder.

Level I Outpatient Treatment

This treatment level will provide organized services that are delivered in a wide variety of settings providing a professionally directed evaluation, treatment and or recovery services. The treatment is provided in regularly scheduled sessions and follows a defined set of policies and procedures or medical protocols. Services address major lifestyle attitudinal and behavioral issues that have the potential to undermine goals of treatment or inhibit the individual's ability to cope with major life tasks without non-medical use of alcohol or other drugs.

Level I was expanded in the Second Edition Revisions to promote greater access to care for dual diagnosis (alcohol and drug abuse)

patients, unmotivated patients mandated into treatment and others who previously only had access to care if they agreed to intensive periods of primary treatment.

Interventions would include the use of motivational interviewing, motivational enhancement, and solution-focused therapy by credentialed substance abuse professionals provided in office and/or health clinics, primary care clinics, addiction and mental health clinics.

Support systems include the provision of medical, psychiatric, psychological on site with the availability of emergency medical psychiatric consultation by phone 24 hours a day, 7 days a week (24/7).

Therapies would include individual/group counseling, motivational enhancement, dual diagnosis therapy.

The assessment process would include a biopsychosocial assessment, individual treatment plan with review.

Level II Intensive Outpatient Treatment/Partial Hospitalization

This treatment level provides organized outpatient services that provide treatment services during the day, before or after work or school, in the evenings or on the weekends. Programs are available to support medical and psychiatric consultation, dual diagnosis, medication management, and a 24-hour crisis management.

Services are provided in settings that meet state licensure or certification criteria and are provided by interdisciplinary teams certified to provide substance abuse treatment and counseling.

Family therapy, motivational enhancement, and dual diagnosis treatment modalities are provided up to 9 hours weekly for Intensive Outpatient services and up to 20 hours weekly for Partial Hospitalization services.

Assessment includes a comprehensive substance abuse history, physical exam, individual biopsychosocial assessment, individual

treatment plan with scheduled revisions and dual diagnosis treatment programs.

Level III Residential/Inpatient Treatment

Programs at these facilities are staffed by addiction treatment and mental health professionals who provide services in a 24-hour in care setting. There are four types of programs in a Level III treatment facility:

111.1-Clinically managed low-intensity residential treatment
111.3-Clinically managed medical-intensive residential treatment
111.5-Clinically managed high-intensity residential treatment
111.7-Medically monitored inpatient treatment

The services are provided in a free standing/licensed setting. Support systems include phone or in person consultation with a licensed medical doctor and has the ability to provide emergency services on a 24/7 basis. Staff will include doctors, clinical staff, and nursing staff.

Therapies provided include 5 hours of counseling a week, relapse prevention activities, motivational enhancement, and development of social networks and services to the family of patient.

Random drug screens are conducted.

Individualized comprehensive biopsychosocial assessments with an individualized treatment plan, medical exam, and dual diagnosis programs are provided.

Level IV Medically Managed Intensive Inpatient Treatment

This treatment level provides a planned regimen of 24 hour medically directed evaluations, care, and treatment of mental and substance abuse related disorders in an acute care inpatient setting. Staff include addiction-credentialed physicians and psychiatrists. The facility has inpatient beds for substance abusing individuals who require biomedical, psychiatric and nursing care. Opioid (drugs derived from opium) maintenance therapy is provided with expanded

services beyond methadone maintenance including other narcotic based drugs. (*Opioid drugs are used to extinguish drug craving and to establish a maintenance state. They do not produce euphoria, intoxication, or withdrawal symptoms).*

Intensive treatment is provide in licensed acute care facilities such as general hospitals and/or psychiatric hospitals staffed through interdisciplinary teams, credentialed clinical staff, and medical staff available for medical treatment 24/7.

Therapies include highly individualized treatment with concurrent biomedical, emotional, behavioral or cognitive programs, full range of health services and services provided to the patient's family.

A comprehensive nursing assessment and physician meeting at admission is provided along with the completion of a comprehensive history and biopsychosocial assessment. An individual treatment plan is developed and reviewed.

Opiod maintenance is provided.

Adolescent

Level 0.5-Early Intervention

Treatment for adolescents at this level can be provided in school settings or clinical offices. Support might include referrals for ongoing treatment, referral for medical or psychological services, or referral to community services.

Programs at this level are staffed with professionals knowledgeable about biopsychosocial dimensions and therapies might include individual/group/or family counseling. Assessment would include screening in or out substance abuse disorders.

Level I
Outpatient Treatment

Treatment provided in settings that meet licensing requirements and supports include medical, psychiatric, and laboratory services directly affiliated with more and less intensive levels of care provided by credentialed treatment professionals. Emergency services are also provided as needed. Therapies include individual and group counseling and a individual biopsychosocial assessment is provided with the development of an individual treatment plan that is reviewed.

Level II
Intensive Outpatient Treatment/Partial Hospitalization

Treatment is provided in after school, evening or in weekend settings which meet licensing requirements. Medical, psychological, psychiatric support is provided within in 24 hours with a face-to-face contact within 70 hours. Emergency services are provided 24/7.

The settings are staffed with an interdisciplinary team with knowledge of adolescent development. Therapies include individual, family, and group therapy with intensive out-patient services provided 6 or more hours weekly.

Assessments include a comprehensive substance abuse history, individual biopsychosocial assessment including information obtained from family, teachers, probation officers and other involved individuals.

Level III
Residential/Inpatient Treatment

There are three sub levels with Level III Treatment settings which are;

111.1-Clinically managed low-intensity residential treatment
111.3-Clinically managed medium intensity residential treatment
111.5-Clinically managed high intensity residential treatment

Programs are housed in freestanding, licensed facilities, community settings or psychiatric hospital settings. Support is provided through emergency consultation by phone or person, physician monitoring and licensed nursing care staff by health professionals from counselor aids to medical doctors.

Therapies include structured therapeutic services, random drug screens, and relapse prevention. Services include individual biopsychosocial assessment, individual treatment plan reviewed and updated, physical exams and psychiatric assessment. Detoxification planning and withdrawal assessments are also provided.

Level IV
Medically Managed Intensive Inpatient Treatment

Treatment is provided in acute care general hospital or psychiatric hospital/unit settings. Specialty consultation, medicated laboratory and toxicology testing is provided along with intensive care.

The settings are staffed with an interdisciplinary team of credentialed staff including medical doctors and facility approved addiction counselors. Therapies include individual program including medication, health services, planned clinical interventions, services for families. Detoxification services are also provided.

Comprehensive nursing assessments are provided along with complete physical exams and comprehensive biopsychosocial assessment. Educational assessments, referral arrangements, individual treatment plan with review services are also provided.

The Readiness to Change Dimension Criteria for adolescents has five (0-4b) risk ratings identified as:

- Risk Rating 0 is indicative of a patient's engagement in treatment as a proactive participant and is committed to change his/her alcohol or other drug disorder.

- Risk Rating 1 is indicative of the patient's willingness to enter treatment.

- Risk Rating 2 is indicative of the patient exhibiting inconsistent follow through with treatment; shows minimal awareness of problem.

- Risk Rating 3 is indicative of the patient's inability to follow through recognizing only minimal awareness of the problem.

- Risk Rating 4a is indicative of a patient who is unable to follow through with little or no awareness of the problem.

- Risk Rating 4b is indicative of a patient's whose behavior represents imminent danger of harm to self or others.

ASAM Assessment Dimensional Criteria

The following problem areas or dimensions have been identified as most commonly addressed in making patient placement decisions and the subsequent formulation of an individual patient's treatment plan:

D1-Acute Intoxication and/or withdrawal potential

> Are there any risks associated with the patient's current level of acute intoxication? Is there significant risks of severe withdrawal symptoms or seizures based on the withdrawal history of the patient?

D2-Biomedical Conditions and Complications

> Are there current physical illnesses other than withdrawal that need to be addressed because they create a risk or may complicate treatment?

D3-Emotional, Behavioral, or Cognitive Conditions and Complications

> Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive problems that need to be addressed because they create risk or complicate treatment?

D4- Readiness to Change

> What is the patient's degree for readiness for change?

D5-Relapse, Continued Use or Continued Problem Potential

> Is the patient exhibiting psychotic signs such as being fearful of being poisoned? If so, he/she would be described as high relapse potential. Is the patient in immediate danger of severe mental health distress and/or alcohol or substance abuse use? Does patient understand his/her addictive disorder? How aware is the patient of relapse triggers?

D6-Recovery/Living Environment

> Do family members, living situations, or school or work situations pose a threat to the patient's safety or engagement in treatment? Does patient have a supportive network? Does the patient have finances, educational resources, legal mandates, childcare arrangements, housing?

The prognosis for resolution of these problems depends on the clinician's knowledge of the problem's severity and the level of difficulty of resolving the problems. This knowledge forms the basis for the clinician's ability to obtain informed consent from the patient, prescribe or direct treatment and establish an estimated length of service. The goals for each problem may need to be reviewed from the standpoint of resolution of the acute crisis and/or alteration of the course of the chronic illness.

The patient is evaluated based on the six ASAM assessment dimensions. The type and level of service also may depend on other diagnoses, both physical and emotional/behavioral, as well as psychosocial variables, stressors and conditions. The field of addiction treatment, of necessity, recognizes the totality of the individual in his/her life situation.

Exceptions to the Patient Placement Criteria

In making treatment placement decisions, three important factors override the patient-treatment match with regard to levels of service:

1. Lack of availability of appropriate, criteria-selected care

2. Failure of a patient to progress at any given level of carte, so as to warrant a reassessment of the treatment plan with a view to modification of the treatment approach. Such situations may require transfer to a specialized program at the same level of service or to a different, more intensive or less intensive level of service to achieve, a better therapeutic response

3. State laws regulating the practice of medicine or licensure of a facility requiring criteria different from these dimensions

A Twelve-Step Program

A twelve-step program is a self-help group whose members attempt recovery from various addictions and compulsions through the use of a plan referred to as the "twelve steps".

Characteristics

All twelve-step programs follow some version of the twelve steps. They meet regularly to discuss their problems and share their victories.

One of the most widely recognized characteristics of twelve-step groups is the requirement that members admit that they "have a problem". In this spirit, many members open their address to the group along the lines of, "Hi, I'm David, and I'm an alcoholic" -- a catchphrase now widely identified with support groups.

Visitors to group meetings share their experiences, challenge successes and failures, and provide peer support for each other. Many people who have joined these groups report they found success that previously eluded them, while others -- including some ex-members -- criticize their efficacy or universal applicability.

The twelve steps

The twelve steps for Alcoholics Anonymous are as follows.

1. **We admitted that we were powerless over alcohol -- that our lives had become unmanageable.**
2. **We came to believe that a Power greater than ourselves could restore us to sanity.**
3. **Made a decision to turn our will and our lives over to the care of God *as we understood Him*.**
4. **Made a searching and fearless moral inventory of ourselves.**
5. **Admitted to God, to ourselves and to another human being the exact nature of our wrongs.**
6. **Were entirely ready to have God remove all these defects of character.**
7. **Humbly asked Him to remove our shortcomings.**
8. **Made a list of all persons we had harmed, and become willing to make amends to them all.**
9. **Made direct amends to such people wherever possible, except when to do so would injure them or others.**

10. **Continued to take personal inventory and when we were wrong promptly admitted it.**
11. **Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.**
12. **Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all of our affairs.**

(Source: Alcoholic's Anonymous (*http://www.alcoholics-anonymous.org/default/en_about_aa_sub.cfm?subpageid=76&pageid=12*))

Other twelve-step groups have modified these steps slightly to refer to problems other than alcoholism.

History

The first such program was Alcoholics Anonymous (AA), which was begun in 1935 by Bill Wilson and Dr. Bob Smith. He established the tradition within the "Anonymous" 12-step programs of using only his first name. The 12 Steps were originally written by Wilson and other early members of AA to codify the process that they felt had worked for them personally. This "codex" is the book "Alcoholics Anonymous", often referred to as the "Big Book".

The twelve steps were eventually matched with twelve traditions a set of guidelines for running individual groups and a sort of constitution for the program (eg, AA) as a whole.

Many other programs since have adapted AA's original steps to their own ends. Related programs exist to help family and friends of those with addictions. These programs also follow modified versions of the 12 Steps of Alcoholics Anonymous.

One organization, which is often confused with an "Anonymous" 12-step program, due to the intentional similarity of its name -- but is *not* one -- is Narconon. Narconon is a branch of the Church of Scientology, presenting Scientology doctrine and practices as a therapy for drug abusers. Narconon does not use the 12 steps, and is not related to Narcotics Anonymous.

Relation to religion

A primary belief of members is that their success is based on giving up on self-reliance and willpower, and instead relying on God, or a "Higher Power". Critics of these programs, however, often hold that this reliance is ineffective, and offensive or inapplicable to atheists and others who do not believe in a salvific deity. Proponents of 12-step programs argue that many atheists have been helped by the program.

The role of religion in 12-step groups is an argument of significance in some parts of the United States, where the criminal justice system has held out group participation to inmate addicts as a condition of parole or shortened sentences. Governments in the U.S. are disallowed under the First Amendment from granting privilege to religious belief. Thus, if 12-step groups are religious (which a facial reading of the 12 steps makes plain) then this condition is unconstitutional. Members of 12-step groups commonly attempt to finesse this conflict by making the semantic distinction that they are "spiritual, but not religious."

Some critics — again, particularly atheists and humanists — also question directly the idea of giving up on self-reliance, which can be seen as a form of idealized despair. Secular alternatives to 12-step programs, such as Rational Recovery, are for this reason in many ways opposite to the 12-step process. Others, such as YES Recovery, acknowledge a debt to the 12 Steps movement but do not have a culture of belief in God.

As with the Bible and other similar texts, there are many different ways of interpreting the intent behind 12-step programs. And as with the Bible, there are those who argue strongly for a relatively literal adherence to program literature (often referred to as "Big Book Thumpers"), and then there are those who take the big book admonition to "take what you like and leave the rest" very seriously and advocate a much more liberal approach, which also leaves much room for personal interpretations of 12-step literature. Two books that look at the 12-step literature from a more liberal point of view are *The Zen of Recovery* by Mel Ash and *A Skeptic's Guide To The Twelve Steps* by Z. Phillips.

ACTIVITY

Activity

Ridgeview Treatment

TIME: 15 Minutes

PURPOSE: To provide an example of a treatment program

INSTRUCTIONAL METHOD: CD Presentation
Large Group Discussion

INSTRUCTIONS:

1. Refer to the *Ridgeview Treatment* Discussion Points below
2. Prepare to share responses with large group

Discussion Points:

1. How dealing with denial is the starting point for treatment.

2. The effectiveness of group therapy/intervention in this stage of treatment.

3. How can the self-awareness that is part of treatment create new problems for recovery**?**

ACTIVITY

Activity

Unique Intervention Program for Mothers Who Are Addicted

TIME: 15 Minutes

PURPOSE: To provide an example of an effective treatment program designed especially for women

INSTRUCTIONAL METHOD: CD Clip
Large Group Discussion

INSTRUCTIONS:

1. Refer to the *Unique Intervention* Discussion Points below
2. Prepare to share responses with large group

Discussion Points:

1. The importance of peer support for change

2. How the group practices the principle of non-judgment

3. The importance of groups in change

“NEW LIFE" ACCEPTANCE PROGRAM
13 Affirmations

1. I have a life-threatening problem that once had me.

I now take charge of my life. I accept the responsibility.

2. Negative thoughts destroy only myself.

My first conscious act must be to remove negativity from my life.

3. Happiness is a habit I will develop.

Happiness is created, not waited for.

4. Problems bother me only to the degree I permit them to.

I now better understand my problems and do not permit problems to overwhelm me.

5. I am what I think.

I am a capable, competent, caring, compassionate woman.

6. Life can be ordinary or it can be great.

Greatness is mine by a conscious effort.

7. Love can change the course of my world.

Caring becomes all important.

8. The fundamental object of life is emotional and spiritual growth.

Daily I put my life into a proper order, knowing which are the priorities.

9. The past is gone forever.

No longer will I be victimized by the past, I am a new person.

10. All love given returns.

I will learn to know that others love me.

11. Enthusiasm is my daily exercise.

I treasure all moments of my new life.

12. I am a competent woman and have much to give life.

This is what I am and I shall know it always.

13. I am responsible for myself and for my actions.

I am in charge of my mind, my thoughts, and my life.

To make the Program effective for you, arise each morning fifteen minutes earlier than usual and go over the Thirteen Affirmations. Then begin to think about each one by itself. Take one Statement and use it consciously all day. At the end of the day review the use of it and what effects it had that day for you and your actions.

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ACTIVITY

Activity

T.J.

TIME: 30 Minutes

PURPOSE: To show participants how a family dealing with drug abuse gets involved in treatment and what effects the use has on the family.

INSTRUCTIONAL METHOD: CD Presentation
Individual reflection
Large Group Discussion

MATERIALS:
Participant Guide
T. J. Worksheet

INSTRUCTIONS:

1. Watch the CD Clip
2. Answer questions on *T.J* Worksheet
3. Be prepared to discuss in large group

T.J. Worksheet

1. What type of treatment is this family involved?

2. How is this family responding to treatment?

3. What is the psychological impact on T.J.?

4. If you were a case manager working on a case like this, what would be the challenges you would face in meeting ASFA timeframes?

NOTES

MODULE EIGHT
Moving the Family towards Change

PURPOSE: To teach engagement skills in working with families with chemical dependence to facilitate change.

LEARNING OBJECTIVES:

- Increase the probability for change through demonstrating the five principles of Motivational Interviewing and how they relate to DFCS case management intervention.
- Use positive reframing skills in their engagement of families
- Use joining skills in engaging family members

"Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are, it turns out, many ways to help people move toward such recognition and action.

Miller, 1995

MOTIVATIONAL INTERVIEWING: A COUNSELING STYLE BASED ON ASSUMPTIONS

1. Ambivalence about substance abuse (and change) is normal and constitutes an important motivational obstacle in recovery.

2. Ambivalence can be resolved by working with individual's intrinsic motivations and values.

3. The alliance between the case manager and the individual is a collaborative partnership to which you each bring important expertise.

4. An empathic, supportive, yet directive, interviewing style provides conditions under which change can occur. (Direct argument and aggressive confrontation may tend to increase the individual's defensiveness and reduce the likelihood of behavioral change.)

AMBIVALENCE
Stage-Specific Motivational Conflicts

Stage of Change	Client Conflict
Precontemplation	I don't see how my cocaine use warrants concern, but I hope that by agreeing to talk about it, my wife will feel reassured.
Contemplation	I can picture how quitting heroin would improve my self-esteem, but I can't imagine never shooting up again.
Preparation	I'm feeling good about setting a quit date, but I'm wondering if I have the courage to follow through.
Action	Staying clean for the last 3 weeks really makes me feel good, but part of me wants to celebrate by getting loaded.
Maintenance	These recent months of abstinence have made me feel that I'm progressing toward recovery, but I'm still wondering whether abstinence is really necessary.

FIVE GENERAL PRINCIPLES OF MOTIVATIONAL INTERVIEWING

Principle	Points to Remember
Express Empathy	
Develop Discrepancy	
Avoid Arguments	
Roll With Resistance	
Support Self-efficacy	

REFLECTIVE LISTENING SCRIPT

Client: I worry sometimes that I may be drinking too much for my own good.

Therapist: You've been drinking quite a bit.

Client: I really don't *feel* like it's that much. I can drink quite a lot and not feel it.

Therapist: More than most people.

Client: Yes. I can drink most people under the table.

Therapist: And that is what worries you.

Client: Well, that, and how I feel. The next morning I'm usually in bad shape. I feel jittery and I can't think straight through most of the morning.

Therapist: And that doesn't seem right to you.

Client: No, I guess not. I haven't thought about it that much, but I don't think it's good to be hung over all the time. And sometimes I have trouble remembering things.

Therapist: Things that happen while you are drinking.

Client: That, too. Sometimes I just have a blank for a few hours.

Therapist: But that isn't what you meant when you said you had trouble remembering things.

Client: No. Even when I'm not drinking, it seems like I'm forgetting things more often and I'm not thinking clearly.

Therapist: And you wonder if it has something to do with your drinking.

Reflective Listening Script (continued)

Client: I don't know what else it could be.

Therapist: You haven't always been like that.

Client: No! It's only the last few years. Maybe I'm just getting older.

Therapist: It might just be what happens to everyone when they reach your age.

Client: No, it's probably my drinking. I don't sleep very well either.

Therapist: So maybe you're damaging your health and your sleep and your brain by drinking as much as you do.

Client: Mind you, I'm not a drunk. Never was.

Therapist: You're not that bad off. Still, you're worried.

Client: I don't know about "worried," but I guess I'm thinking about it.

Therapist: And wondering if you should do something, so that's why you came here.

Client: I guess so.

Therapist: You're not sure.

Client: I'm not sure what I want to do about it.

Therapist: So, if I understand you so far, you think that you've been drinking too much and you've been damaging your health, but you're not sure you want to change that.

Client: Doesn't make much sense, does it?

Therapist: I can see how you might feel confused at this point.

Examples of Non-Empathic Responses

1. *Ordering or directing.* Direction is given with a voice of authority. The speaker may be in a position of power. (e.g., parent, employer) or the words may be simply phrased and spoken in an authoritarian manner.
2. *Warning or threatening.* These messages are similar to ordering but they carry an overt or covert threat of impending negative consequences if the advice or direction is not followed. The threat may be one the case manager will carry out or simply a prediction of negative outcome if the individual doesn't comply- "if you don't listen to me, you'll be sorry."
3. *Giving advice, making suggestions, or providing solutions prematurely or when unsolicited.* The message recommends a course of action based on the case manager's knowledge and personal experience. These recommendations often begin with phrases such as, "What I would do is…"
4. *Persuading with logic, arguing, or lecturing.* The underlying assumption of these messages is that the individual has not reasoned through the problem adequately and needs help to do so.
5. *Moralizing, preaching, or telling the individual their duty.* These statements contain such words as "should" or "ought" to convey moral instructions.
6. *Judging, criticizing, disagreeing, or blaming.* These messages imply that something is wrong with the individual or with what the individual has said. Even simple disagreement may be interpreted as critical.
7. *Agreeing, approving, or praising.* Surprisingly, praise or approval can also be an obstacle if the message sanctions or implies agreement with whatever the individual has said. Unsolicited approval can interrupt the communication process and can imply an uneven relationship between the speaker and the listener. Reflective listening does not require agreement.
8. *Shaming, ridiculing, labeling, or name*-calling. These messages express overt disapproval and intent to correct a specific behavior or attitude.
9. *Interpreting or analyzing.* Case managers are frequently and easily tempted to impose their own interpretations on an

individual's statement and to find some hidden, analytical meaning. Interpretive statements might imply that the case manager knows what the individual's *real* problem is.

10. *Reassuring, sympathizing, or consoling.* Case managers may want to make the individual feel better by offering consolation. Such reassurance can interrupt the flow of communication and interfere with careful listening.
11. *Questioning or probing.* Case managers may mistake questioning for good listening. Although the case manager may ask questions to learn more about the individual, the underlying message is that the case manager might find the right answer to all of the individual's problems if enough questions are asked. In fact, intensive questioning can interfere with the spontaneous flow of communication and divert it in directions of interest to the case manager rather than the individual.
12. *Withdrawing, distracting, humoring, or changing the subject.* Although humor may represent an attempt to take the individual's mind off emotional subjects or threatening problems, it can also be a distraction that diverts communication and implies that the individual's statements are unimportant.

OTHER: Ethnic and cultural differences must be considered when expressing empathy because they influence how both you and your individual interpret verbal and nonverbal communications.

Source: Motivational Interviewing, William Miller & Stephen Rollnick, 1991, pages 75-76.

TECHNIQUES USEFUL IN DEVELOPING DISCREPENCY

Motivation for change is enhanced when individual perceives discrepancies between their current situation and their hopes for the future.

1. Help focus the individual's attention on how current behavior differs from ideal or desired behavior by raising the individual's awareness of the negative personal, familial, or community consequences. Carefully chosen and strategic reflecting can underscore incongruities.
2. Separate the behavior from the person and help the individual explore how important personal goals (e.g., children's well being, good health, marital happiness, and financial success) are being undermined by current substance use patterns. This requires you to listen carefully to the individual's statements about values and connections to the community, family, and church. Highlight any concern expressed by the individual to heighten his perception and acknowledgement of the discrepancy.
3. Amplify and focus on discordance with significant personal values until the individual can articulate consistent concern and commitment to change.
4. Try the "Columbo approach" which is particularly useful for an individual who prefers to be in control. Play the role of a detective who is trying to solve a mystery but is having a difficult time because the clues don't add up.

   Example: "Hmm. Help me figure this out. You've told me that keeping custody of your daughter and being a good parent are the most important things to you now. How does your heroin use fit in with that?"

   The case manager expresses confusion, which allows the individual to take over and explain how these conflicting desires fit together.

5. Tools other than talking can be used to reveal discrepancy. For example, show a video and then discuss it with the individual, allowing him to make the connection to his own situation.

WAYS TO REACT APPROPRIATELY TO INDIVIDUAL RESISTANCE

How do you avoid arguing and, instead, adapt to resistance? Miller and colleagues have identified and provided examples of at least seven ways to react appropriately to resistance (Miller and Rollnick, 1991, Miller et al., 1992). These are described below.

1. Simple Reflection

The simplest approach to responding to resistance is with non-resistance, by repeating the individual's statement in a neutral form. This acknowledges and validates what he has said and can elicit an opposite response.

Client: I don't plan to quit drinking any time soon.
CM: You don't think that abstinence would work for you right now.

2. Amplified Reaction

Another strategy is to reflect the individual's statement in an exaggerated form-to state it in a more extreme way but without sarcasm. This can move him toward positive change rather than resistance.

Client: I don't know why my wife is worried about this. I don't drink any more than any of my friends.
CM: So your wife is worrying needlessly.

3. Double-sided reflection

A third strategy entails acknowledging what the individual has said but then also stating contrary things she has said in the past. This requires the use of information that has been offered previously.

Client: I know you want me to give up drinking completely, but I'm not going to do that!
CM: You can see that there are some real problems here, but you're not willing to think about quitting altogether.

4. Shifting Focus

You can defuse resistance by helping the individual shift focus away from obstacles and barriers. This method offers an opportunity to affirm his personal choice regarding the conflict of his own life.

Client: I can't stop smoking refer when all my friends are doing it.
CM: You're way ahead of me. We're still exploring your concerns about whether your children will be able to stay with you.

5. Agreement with a twist

A subtle strategy is to agree with the individual, but with a slight twist or change of direction that propels the discussion forward.

Client: Why are you and my wife so stuck on my drinking? What about all *her* problems? You'd drink too if your family were nagging you all the time.
CM: You've got a good point there, and that's important. There is a bigger picture here, and maybe I haven't been paying enough attention to that. It's not as simple as one person's drinking. I agree with you that we shouldn't be trying to place the blame here. Drinking problems like these do involve the whole family.

6. Reframing

A good strategy to use when an individual denies personal problems is reframing-offering a new and positive interpretation of negative information provided by her.

Client: My husband is always nagging me about my drinking-always calling me an alcoholic. It really bugs me.
CM: It sounds like he really cares about you and is concerned, although he expresses it in a way that makes you angry. Maybe we can help him learn how to tell you he loves you and is worried about you in a more positive and acceptable way.

7. Siding with the negative

In this strategy, you take up the negative voice in the discussion. Typically, siding with the negative is stating what the individual has already said while arguing against change, perhaps as an amplified reflection. If he is ambivalent, your taking the negative side of the

argument evokes a “Yes, but…” from the client, who then expresses the other (positive) side. Be cautious, however in using this too early in your relationship or with people who appear depressed.

Client: Well, I know some people think I drink too much, and I may be damaging my liver, but I still don’t believe I’m an alcoholic or in need of treatment.
CM: We’ve spent considerable time now going over your positive feelings and concerns about your drinking, but you still don’t think you are ready or want to change your drinking patterns. Maybe changing would be too difficult for you, especially if you want to stay the same. Anyway, I’m not sure you believe you could change even if you wanted to.

TECHNIQUES OF POSITIVE REFRAMING

Positive reframing can be used during family interviews, with children, in groups, with separate family members, during phone calls or with other colleagues. You as a worker can also positively reframe your own behavior. In other words, the worker can describe his or her behavior to families in ways that will be less threatening to them.

Positive reframing can be used as a springboard to switch the member or family to a more productive topic

> A client says, "My husband won't listen to me when I try to talk to him about his marijuana use."
>
> Worker's positive reframe: "It's clear that you want him to understand how you feel about this. What have you tried and how did it work?"

Reframe one person's statement through another person.

> A mother says, "My husband doesn't agree with me about our daughter's drug problem."
>
> The worker says to the husband, "It's obviously important to your wife that you two are together on this."

Reframe the interaction between two or more people.

> We are always arguing about how to address our child's drug use.
>
> The worker can positively reframe an argument between two people: "You are trying very hard to communicate with each other about this."

The worker can reframe behaviors and body language instead of words.

> In an interview, the worker could say to a silent, non-participating family member, “You have found a way to keep yourself more comfortable by not talking about substance abuse and how it impacts your family.”

ASK: What do you think of these techniques?

Possible Responses:

- You are more likely to engage the family buy keeping the focus positive,
- The techniques demonstrate respect and empathy yet get to the heart of the matter.

ACTIVITY

Activity

Practicing Positive Reframing

TIME: 15 Minutes

PURPOSE: To practice developing positive reframes.

INSTRUCTIONAL METHOD: Small Group Activity

MATERIALS:

Participant's Guide:

Practicing Positive Reframing Worksheet

INSTRUCTIONS:

1. Break into your small groups
2. Select a recorder/reporter
3. Discuss the statements listed on the *Practicing Positive Reframing w*orksheet made by family members
4. Develop positive reframes for each one
5. Reporter will share his/her group's reframed statements with the large group.

PRACTICING POSITIVE REFRAMING
Worksheet

Instructions: In your small groups, discuss the following statements made by family members and develop positive reframes for them. Keep in mind the definition of positive reframing and the difference between reframing and simple reflection or interpretation.

1. I don't understand why people keep forcing me to do things. They need to leave me alone.

2. You don't believe me. Why should I talk to you?

3. Coming to these meetings is a waste of time.

4. My father is always checking up on me like I'm a criminal.

5. You people don't know what you're doing!

GUIDELINES FOR JOINING WITH FAMILIES WITH CHEMICAL DEPENDENCE

- At the first mention of AOD abuse, listen but do not pursue.
- Use positive reframing where possible.
- Make the parent(s) the expert on their children.
- Discover what the parent(s) want or need for their family.
- Do not mention legal leverage.
- Listen more than talk.
- Point out strengths and successes.
- Find something you like about the children. Compliment the parents.
- Learn about the extended family and social network.

HOW DO WE JOIN?

HOW TO JOIN WITH FAMILIES:

1. Take some time to be human rather than being all business with families. Taking a few minutes to discuss sports, for example, can alter the family's seeing you as an intrusive authority figure.

2. Respect the parental hierarchy and talk with the parents as the experts on their children, in spite of what has happened in the family.

3. Meet with the family as a whole as much as possible, even though it may be easier to arrange to meet family members separately. If you have a sound reason for meeting separately with one family member or part of the family, let the other family members know why you are not meeting with them. A brief phone call can prevent family members from becoming resistant because they feel they are being "ganged up on." Always do this unless agency protocol clearly directs you to approach one family member separately, as in a child protective services investigation.

4. Recognize and support individual and family strengths.

5. Accommodate to the family's values and lifestyle. Be alert not to force your own values and lifestyle on families from other ethnic cultures, socioeconomic levels, etc.

6. Show consistent respect through attending to details, such as scheduling meetings at convenient times and places for the family, following through on commitments, returning phone calls promptly, and providing concrete services such as day care, food stamps, housing and medical care.

7. Use interpersonal helping skills effectively.

HOW DO WE JOIN?

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OBSTACLES TO JOINING:

1. The family initially will see you as an outsider, forcibly entering into their lives and demanding change.

2. If you do not work to join with the entire family, those family members you neglect will be likely to undermine your efforts to bring about change.

3. An attitude of professional remoteness and authority will undermine joining. You will not be able to join and thereby bring about change unless you are willing to make a personal and human connection with the pain the family is experiencing.

ACTIVITY

Activity

Practicing the Practice Principal
Of Being Non-Judgmental

TIME: 10 Minutes

Purpose: To identify judgmental statements and practice turning them into more positive statements.

INSTRUCTIONAL METHODS: Individual Reading
Individual Exercise
Large Group Discussion

MATERIALS:

Participant's Guide:

Practicing the Practice Principle of Being Non-Judgemental

INSTRUCTIONS:

1. Read "*Practicing the Practice Principal of Being Non-Judgmental"* and look at each statement as if it were made by you about your client.
2. Rewrite the statement in a more positive and non-judgmental manner.
3. Share alternative, nonjudgmental ways to convey the message with the large group.

PRACTICING THE PRINCIPLE OF BEING NON-JUDGEMENTAL

Activity Statements

Statement #1: If they really loved their children, they'd stop using.

_____

_____

Statement #2: You promised me you weren't going to drink again- why did you do it?

_____

_____

Statement #3: He's just a crack head (or "dope head" or "pothead").

_____

_____

ACTIVITY

Activity **Interviewing for Change**

TIME: 15 Minutes

PURPOSE: This activity allows you to apply skills and underpinning knowledge introduced in *Core* in addition to practice using the general principles of Motivational interviewing.

INSTRUCTIONAL METHOD:

Small Groups Discussion

MATERIALS:

Participant's Guide:

- *Case Scenario*
- *Observation Worksheet*

INSTRUCTIONS:

- Divide into groups of 3.
- Work within your small group. Decide who will be the case manager, client and observer.
- Read the case information on the French case.
- Case managers; review the Five General Principles of Motivational Interviewing.
- Observers review the Five General Principles of Motivational Interviewing, Examples of Non-Empathic Responses, Techniques useful in Developing Discrepancy, Ways to react appropriately to individual resistance, Techniques for Positive Reframing, Guidelines for Joining with Families with Chemical Dependence and How we join.
- Complete the Observation Worksheet for the case managers interviewing strategies. Record statements made by the Interviewer that demonstrates the Principle. Do not interrupt. At the end of the interview, provide feed-back to the case manager.
- Be prepared to discuss observations in large group.

Scenario: Donna French

Referral Information:

Madeline French was born on Christmas day 2004. She weighed 3.1 lbs. at birth and had a stomach infection. Upon further investigation, it was found that her mother, Donna French (26) had no place to live, and no means of support. She admitted that she was receiving physical therapy for a chronic leg injury and was taking prescription medications. She could not remember the name of the physician who prescribed the medicine. She would sign Releases of Information Forms "as soon as she remembered." When Ms. French began to look through purse to find the doctor's name, it was observed that she had several medicine bottles. The investigator requested Ms. French show her the medicine bottles. While the bottles were empty, they had been filled at two different pharmacies and had a different doctor's name on each prescription even though they were for the same medication.

Ms. French had also been in foster care between the ages of 12-18 years old and exhibited a variety of disturbing behaviors that were not resolved.

While in the hospital Ms. French's former foster parents Hank and Purdie Dinet were contacted. They were no longer DFCS foster parents but agreed that Donna and Madeline could stay with them temporarily.

✓ Observation Worksheet

Principle #1: Express Empathy: Demonstrated Reflective Listening **Example observed:**
Principle #2: Develop discrepancy between present behavior and important goals **Example observed:**
Principle #3: Avoid Argumentation **Example observed:**
Principle #4: Roll with Resistance: Reframing **Example observed:**
Principle #5: Support Self-Efficacy **Example observed:**

NOTES

MODULE NINE
CONCLUSION

PURPOSE: To summarize information presented in the training and to complete the post-course activities.

LEARNING OBJECTIVE: To demonstrate understanding of key concepts presented during the three day training.

WORKING WITH FAMILIES: A SUBSTANCE ABUSE CURRICULUM

Review Worksheet

1. What new facts did you learn about substance abuse in our discussion of facts and figures about Georgia?

2. What are some street names for Meth?

3. What can you remember that indicates that addiction is a brain disease?

4. When does recovery begin?

5. What types of triggers might lead to relapse?

6. What do you recall about looking at substance abuse in terms of being a family disease?

7. What are the three traditional treatment approaches?

8. What are the five general principles of motivational interviewing?

9. Name one way to effectively engage a family.

10. What is one thing that is important to remember when developing a family plan with a family that has a substance abuse problem?

ACTIVITY

Activity

Examining Participants'
Thoughts on Substance Abuse

TIME: 20 Minutes

PURPOSE: To give participants an opportunity to examine and express their thoughts, feelings, and opinions of substance abusers to see if there are any change in their perceptions about this topic since the beginning of the training.

INSTRUCTIONAL METHOD: Large Group Discussion

INSTRUCTION:

1. Take 2-3 minutes to quickly record the words (one word responses or short phrases) that come to mind when they think about substance abusers.
2. Share your responses as directed by the trainer.

NOTES