Methamphetamine Addiction, Treatment, and Outcomes: Implications for Child Welfare Workers

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1. Introduction

Methamphetamine is a highly addictive stimulant associated with serious health and psychiatric conditions, including heart damage and brain damage, impaired thinking and memory problems, aggression, violence, and psychotic behavior. Methamphetamine is also associated with the transmission of infectious diseases such as HIV/AIDS and hepatitis.

Child welfare workers are seeing growing numbers of children and families affected by the parent's use of methamphetamine. In order to make sound decisions for the benefit of children and families, child welfare workers need accurate information about methamphetamine, its effects on parents and their children, and the effectiveness of treatment. This paper presents the most current research in these areas, and offers recommendations for child welfare workers to help them identify and assist children and families affected by a parent's use of methamphetamine.

2. Patterns of Methamphetamine Use

In 2004, an estimated 1.4 million persons (0.6 percent aged 12 or older) had used methamphetamine in the past year, 583,000 (0.2 percent) had used in the past month, and an estimated 318,000 used methamphetamine for the first time in the past year.[1] Between 2002 and 2004, the number of methamphetamine users and the number of new methamphetamine users remained relatively stable. During the same 2002 to 2004 time period, the number of past month methamphetamine users who met the Diagnostic and Statistical Manual (DSM IV) criteria for substance abuse or dependence in the past year increased from an estimated 164,000 (27.5 percent of past month methamphetamine users) in 2002 to 346,000 (59.3 percent) in 2004.[2]

To provide a perspective on methamphetamine use, it is helpful to compare methamphetamine users with the users of cocaine, another stimulant that has been a child welfare issue for the past two decades. Compared with cocaine users, methamphetamine users exhibit the following characteristics[3,4,5]:

- begin using substances at a younger age
- enter treatment at a younger age
- are more likely to use multiple drugs (especially marijuana)

- have a higher frequency of use
- are less likely to use alcohol
- report feeling less "addicted" than cocaine users
- are more likely to use methamphetamine continuously throughout the day at evenly spaced intervals and consistently over time, rather than concentrating use in the evening as cocaine users tend to do
- use fewer times per day than cocaine users (though the same amount of drug is used)
- spend less money to purchase the drug
- are more likely to be female and Caucasian

Of the total number of individuals admitted to treatment in 2003 for methamphetamine, 45% are women. This percentage of female admissions is higher than the percentage of female admissions associated with any other drugs except tranquilizers, sedatives and other opiates (i.e. non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects).[6] The implication is that more children are likely to be affected by a parent's use of methamphetamine since caretakers are often predominately female.

Compared with male methamphetamine users, female methamphetamine users[7,8]:

- use methamphetamine more days in a 30-day period
- smoke rather than snort or inject the drug
- are more likely to be single parents who live alone with their children
- have worse medical, psychiatric, and employment profiles

These statistics indicate a greater risk for the children of mothers who use methamphetamine. The parent is likely to use the drug more often and have greater difficulty providing adequate parenting and economic support for the child.

Methamphetamine users, like other drug users, are more likely than non-users to have experienced physical or sexual abuse as children. A recent study found that 33% of methamphetamine users had been sexually abused before the age of 15 and a similar percentage reported childhood physical abuse.[9]

There is a well-documented relationship between substance abuse and child abuse and neglect.[10,11,12,13] Those who have been abused or neglected as children are more likely to have substance use disorders as adults, and adults with substance use disorders are more likely to abuse or neglect their own children. The result is a multigenerational cycle of substance abuse and child abuse and neglect. For this reason, effective intervention by child welfare becomes crucial, and comprehensive, integrated services are needed to break the cycle of abuse and addiction.

3. Effects of Methamphetamine Addiction

To understand the physiological and psychological effects of methamphetamine use, it is helpful to review the effects of methamphetamine on the brain.

Methamphetamine appears to cause long-term structural damage to the regions of the brain that control memory and motor coordination. These effects may be related to the length of time that methamphetamine remains in the user's system.[14] Compared to cocaine and other drugs, methamphetamine remains active in the body much longer, and a greater percentage of the drug remains unchanged in the body.[15] Smoking cocaine produces a high that lasts 20-30 minutes, while smoking methamphetamine produces a high that lasts 8-24 hours. It takes one hour for 50% of a specified amount of cocaine to be removed from the body, while it takes twelve hours for 50% of the same amount of methamphetamine to be removed. For these reasons, methamphetamine remains in the brain longer, producing prolonged stimulant effects that may permanently damage blood vessels in the brain.[16] Methamphetamine use produces abnormal brain chemistry in all areas of the brain, and users with the greatest cumulative lifetime use have the strongest indications of cell damage.[17]

A significant effect of methamphetamine use is the loss of dopamine transporters in the brain.[18,19,20,21] Dopamine is a brain chemical that facilitates critical brain functions. Methamphetamine triggers the release of large amounts of dopamine in areas of the brain that regulate feelings of pleasure and body movement.[22] Dopamine transporters are structures on the neurons that clear dopamine from the space between neurons. Earlier studies speculated that the loss of dopamine transporters represented irreversible degeneration in the brain.[23] However, Volkow and colleagues[24] found that the number of dopamine transporters increased significantly after 12 and 17 months of abstinence. Their study also found that motor skills and memory did not improve at the same rate that dopamine transporters increased, within the 12- and 17-month periods of abstinence. However, in a study involving longer periods of abstinence, Lundahl and colleagues[25] found no deficits in motor function, memory, learning, attention, or executive function in methamphetamine users after four years of abstinence.

Methamphetamine use does cause brain damage, but protracted abstinence appears to reverse at least some of that damage. The degree of recovery is related to the length of time that the methamphetamine user remains abstinent.[26,27]

Cognitive Deficits

The observable effects of methamphetamine use include cognitive deficits, health problems, and psychological problems. The cognitive deficits are discussed below, and the health and psychological effects are discussed in the next section.

Studies have found that methamphetamine users exhibit cognitive impairment. Active methamphetamine users are impaired in their ability to learn, recall, make inferences, manipulate information, and ignore irrelevant information.[28] Some of these cognitive deficits, including deficits in the ability to manipulate information and ignore irrelevant information were no longer present after 12 weeks of abstinence. The abstinent methamphetamine user regained the ability to manipulate information and to ignore irrelevant information. Other deficits, such as the ability to recognize and recall word became worse in this initial phase of abstinence. The deficit in picture recognition also became worse, but to a lesser degree than did the deficit in word recognition and recall.[29]

Research also shows that exposure to stimulant drugs such as methamphetamine can impair the ability of specific brain cells to change as a result of experience. Thus, the ability to learn from experience may be diminished by the use of stimulant drugs.[30]

These cognitive impairments become significant when child welfare workers work with parents who are using methamphetamine or are in the first few months of abstinence. These parents may find it difficult to pay attention, to comprehend spoken or written information, and to retain information. Because the ability to recognize pictures is less impaired than the ability to recognize words, treatment providers have begun using visual cues, such as handouts with pictures when working with these clients.[31] Child welfare workers can use this strategy to provide information to parents in a way they can more easily comprehend and retain.

Health Effects and Psychological Effects

Methamphetamine use is associated with serious health problems, including cardiovascular problems and HIV risk behavior.[32,33] Side effects include rapid and irregular heartbeat, increased blood pressure, hyperthermia, convulsions, stroke, insomnia, restlessness, and tremors[34,35,36]. After prolonged use, methamphetamine users may exhibit nosebleeds, itching, skin welts and lesions, and infected injection sites.[37] They may also experience nausea, vomiting, and diarrhea. Weight loss and malnutrition are common, due to the decrease in appetite caused by the drug. Users may have significant dental problems, including gum disease and tooth loss, after long-term use.[38] Dental problems result from a combination of factors, including the reduction in saliva caused by methamphetamine, poor dental hygiene, and poor nutrition due to decreased appetite.

Methamphetamine use is also associated with a variety of psychological problems. Methamphetamine users appear to be more psychologically disturbed, to have more psychological problems, and to be more out of control than other substance abusers.[39] Chronic methamphetamine use can lead to psychotic behavior, including intense paranoia, confusion, visual and auditory hallucinations, and violent behavior.[40,41] Psychotic symptoms can sometimes persist for months or years after use has stopped.[42,43]

Individuals who stop using methamphetamine may experience depression and anxiety. In the 12 months following treatment, methamphetamine users were more likely to have psychiatric difficulties, legal difficulties, family problems, and dissatisfaction with their lives than other substance users.[44] Even at two to five years after treatment, the rate of headaches and depression reported by former methamphetamine users was similar to the rate they reported at admission to treatment.[45] A recent study of methamphetamine users found higher levels of glucose (indicating greater activity) in brain regions linked to anxiety and drug cravings, compared to the levels found in non-abusers.[46] It is unclear whether these findings are specific to methamphetamine addiction, or may apply to other stimulant users as well.

It is critical that child welfare workers recognize the implications of the health and psychological effects of methamphetamine use. These effects can seriously interfere with a parent's ability to comply with case plan requirements. Primary health care and mental health treatment may need to be included in the case plan, and parents may need continued support in accessing and receiving those services.

4. Effects of Parental Methamphetamine Use on Children

Situations in which children are affected by their parent's involvement in methamphetamine include:

- The parent uses or abuses methamphetamine (episodic use)
- The parent is chemically dependent on methamphetamine
- The mother uses methamphetamine while pregnant with the child
- The parent "cooks" small quantities of methamphetamine in the home
- The parent sells, transports, or distributes methamphetamine (traffickers)
- The parent manufactures large quantities of methamphetamine (superlabs)[47]

Each situation presents specific risks and dangers for the child and specific concerns for the child welfare worker. Each separate situation is discussed below.

Parents Who Use or Abuse Methamphetamine

In 2004, an estimated 418,000 (0.2 percent aged 18 or older) had used methamphetamine in the past month.[48] Given the number of adults who currently use methamphetamine, episodic parental use or abuse of methamphetamine is the most common means by which children are affected by parental methamphetamine use. This method of exposure accounts for the highest number of children exposed to methamphetamine, compared to the numbers found in the other categories.[49]

Parents under the influence of stimulants, including methamphetamine, pose a danger their children. When high, the parent may exhibit poor judgment, confusion, irritability, paranoia, and increased violence; they may fail to provide adequate supervision. The family and social environment may be poor, and the children may be at risk of abuse and neglect due to the family dynamics associated with substance use.[50]

In households where a family member smokes the substance, children may be exposed to secondhand methamphetamine smoke. They may accidentally ingest the substance if it is kept in the home.

Because methamphetamine users typically use other substances at the same time, including alcohol, tobacco, and other drugs, the risks to their children accumulate, and it becomes difficult to attribute a particular effect to a particular substance.

Parents with Methamphetamine Dependence

When the parent is dependent on methamphetamine, chronic neglect of the children becomes more likely, and the family and social environment is more likely to be inadequate. The children are exposed to the drug-affected parent more frequently and for longer periods of time. They may be found living in poor conditions, lacking food, water, gas, and electricity. They may lack medical care, dental care, and immunizations. These children are also at greater risk of abuse.[51]

Prenatal Exposure

Pregnant methamphetamine users appear to know less about the potential harm to themselves or the fetus, compared to users of crack cocaine or heroin.[52] Crack cocaine users were more likely than the other two groups to fear the negative effects of their drug

use on their fetus. Heroin-using women were concerned about the effects of their drug use, but primarily concerned with avoiding potential parental custody problems. Women in all three groups tended to avoid prenatal care clinics.[53]

Since the crack epidemic of the late 1980's, researchers have been aware that prenatal stimulant exposure has both direct and indirect effects.[54] The fetus is directly affected by the cocaine that enters its system, and it is indirectly affected by the decrease in the mother's blood flow that results from cocaine use. Many of the effects of prenatal exposure to methamphetamine have also been documented among infants exposed to other substances, particularly cocaine/crack.[55] Many studies of the effects of prenatal exposure however compare methamphetamine-exposed infants to non-exposed infants without also comparing them to cocaine-exposed or other stimulant-exposed infants, so it is not known whether the effects are associated with methamphetamine in particular or with all stimulants.

Stimulant-exposed children may also be affected by other substances used by the mother, and by environmental risk factors such as the mother's nutritional and health status. Recent surveys indicate that 12-14% of all pregnant women consume alcohol[56] and two-thirds of female smokers continue to smoke during pregnancy.[57] Among meth using pregnant women[58], nicotine use is nearly universal while marijuana and alcohol were secondary drugs used by 60% of the women. The cumulative effects of the use of multiple substances and other environmental risk factors have significant adverse effects on the newborn. These effects may be greater than the effects of stimulant use alone.[59] Prenatal substance exposure can cause birth defects, fetal death, growth retardation, premature birth, low birth weight, developmental disorders, difficulty sucking and swallowing, and hypersensitivity to touch after birth.[60,61,62]

Methamphetamine exposure during pregnancy can jeopardize the development of the fetal brain and other organs. An echoencephalographic study of neonates who were exposed prenatally to methamphetamine or cocaine indicated higher rates of bleeding, decay, and lesions in the brain.[63] A high dose of methamphetamine taken during pregnancy can cause a rapid rise in temperature and blood pressure in the brain of the fetus, which can lead to stroke or brain hemorrhage. Infants prenatally exposed to methamphetamine are significantly smaller for their gestational age compared with unexposed infants[64], and methamphetamine-exposed infants whose mothers also smoked tobacco had significantly decreased growth, compared with infants exposed to methamphetamine alone.[65]

Earlier studies of infants prenatally exposed to cocaine, methamphetamine, or both revealed no significant differences in perinatal variables among the three drug-exposed groups.[66] All three groups had altered neonatal behavioral patterns, characterized by abnormal sleep patterns, poor feeding, tremors, and hypertonia (excessive muscle tension). All three groups also had significantly higher rates of prematurity and intrauterine growth retardation, and had smaller head circumferences, compared to the drug-free comparison group.[67] Infants exposed prenatally to methamphetamine are more likely than other prenatally exposed infants to experience feeding problems due to difficulty in sucking and swallowing. Shah[68] found that 34.4% of methamphetamine exposed infants had feeding problems compared to 9.4% of infants prenatally exposed to cocaine. These difficulties suggest that infants prenatally exposed to methamphetamine may be at risk for failure to thrive issues.

Longer-term effects of prenatal methamphetamine exposure may be similar to other substances: long-term cognitive deficits, learning disabilities, and poor social adjustment in older children.[69,70] Over-stimulation and self-regulation difficulties have been observed with

cocaine-exposed children[71], and these effects may be seen in children exposed to other stimulants. A study showed alterations of brain chemistry in children that may be related to findings that some cocaine-exposed children are more impulsive and easily distracted than their non-exposed peers.[72] Additional research is needed to determine if the same effects are found in methamphetamine-exposed children. Shah[73] describes the symptoms of prenatal exposure to methamphetamine in children 18 months to 5 years include less focused attention, easily distracted, poor anger management, and aggressive outbursts.

For many years child welfare agencies have been working with mothers, their infants and the families affected by prenatal stimulant exposure and can draw on those experiences to create the programs and services needed to address the needs of families affected by prenatal methamphetamine exposure as well.

Home Labs

Some parents produce relatively small quantities of methamphetamine in their homes for their own use or small-scale distribution. Children in these homes are subject to the same risks noted in the sections on parents who use/abuse and are dependent on the drug, but they have additional risks associated with the substances used in the production of methamphetamine and the method of production. The children may be exposed to toxic chemicals, contaminated food, fumes released during the "cooking" process, and the danger of fire or explosion from the manufacturing process.

The risk of toxic exposure for children in homes where methamphetamine is manufactured is high. Children are more likely than adults to suffer health effects from exposure to chemicals. They have higher metabolic rates; their skeletal systems and nervous systems are developing; their skin is not as thick as an adult's skin, which means they absorb chemicals faster; and children tend to put things in their mouths and use touch to explore the world. Some fumes or gases are heavier than air, and will sink down to the child's level, increasing their exposure. Children also tend to imitate adult behavior and are vulnerable in chaotic and unsafe environments.[74] A review by Kolecki[75] revealed that pediatric patients with methamphetamine poisoning often exhibited rapid heartbeat, agitation, inconsolable crying, irritability, and vomiting.

The section on superlabs below includes signs of methamphetamine production and symptoms of methamphetamine exposure.

Trafficking

Parents who traffic in methamphetamine by selling, transporting, or distributing it, expose their children to an increased risk of violence and abuse associated with drug trafficking. There may be weapons in the home. The parent's associates or customers may carry weapons, putting the children at risk for violence. These children are also at increased risk of physical and sexual abuse by those who visit the home.[76,77,78,79]

Superlabs

Superlabs are methamphetamine laboratories where methamphetamine is produced on a large scale. Children are sometimes found in these superlabs, but they are less likely to be present in superlabs than in the homes where smaller quantities are produced. From 2000 to 2003, there were 7,513 known cases of children present at seized methamphetamine laboratory sites nationwide, with only 2,881 taken into protective custody.[80] During the same time frame, almost 1.2 million children were taken into protective custody for all

reasons.[81] The number of children removed from their parents due to methamphetamine lab involvement is an extremely small percentage of the total number of removals.

In 2001, the states reporting the highest number of children present at methamphetamine labs were California (503), Washington (326), Oregon (241), and Missouri (161). These figures are probably underreported, since many states do not keep records on children present at laboratory sites, nor do they medically evaluate the children for the presence of drugs or chemicals.

Children in methamphetamine labs are exposed to great risk. They are exposed to the chemicals used in the production of methamphetamine. They may be at increased risk for severe neglect, and may be physically or sexually abused by family members or others who frequent the lab.[82,83] They are exposed to the toxic effects of methamphetamine manufacturing such as fire explosions, toxic gas, and toxic waste. A child can also be harmed by consuming a chemical from a container or ingesting methamphetamine.[84]

Child welfare workers should be aware of the symptoms of methamphetamine exposure so that they can identify children affected by methamphetamine labs or their own exposure to toxic chemicals. Because of the creation of toxic waste at methamphetamine labs, many first response personnel incur injury when dealing with the hazardous substances.[85] Medical evaluation and treatment may be indicated if symptoms of illness develop following contact with methamphetamine lab chemicals or residual toxins. Symptoms[86] include:

- Chronic cough
- Chest pain or tightness
- Shortness of breath
- Dizziness
- Headache
- Skin and eye irritation
- Chemical burns
- Nausea
- Lethargy

In addition to the toxic effects, there are other signs that could signal the presence of a methamphetamine lab. These include:

- Unusual, strong odors (like cat urine, ether, ammonia, acetone, or other chemicals) coming from sheds, outbuildings or other structures, orchards, campsites, or vehicles
- Possession of unusual materials, such as large amounts of over-the-counter allergy/cold/diet medications (including ephedrine or pseudoephedrine), or large quantities of solvents (such as acetone, Coleman fuel, or toluene)
- Discarded items such as ephedrine bottles, coffee filters with oddly-colored stains, lithium batteries, antifreeze containers, lantern fuel cans, and propane tanks
- The mixing of unusual chemicals in house, garage, or barn, or the possession of chemical glassware by persons not involved in the chemical industry
- Heavy traffic during late hours
- Residences with operating fans in windows in cold weather or blacked out windows
- Renters who pay their landlords in cash.[87]

Through a grant funded by the Children's Bureau (DHHS), Crowell and Webber at the Illinois State University School of Social Work have created a training program for child welfare supervisors. This document provides information on signs of client methamphetamine use

and caseworker safety procedures. It can be found at: http://www.drugfreeinfo.org/PDFs/strengthensupervision.pdf.

The California Attorney General's Office Crime and Violence Prevention Center has created a synopsis of information about methamphetamine labs and how to respond. This is excellent information for child welfare workers who may be entering a house for the first time. This can be found at: http://www.safestate.org/shop/files/clanlab.pdf.

The considerations are complicated for child welfare workers dealing with a case where a methamphetamine lab is involved. Family reunification considerations must address the issues of child safety and well-being based on the child's potential exposure to toxic substances. Reunifying families where the home environment is literally toxic is problematic. Child welfare workers must also consider the possibility of methamphetamine use among potential relative caregivers.

5. Medical Interventions for Children

Drug Endangered Children (DEC) teams have been created in several counties across the nation to deal specifically with methamphetamine labs.[88] Each DEC team includes a specially trained public health nurse, a county physician, and a social worker, to ensure that children are properly documented and monitored to keep them away from the dangerous conditions of a methamphetamine lab. Children are examined several times during the 18 months following identification to ensure that they have not suffered ill effects from the chemicals found in methamphetamine labs. During a typical DEC response, a public health nurse examines the child at the scene to determine whether emergency health care is needed. If not, the child is scheduled for a doctor visit within 48 hours. Follow-up exams are set for 30 days, six months, a year, and 18 months later. The Office of National Drug Control Policy (ONDCP) provides medical protocols for children found at methamphetamine lab sites (See Appendix 1). These protocols are color coded to identify the agency responsible for each part of the protocol. This document includes:

- A field medical assessment protocol to determine whether children are in need of emergency medical care
- An immediate care protocol for those problems that cannot wait 24 hours to be treated at the baseline exam; immediate care should be provided as soon as possible after significant health problems are identified
- A baseline assessment protocol to ascertain a child's general health status
- An initial follow-up care protocol to reevaluate the comprehensive health status of the child, identify any latent symptoms, and ensure appropriate and timely follow-up of services as the child's care plan and placement are established
- A long-term follow-up care protocol to: 1) monitor physical, emotional, and developmental health; 2) identify possible late developing problems related to the methamphetamine environment; and, 3) provide appropriate intervention.

Dr. Rizwan Z. Shah, the Medical Director of the Child Abuse Program at Blank Children's Hospital in Des Moines, developed an "effective care plan for drug-exposed infants" (See Appendix 2). This treatment plan was developed in response to infants exposed to any stimulant and has been effective when used with methamphetamine-affected infants.

It is difficult to grasp the true extent of the methamphetamine problem that child welfare workers face. Child welfare systems generally do not indicate whether reports of child abuse are related to substance abuse in general or methamphetamine use in particular. Much of what we know about children living with methamphetamine-using parents comes through the criminal justice arena.[89]

Although DEC teams incorporate medical and child welfare responses, they do not typically include substance abuse treatment agencies in their operations. Perhaps DEC teams assume that the criminal justice system will motivate parents toward treatment and provide access to appropriate treatment programs. Unfortunately, many jurisdictions do not have the structures or linkages in place to effectively address the needs of the parent for treatment. Intervention for the parent and entry to treatment programs may be the appropriate response in many cases. Research has established the efficacy of treatment programs for methamphetamine users. DEC programs focus their energy and attention on the children. It is crucial to create linkages between substance abuse treatment providers, child welfare services, and the courts, particularly in those jurisdictions that are experiencing increased methamphetamine use, in order to achieve positive outcomes for children affected by their parent's methamphetamine use.

6. Treatment Options for Parents

There are various treatment options for methamphetamine users. These include inpatient hospitalization for severe cases of long-term methamphetamine dependence, and outpatient treatment with behavioral therapies such as cognitive behavioral therapy, contingency management, and the Matrix Model.[90] Contingency management reinforces the person for not using the drug by providing vouchers or other reinforcements. This method effectively reduces methamphetamine use during treatment.[91] Motivational interviewing and brief intervention models also hold promise for early intervention.[92] Anglin and colleagues[93] suggest that the optimum treatment for methamphetamine users is an intensive outpatient setting where the client receives comprehensive counseling three to five times per week for at least the first three months.

Between 1999 and 2001, the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, supported the largest randomized clinical trial of treatment for meth dependence based on the Matrix Treatment Model. The Matrix Model provides a structured outpatient treatment program that combines behavioral, educational, and 12-step counseling techniques; relapse prevention groups; social support groups; individual counseling; family and group sessions; and urine and breath testing.[94,95] Clients participate in the program three times a week for six months. The program is based on a cognitive-behavioral approach, and is designed in phases that decrease in intensity. The Matrix Model has been found to retain more than 50% of patients for a clinically meaningful treatment episode.[96] Evaluations of the Matrix Model have supported its usefulness and efficacy with methamphetamine users.[97,98,99] The Matrix Model is documented in a manual that allows providers to present the program in their own setting.

The findings from these treatment approaches indicate that treatment models for cocaine and other substance users are equally effective when used with methamphetamine users. The "best practices" developed for treatment of other substances of abuse can also be applied in the case of methamphetamine.

Treatment practices may require some modification for methamphetamine users. The cognitive deficits found in methamphetamine users, and the tendency for the deficits to worsen in the early phase of recovery, may need to be accommodated. Because the impairment of picture recognition is less severe than the impairment of word recognition, some treatment programs have relied on visual cues in providing information to clients. Methamphetamine users in recovery are more likely to understand and remember handouts that include pictures.[100]

Another issue that needs to be considered in methamphetamine treatment is the generally continual pattern of use. Understanding this pattern helps treatment providers and substance users identify the circumstances and triggers that may lead to relapse.[101]

There are no effective pharmacological treatments for methamphetamine dependence at the present time. Medication adjuncts to behavioral therapy are being researched.[102,103]

Recent research into the correlation between methamphetamine use and psychiatric disorders, particularly depression and anxiety, has highlighted the need for a mental health component in methamphetamine treatment. Treatment outcomes may improve if the client's mental health problems are addressed during treatment.[104,105,106]

A child welfare worker who encounters a parent in need of treatment for methamphetamine use should refer the parent to a treatment agency for a comprehensive assessment. The assessment should determine the level of care the person needs and the ancillary services they require, including mental health services, medical treatment, housing, parenting classes, etc. Once the parent has entered a treatment program, the child welfare worker may want to learn what services the parent is receiving in addition to treatment.

7. Treatment Outcomes

Research indicates that treatment outcomes for methamphetamine users are similar to those of other drug users, including cocaine users.[107,108] In the year following discharge from treatment, no differences in treatment outcomes, such as treatment readmission, arrests, convictions, and employment, have been found between methamphetamine users and users of other substances.[109] Methamphetamine users appear to respond to treatment in the same way cocaine users respond, and many continue to show improvements with increasing length of abstinence.[110] The treatment response to a multi-component outpatient program has been found to be very similar for users of all stimulant drugs, including methamphetamine.[111]

Relapse rates for methamphetamine users are similar to those for other drugs. A study of substance users who were treated in publicly-funded residential or outpatient treatment programs in Los Angeles County found a 50% relapse rate for methamphetamine users, with 36% of relapses occurring within six months of completing treatment and an additional 15% within seven to 19 months after treatment.[112] The California Drug and Alcohol Treatment Assessment (CALDATA) study, which included residential and outpatient treatment modalities, found that 60% of methamphetamine users had relapsed at 12 months, which was similar to users of heroin and cocaine concurrently and marijuana abusers, better than heroin abusers, and less successful than cocaine or crack users.[113] A third study, the Los Angeles Target Cities Treatment Enhancement Project (TCTEP), showed that 35% of outpatient methamphetamine users had relapsed at 12 months compared to 23% of other outpatient drug users, a nonsignificant difference in rates.[114] In examining

gender differences in treatment outcomes, recent study of former clients of a large publicly funded treatment system found no differences in relapse rates among male and female methamphetamine users.[115]

Treatment completion rates for methamphetamine users appear to be similar or somewhat lower to that of other drug users.[116] One study found that 23.3% of methamphetamine users completed treatment, a rate similar to that for users of other drugs throughout California.[117] Methamphetamine users experienced somewhat greater difficulty in completing their programs than users of other drugs, and were marginally more likely to leave treatment prior to its completion.[118] Several types of methamphetamine users were found to be significantly more likely to complete treatment: those who were over 40 years old, those who had less severe drug use patterns (did not use every day or did not inject), and those who were ordered into treatment by the criminal justice system.[119] Methamphetamine users who did not complete their treatment program either relapsed and did not return to the program or were asked to leave.[120]

The relapse rates and treatment retention rates of methamphetamine users may reflect the cognitive impairments and mental health issues such as depression and anxiety that may arise and persist during recovery. Women often cite "to help with depression," as one of the reasons that they initiate methamphetamine use. If these issues are addressed in a comprehensive treatment program, relapse and retention rates may improve.

Child welfare workers should be familiar with the treatment options available in their communities. Because a high percentage of those who enter treatment experience relapse, case plans need to include a contingency plan to cover the possibility of relapse. The case plan should specify an individual the child can stay with to remain safe.

8. Summary

As child welfare workers encounter children affected by their parents' use of methamphetamine, they need accurate information about the drug, its effects on parents, the potential dangers to children, the efficacy of treatment, and the possibility of recovery for the parent.

Methamphetamine is a dangerous drug that can lead to severe problems for users and puts their children at risk. However, research indicates that the physiological damage created by methamphetamine use is reversible with long-term abstinence. Research also shows that treatment models that work for addiction to other substances are also effective for methamphetamine addiction. Treatment outcomes for methamphetamine users appear to be similar to those for users of other drugs. Successful treatment for the parent may lead to family reunification and resultant benefit to both the child and the parent.

In dealing with the children of methamphetamine-using parents, child welfare workers must be alert to the immediate and long-term symptoms of exposure to the drug itself and the chemicals used in its manufacture. They must also be aware of the potential dangers to children in a methamphetamine manufacturing situation. They need to understand the danger they themselves face in visiting a location where methamphetamine may be produced. See Appendix 3 for additional resources related to methamphetamine prevention and treatment.

Child welfare workers must take into consideration the cognitive impairments that result from prolonged use. Residual impairments may be apparent for a year or more after

treatment begins. A parent who appears unwilling to meet case plan requirements may in fact be unable to meet the requirements without additional support.

The issue of prenatal exposure requires attention as well. Early intervention, effective treatment, and supportive follow-up are the keys to ensuring that a healthy baby is born to a healthy mother.

Methamphetamine-using parents may have needs beyond treatment for addiction, such as needs for mental health services, medical services, housing, and employment. Their children may have needs beyond safety from immediate harm. The most effective approach to the problem of methamphetamine-using parents and their at-risk children is a comprehensive integrated services strategy, where treatment includes a range of services that support the parent in leaving addiction behind and stepping into the role of a positive, successful parent.

Appendix 1

Medical Protocols for Children Found at Methamphetamine Labs

#1 FIELD MEDICAL ASSESSMENT PROTOCOL

The field medical assessment is done to determine whether children discovered at the scene of a methamphetamine laboratory discovery are in need of ***emergency medical care.*** Medically trained personnel (e .g. EMT or paramedic) must do the assessment. If no medical personnel are available on-site, the child must be seen at a medical facility. In either case, a medical assessment should be done for each child ***within* 2 *hours*** of discovering children at a methamphetamine lab site.

#1 STEPS (Items 1 and 2 are the responsibility of emergency medical personnel. Item 3 is the responsibility of HAZMAT/law enforcement/fire personnel. Item 4 is the responsibility of social services.)

1. For child with obvious injury or illness, call 911 or other emergency number
2. For all children who are not obviously critical, perform medical assessment consisting of:
   a. Vital signs (temperature, blood pressure, pulse, respirations)
   b. Pediatric Triangle of Assessment (Airway, Breathing, Circulation)
   c. For life-threatening findings, seek immediate medical attention (See Protocol #2). Transport to a facility capable of pediatric emergency response appropriate to findings.
3. A child's personal possessions should always be left at lab scene to avoid possible chemical/drug contamination in other settings. It is necessary to remove a child's clothing, decontaminate the chi ld in minimally traumatic manner (such as warm water) and provide clean and appropriate attire prior to removing them from scene (The child's clothing and belongings remain at the scene and are bagged as evidence.)
4. If there are no pressing clinical findings, short-term shelter or other secure placement should be implemented by child welfare personnel.

#2 IMMEDIATE CARE PROTOCOL

Problems requiring immediate care are those that cannot wait hours to be treated at the baseline exam (discussed in Protocol #3). Immediate care must be provided as soon as possible after significant health problems are identified. Care should preferably be provided ***within 2 hours, but not later than 4 hours*** after the child is identified at a lab site. Immediate care may be provided in a hospital emergency room, or pediatric or urgent care facility depending on the severity/urgency of the problem and the time of day. If a field medical assessment was not completed (Protocol #1), children should be taken to an immediate care facility within 2 hours for the medical assessment

#2 STEPS (Items 1 thru 4 are the responsibility of a physician. Numbers 5 thru 6 are the responsibility of social services.)

1. Perform the field medical assessment (follow Protocol #1 if not already done in the field).
2. Administer tests and procedures as indicated by clinical findings. A urine specimen for toxicology screening should be collected from each child within 12 hours of identification because some chemicals/drugs are eliminated in a short time. Use appropriate chain of evidence procedures and request urine screen and confirmatory test results to be reported at any detectable level.
3. Call Poison Control if clinically indicated (800-222-1222).
4. Follow baseline assessment (see Protocol #3) if appropriate to medical site and time permitting or schedule baseline assessment exam to be completed within 24 hours of lab discovery.
5. Secure the release of the child's medical records to all involved agencies to ensure ongoing continuity of care.
6. Child welfare personnel should evaluate placement options and implement short-term shelter for the child in which they will be closely observed for possible developing symptoms.

#3 BASELINE ASSESSMENT PROTOCOL

The baseline assessment exam needs to be done **within 24 hours** of a lab discovery to ascertain a child's general health status. Prompt medical assessment is warranted due to the risk of toxicologic, neurologic, respiratory, dermatologic, or other adverse affects of methamphetamine lab chemical and/or stimulant or other drug exposure, and the high risk of neglect/abuse.

#3 STEPS (Items 1 thru 9 are the responsibility of a physician. Numbers 10 and 11 are the responsibility of social services.)

1. Obtain child's medical history by calling parents directly for the information, or, if impossible, seek information from social workers who have taken the medical history or from the child's pas medical record.
2. Perform complete pediatric physical exam to include as as much of the Early Periodic Screening, Detection, and Treatment (EPSDT) exam as possible. Pay particular attention to:
   a. Neurologic screen
   b. Respiratory status
3. Call Poison Control if clinically indicated (800-222-1222)
4. Required Medical Evaluations
   a. Temperature (otic, rectal, or oral)
   b. Oxygen saturation levels
   c. Liver function tests: AST, ALT, Total Bilirubin and Alkaline Phosphatase.
   d. Kidney function tests BUN and Creatinine
   e. Electrolytes: Sodium, Potassium, Chloride, and Bicarbonate
   f. Complete Blood Count (CBC)
   g. Chest x-ray (AP and lateral)
   h. Urinalysis and urine dipstick for blood
      If not done earlier, a urine specimen should be collected. This should be done **within 12 hours** of identification of the child because some chemicals/drugs are eliminated in a short time. Urine screen and confirmatory results should be reported at ***any detectable level***.

   Optional Clinical Evaluations
   i. Complete metabolic panel (Chem 20 or equivalent)
   j. Pulmonary function tests
   k. CPK
   l. Lead level (on whole blood)
   m. Coagulation studies
   n. Carboxyhemoglobin level
5. Refer for local (county department of social services/law enforcement) child abuse and neglect evaluation.
6. Conduct a development screen. This is an initial age-appropriate screen, not a full-scale assessment, may need referral to a pediatric specialist.
7. Provide a mental health screen on all children and crisis intervention services as clinically indicated. These services require a qualified pediatrician or mental health professional and may require a visit to a separate facility.
8. Secure the release of child(ren)'s medical records to involved agencies including child welfare worker.
9. *Note. Child welfare personnel may not have immediate legal access to certain health care records Every effort should be made to facilitate transfer of medical/records, by providing information about where, when, and to whom records should be transferred.*
10. For any positive findings, follow-up with appropriate care as necessary. ALL children must be provided long-term follow-up care (see Protocol #5) using specified schedule.

11. Long-term shelter and placement options should be evaluated and implemented by child welfare worker.

#4 INITIAL FOLLOW-UP CARE PROTOCOL
A visit for initial follow-up care occurs **within 30 days** of the baseline assessment to reevaluate comprehensive health status of the child, identify any latent symptoms, and ensure appropriate and timely follow-up services as the child's care plan and placement established. If possible, the visit should be scheduled late in the 30-day time frame for more valid developmental and mental health status.

#4 STEPS (Items 1 thru 4 are the responsibility of physicians. Item 5 is the responsibility of social services.)
1. Follow-up of any abnormal baseline test results
2. Perform developmental examination (using instruments such as the Denver, Gesell, and Bayley) as indicated by the developmental screen in Protocol #3.
3. Conduct mental health history and evaluation (requires a qualified pediatric professional).
4. If abnormal findings on any of the above, schedule intervention and follow-up as appropriate to the findings; then proceed with long-term follow-up protocol (see Protocol #5). If no abnormal findings, schedule visits per long-term follow-up protocol (Protocol #5).
5. Adequacy of child's shelter/placement situation should be reviewed by child welfare worker and modified if necessary.

#5 LONG-TERM FOLLOW-UP CARE PROTOCOL
Long-term follow-up care is designed to 1) monitor physical, emotional, and developmental health, 2) identify possible late developing problems related to the methamphetamine environment, and 3) provide appropriate intervention. At minimum, **a pediatric visit is required 12 months** after the baseline assessment. Children considered to be Drug Endangered Children (DEC) cases should receive follow-up services a minimum of 18 months post identification.

#5 STEPS (Item 1 is the responsibility of social services. Items 1a thru 1d and item 2 are the responsibility of physicians. Items 3 and 4 are the responsibility of social services.)
Required Components of Follow-up Care
1. Pediatric Care Visits. The visits should occur according to the American Academy of Pediatrics' schedule.
   a. Follow-up of previously identified problems.
   b. Perform comprehensive (EPSDT) physical exam and laboratory examination with particular attention to:
      1) Liver function (repeat panel at first follow-up only unless abnormal)
      2) Respiratory function (history of respiratory problems, asthma, recurrent pneumonia, check for clear breath sounds).
      3) Neurologic evaluation.
   c. Perform full developmental screen
   d. Perform mental health evaluation (requires a qualified mental health professionals, pediatrician, licensed therapist, child psychologist or licensed child mental health professional)
2. Plan follow-up and treatment or adjust existing treatment for any medical problems identified. Medical records should continue to accompany the child's course of care.
3. Adequacy of child's shelter/placement situation should be reviewed by child welfare worker and modified as necessary.
4. Plan follow-up strategies for developmental, mental health or placement problems identified.

Optional Enhancements of Follow-up Care (responsibility of social services.)
1. Conduct pediatric care visits including developmental screen and mental health evaluation at 6, 12, and 18 months post-baseline assessment.
2. Conduct home visit by pediatrically trained PHN or other nurse at 3, 9, 15, and 18 months post-baseline assessment. Ensure that home visits occur between the pediatric clinic visits until the last visit at 18 months.

For further information contact:
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This protocol was modified slightly from the original DEC Protocol that was developed by the DEC Resource Center for the purpose of improving multi-agency response to children found in clandestine methamphetamine labs. The DEC Resource Center, The Children's Hospital and The Kempe Children's Center disclaim liability for outcomes from use of this protocol or misuse of the sequential steps herein.

IF YOUR COMMUNITY HAS ADDITIONAL SPECIFIC INSTRUCTIONS AND/OR LOCAL PHONE NUMBERS, AFFIX THE ATTACHED POUCH, INSERT INSTRUCTIONS AND PLACE IN THIS SPACE.

Color Code of Agency Responsibility:
HAZMAT/Law Enforcement/Fire
Emergency Medical Personnel
Social Services
Physicians

Appendix 2

Second Chance Kids

Providing Development Focused Care For Drug-Exposed Infants

By Rizwan Z. Shah, M.D., FAAP

It is generally assumed that pregnant women will provide a healthy environment for their unborn children and know how to avoid harmful consequences for the unborn. But this is not so when the compulsive need to remain high on addictive drugs of abuse, such as crack cocaine and other substances, supersedes the need to protect the welfare of unborn children.

Women who use drugs during pregnancy expose their unborn children to harmful effects of illicit drugs at the critical period of neurological development as well as physical growth. Scientific evidence regarding the impact of some drugs such as alcohol, heroine and crack cocaine are better understood than the impact of methamphetamine on infants exposed prenatally to these drugs.

During the 1980s epidemic of crack cocaine use, clinical observations documented a variety of possible abnormalities among infants of mothers who used crack cocaine during pregnancy. These initial observations paved the way for more concrete science-based research into the effect of crack cocaine on fetal development and the infant's outcome. Even though the earlier fears regarding possibility of "crack kids" leading a wasteful vegetative life have been allayed, concerns regarding subtle neurological problems are mounting as new technology helps researchers document brain function abnormalities with accuracy not possible in the 80s.

The ultimate goal of scientific research and service providers remains focused on providing the best possible options for drug-exposed infants to achieve better outcomes for developmental and academic functioning.

For pregnant women abusing cocaine or other drugs, early and regular prenatal care can provide protection against known complications of pregnancy such as premature birth, abruption of placenta, high blood pressure and fetal death. Both crack cocaine and methamphetamine are stimulants with the potential to cause blood vessel spasms resulting in compromising oxygen and blood supply to fetal brain and other organs vital for future functioning of the child. In fact, drug abuse at any stage of pregnancy can compromise infant outcome.

EFFECTIVE CARE PLAN FOR DRUG-EXPOSED INFANTS:

Treatment plans based upon systematic behavior observations of drug-exposed infants provide effective and developmentally appropriate intervention with successful outcome potential.

Age-related intervention plans can be organized in the following time spans of early life of drug-exposed infants:

1) 0–6 Months: Problem areas to focus on are:

Habituation Orientation: Soon after birth, infants need to develop skills to adjust stimulus input from their environment. For instance, infants learn to watch people's faces, react to light, darkness and sounds and learn to take interest in their surroundings. These skills are established in the central nervous system based upon maturity and infant-receptor sites. Drug-exposed infants demonstrate poor orientation and habituations in responding to

environmental stimuli. They either sleep too much or not enough, and they turn away from visual contact, disregarding objects in the surroundings.

Care Plan: By recognizing alert and passive cycles, the care giver can provide appropriate interactive input for necessary neuromotor development. Planning meal time for an infant who is born small for age and has poor suck coordination requires an organized approach to scheduled meal times, rather than waiting for the infant to ask for nourishment. Likewise, avoiding overstimulation for a child who is in down time is equally important.

Interaction Attachment: Providing opportunities for physical contact, visual regard and verbal interaction becomes an integral part of social development in early stages of life.

Response to Stress: A nonverbal child gives out many signals to indicate stress-generated anxiety. These symptoms range from changes in breathing, heart rate and temperature to stiffened arms and legs with obvious shaking; in the face of continued stress, the symptoms can escalate to inconsolable screaming and breath-holding with vomiting and turning blue.

To Minimize Stress: A care plan to deal with stress-related symptoms should include:

- Providing quiet, calm environment without noise or bright lights.
- Providing warmth and comfort by bundling the child in blankets.
- Encouraging habituation by providing sucking opportunity with pacifier.
- Initiating gentle rocking or soothing motions to help achieve neurobehavioral organization.

2) 6 Months–2 Years: Most drug-exposed children should achieve mastery of neurobehavioral organization by the end of 6 months. The age group 6 months to 18 months is typically called "honeymoon" period of development for drug-exposed infants where for all outside measures the child remains symptom-free. By the end of this period, speech and language development difficulties that require follow-up care can surface.

3) 3 Years of Age and Older: The potential for slight difficulty in focusing on tasks or in settling down in preschool years may get progressively worse with more demands on focused tasks in school years, and a child showing minor difficulty in controlling emotions may encounter significant social adjustment difficulties in later childhood. These problems get worse with high-risk social environment and unstable family units.

SUMMARY To summarize this complicated issue, a well-organized, developmentally oriented approach toward early recognition and intervention has the best chance to be a successful treatment outcome for drug-exposed children. Even though current research is reassuring regarding the "damaged goods" picture that earlier observations had painted, continued developmental surveillance is required to recognize minor difficulties early so that major problems are avoided later on in life. A team approach of health professionals, parents, early childhood educators and local support network is essential for achieving this goal.

Methamphetamine and its Impact on Women, Children and Families: Inventory of Select Resources

This document is intended to identify some of the major resources related to methamphetamine prevention, intervention and treatment. The listing of resources is organized in seven major topic areas as follows:

TOPIC AREA **PAGE**

EFFECTS OF METHAMPHETAMINE: PREVENTION, INTERVENTION AND TREATMENT MODELS 20

General Overview and Fact Sheets 20
Prevention and Intervention 20
Treatment Models and Effectiveness 22
Professional Training Resources and Conference Materials 26
Professional Training and Personal Safety Guides 26
Training on Clandestine Labs 29
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Identifying and Serving Children Affected by Methamphetamine 31
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National Drug Endangered Children Materials and Protocols: Children Found in Methamphetamine Labs 31
State Drug Endangered Children Materials and Protocols: Children Found in Methamphetamine Labs 32
County, State and Federal Reports and Resources 35
County and Local Reports and Resources 35
State Reports and Resources 37
Federal Reports and Resources 41
Tribal 42
Policy and Legislation 44
Additional Web Sites 45

This document can be found at http://www.ncsacw.samhsa.gov

Effects of Methamphetamine: Prevention, Intervention and Treatment Models

General Overview and Fact Sheets

- This guide addresses a wide range of questions on methamphetamine including how methamphetamine is made, its effects, treatment, and strategies to combat its use and abuse.

  Institute for Intergovernmental Research. (n.d.). *The methamphetamine problem: A question and answer guide.* Retrieved February 11, 2008, from http://www.iir.com/centf/guide.htm

- This fact sheet provides an overview on methamphetamine, the extent of use, health effects, treatment, arrests and sentencing, production and trafficking, legislation and links to other sources.

  Office of National Drug Control Policy. (2008, January 31). *Facts and figures: Methamphetamine.* Retrieved February 11, 2008, from http://www.whitehousedrugpolicy.gov/drugfact/methamphetamine/index.html

- This fact sheet presents basic information about methamphetamine and features 3 studies on prevalence. (360 – KB)

  United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse and Health. (2006, November). *NIDA Info Facts: Methamphetamine.* Retrieved February 11, 2008, from http://www.drugabuse.gov/pdf/infofacts/Methamphetamine06.pdf

- This is a power point presentation that provides a brief overview on methamphetamine, including effects on the individual and impact on the community.

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (n.d.). *Meth: What's cooking in your neighborhood?* Retrieved February 4, 2008, from http://ncadi.samhsa.gov/multimedia/mediaDetails.aspx?ID=362

Prevention and Intervention

- This report provides information about existing methamphetamine related education programs in Alaska. (268 - KB)

  Alaska Meth Education Project and Four A's. (2006, November). *Alaska meth education project summary of assessment of providers.* Retrieved January 23, 2008, from http://www.alaskamethed.com/images/AssessmentReport.pdf

- This brief article provides tips on effective and appropriate methamphetamine prevention strategies and activities.

  Potter, S. (2006). Best practices in methamphetamine prevention: Repackaging what we already know. *Prevention Forum Magazine.* Retrieved March 12, 2008, from https://www.prevention.org/inc/Publications/documents/BestPractices.pdf

- Methamphetamine education for elementary school students and their teachers is the focus of this program.

  Southeast Missouri State University. (n.d.). *MEDFELS: Meth education for elementary students.* Retrieved January 31, 2008, from http://www6.semo.edu/coned/Medfels/medfels.htm

- This guide is aimed at policymakers in the field of drug abuse prevention and focuses on these drugs: amphetamines and methamphetamine, ecstasy and methylphenidate. (996 – KB)

  United Nations Office on Drugs and Crime. (2007, July). *Preventing amphetamine-type stimulant use among young people: A policy and programming guide.* Retrieved January 30, 2008, from http://www.unodc.org/pdf/youthnet/ATS.pdf

- This brochure targets teens by providing information on the effects and risks of using methamphetamine. (444 – KB)

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2006). *Tips for teens: The truth about methamphetamine.* Retrieved February 22, 2008, from http://download.ncadi.samhsa.gov/Prevline/pdfs/phd861.pdf

- The Iowa Consortium for Substance Abuse Research and Evaluation provides methamphetamine modules for prevention programs developed by its researchers. Retrieved January 28, 2008, from http://iconsortium.subst-abuse.uiowa.edu/new_ReportsPapers.html#MethMod

  - This component is used at the end of the Life Skills Training Course and focuses on methamphetamine prevention with upper middle school youth.

    White, K. & Alger, M. (2005). Iowa City, IA: Iowa Consortium for Substance Abuse Research and Evaluation. *Life skills training component: Myths vs. realities methamphetamine component lesson plan.*

  - This component is used at the end of the Strengthening Families Program Course and focuses on methamphetamine prevention with upper middle school youth.

    White, K. & Alger, M. (2005). Iowa City, IA: Iowa Consortium for Substance Abuse Research and Evaluation. *Strengthening families program: Myths vs. realities methamphetamine component lesson plan.*

- These curriculum materials supplement each other and consist of an activity where participants identify whether commonly heard information about methamphetamine is a myth or a reality.

  Iowa Consortium for Substance Abuse Research and Evaluation. (2005). *Myth or reality?*

  Iowa Consortium for Substance Abuse Research and Evaluation. (2005). *Teacher's guide to methamphetamine: Myths vs. realities activity.*

- The purpose of this report is to provide updated research findings on the effects of methamphetamine abuse and discuss effective prevention and treatment options. (1,668 – KB)

United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. (2006, September). Methamphetamine abuse and addiction. *Research Report Series.* Retrieved February 19, 2008, from http://www.drugabuse.gov/PDF/RRMetham.pdf

- This publication is designed to encourage young people in grades five through nine to learn about the effects of drug abuse on the body and the brain.

United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse and Health. (2000). *Mind over matter: The brain's response to methamphetamine.* Retrieved February 19, 2008, from http://teens.drugabuse.gov/mom/mom_meth1.asp

Treatment Models and Effectiveness

- This is a multi-site initiative funded by SAMHSA/CSAT to study the treatment of methamphetamine dependence. Jointly implemented by the UCLA Integrated Substance Abuse Programs and the Matrix Institute on Addictions, it offers information on special populations, criminal justice, research, policy, treatment and other topics.

Retrieved January 9, 2008, from http://www.methamphetamine.org

- The first video provides an overview of the medical, psychological, and societal effects of methamphetamine abuse and dependence, while the second video addresses methamphetamine treatment with an emphasis on the Matrix Model, an evidence-based treatment protocol. Retrieved January 9, 2008, from http://www.cabhp.asu.edu/treatment/buy/index.aspx

  - Arizona State University, College of Human Services, Center for Applied Behavioral Health Policy. (2004). *Methamphetamine 101: Etiology and physiology of an epidemic.* [Videotape].

  - Arizona State University, College of Human Services, Center for Applied Behavioral Health Policy. (2004). *Methamphetamine 102: Introduction to evidence-based treatments.* [Videotape].

- University of California Los Angeles Integrated Substance Abuse Programs coordinates substance abuse research and treatment under the UCLA Neuropsychiatric Institute & Hospital. This includes a number of Power Point presentations, findings and abstracts from their efforts. Retrieved January 9, 2008, from http://www.uclaisap.org/

  - This resource serves as a comprehensive compilation of methamphetamine background information and treatment strategies for practitioners. (3,299 - KB)

    California Department of Alcohol and Drug Programs & UCLA Integrated Substance Abuse Programs. (2007). *Methamphetamine treatment: A practitioner's reference 2007.*

  - This manual provides several activities for 24 treatment sessions with a specific focus on gay and bisexual males who use methamphetamine.

    Shoptaw, S., Reback, C.J., Peck, J.A., Larkins, S., Freese, T.E., & Rawson, R.A. (2005). *Getting off: A behavioral treatment intervention for gay and bisexual male methamphetamine users. Friends Research Institute, Inc.* (3,431 – KB)

  - A list of 16 Power Point presentations from a variety of presenters around the nation.

    UCLA Integrated Substance Abuse Programs methamphetamine Power Point presentations. (1997-2007).

  - There are 4 volumes focused on screening, assessment and treatment planning; elements of psychosocial treatment; addictions medications and special populations; and an administrative toolkit.

    United Nations Office on Drugs and Crime: Treatnet training package materials. (n.d.).

- This article discusses methamphetamine dependence, treatment and options among women.

  Cohen, J.B., Greenberg, R., Uri, J., Halpin, M., & Sweben, J. (2007, November). Women with methamphetamine dependence: Research on etiology and treatment. *Journal of Psychoactive Drugs,* 347-352.

- This article focuses on California's Substance Abuse and Crime Prevention Act of 2000 and its influence on methamphetamine use and treatment.

  Anglin, M.D., Urada, D., Brecht, M.L., Hawken, A., Rawson, R., & Longshore, D. (2007, November). Criminal justice treatment admissions for methamphetamine use in California: A focus on proposition 36. *Journal of Psychoactive Drugs,* 367-382.

- This study was conducted on 30 adults who sought out treatment for their methamphetamine dependence.

Galloway, G.P., Polcin, D., Kielstein, A., Brown, M., & Mendelson, J. (2007, November). A nine session manual of motivational enhancement therapy for methamphetamine dependence: Adherence and efficacy. *Journal of Psychoactive Drugs,* 393-400.

- This article depicts how Prairie Ridge Addiction Treatment Services used and adapted contents of the Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol 33 for stimulant abuse for their program. (2,745 – KB)

Hansen, J. (2007, April). One program's transition to research-based strategies for treating methamphetamine abuse. *Science and Practice Perspectives, 3*(2), 29-34. Retrieved February 22, 2008, from http://www.drugabuse.gov/PDF/Perspectives/vol3no2/One.pdf

- The following videos are available through Washington State's Alcohol and Drug Clearinghouse. Retrieved January 30, 2008, from http://clearinghouse.adhl.org/videos.html

  - A public forum in Yakima, Washington involved 13 speakers discussing methamphetamine.

    Meth madness town hall meeting-public forum on meth's potential deadly effects. (2001, October 23). [Videotape].

  - This Methamphetamine Forum was held in Tacoma, Washington and focuses on methamphetamine treatment.

    Methamphetamine addiction treatment forum - part 1: Myths and facts about meth addiction. (2001, December 7). [Videotape].

  - A methamphetamine forum held in Tacoma, Washington focuses on the treatment of methamphetamine.

    Methamphetamine addiction treatment forum - part 2 dealing with the issue. (2001, December 7). [Videotape].

  - A drug-specific teleconference on one of the most widely abused illicit drugs in the world, methamphetamine.

    METH: What's cooking in your neighborhood? (2001). [Videotape].

- This article depicts Wyoming's shifting response from enforcement to treatment of individuals who use methamphetamine. (PDF - 229 KB)

  Singh, D. (2001, May). Wyoming's methamphetamine initiative: The power of informed process. *Practitioner Perspective: Onsite visits, case histories and State and Local innovations supported by the Bureau of Justice Assistance.* Washington, D.C.: United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. Retrieved January 23, 2008, from http://www.ncjrs.org/pdffiles1/bja/186266.pdf

- This study conducted telephone surveys of program directors and clinical supervisors to gather information on treatment admissions for individuals who use methamphetamine.

  Smith, R.B. & Gallati, R.J. (2005, August). Addiction treatment for methamphetamine users: A qualitative survey of selected service providers. New York, NY: New York State Office of Alcoholism and Substance Abuse Services. Retrieved December 3, 2008, from http://www.oasas.state.ny.us/meth/documents/providersurvey2005.pdf

- The following research update provides a brief overview on the significance of methamphetamine use, links with HIV and treatment. (79 – KB)

  United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. (2007, March). Methamphetamine addiction: Cause for concern, hope for the future. Topics in Brief. Retrieved February 4, 2008, from http://www.drugabuse.gov/pdf/tib/meth.pdf

- This Treatment Improvement Protocol (TIP) provides information on the effects of stimulant abuse and dependence, discusses these effects in treating individuals who use stimulants, describes treatment approaches, and recommends treatment strategies.

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (1999). *Treatment for stimulant use disorders: TIP 33.* Retrieved January 9, 2008, from http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.57310

- This report shows geographic distribution and treatment admission rates for methamphetamine/amphetamine and marijuana during 1995 and 2005.

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008, January 17). *The DASIS report: Geographic differences in substance abuse treatment admissions for methamphetamine/amphetamine and marijuana: 2005.* Rockville, MD. Retrieved February 11, 2008, from http://oas.samhsa.gov/2k8/stateMethamphetamineTX/methamphetamines.htm

- This report discusses rates, demographics and geographic distribution, source of referral and route of administration for admissions to SAMHSA's Treatment Episode Data Set who report methamphetamines and/or amphetamines as their primary drug of abuse in 2005.

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2008, February 7). *The DASIS report: Primary methamphetamine/amphetamine treatment admissions: 2005.* Rockville, MD. Retrieved February 11, 2008, from http://oas.samhsa.gov/2k8/methamphetamineTX/meth.htm

- This report provides data on treatment admissions for methamphetamine and other drugs of abuse. (380 – KB)

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006, November). *Treatment Episode Data Set (TEDS) Highlights – 2005: National admissions to substance abuse treatment services,* DASIS Series: S-36, DHHS Publication No. (SMA) 07-4229, Rockville, MD. Retrieved January 23, 2008, from http://www.oas.samhsa.gov/teds2k5/tedshi2k5.pdf

- This illustrates the effects methamphetamine use has on the brain and highlights the components of comprehensive drug treatment.

  Vereen, D.R. (n.d.). *Methamphetamine: Why does the brain become addicted?* Washington, D.C.: United States Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. Retrieved February 19, 2008, from http://www.cicp.org/PPT/BrainAddicted_dea.ppt

- This journal article describes the creation and structure of the Methamphetamine Strike Force and the collaborative model.

  Goldberg, A. (2007, November). A collaborative model for community action against methamphetamine. *Journal of Psychoactive Drugs,* 327-336.

Professional Training Resources and Conference Materials

Professional Training and Personal Safety Guides

- This article presents key topics for child welfare workers related to the use, production, and effects of methamphetamine on children and families.

  Connell-Carrick, K. (2007). Methamphetamine and the Changing Face of Child Welfare: Practice Principles for Child Welfare Workers. *Child Welfare, May/June 86*(3): 125-44.

- Kansas Methamphetamine Prevention Project staff provide trainings on a variety of topics, including prevention, safety training, treatment trends and other methamphetamine topics.

  Crank it up! Community methamphetamine prevention training. March 31, 2008 at the Topeka and Shawnee County Library in Topeka, KS. Retrieved February 15, 2008, from http://www.ksmethpreventionproject.org/kmpptrainings.htm

- This article provides information about how to safely investigate and search locations suspected of being methamphetamine laboratories. (2,059 – KB)

  Hanwell, D. (2007, August). Cooperative investigations of methamphetamine laboratories. *FBI Law Enforcement Bulletin, 76*(8): 18-22. Washington, D.C.: Department of Justice. Retrieved February 22, 2008, from http://www.fbi.gov/publications/leb/2007/aug07leb.pdf

- This report lays out guiding principles, needs and recommendations, research priorities to inform future prevention and education, treatment, and law enforcement efforts. (PDF - 315 KB)

  Methamphetamine Interagency Task Force, Federal Advisory Committee. (2000, January). *Methamphetamine interagency task force: Final report.* Washington, D.C.: United States Department of Justice, Office of Justice Programs, Federal Advisory Committee. Retrieved February 11, 2008, from http://www.ncjrs.org/pdffiles1/nij/180155.pdf

- This is approved for 1 hour of Pennsylvania Certification Board continuing education credit as well as 2 hours of National Association of Professionals credits.

  Institute for Research, Education and Training in Addictions. (2006). Methamphetamine: Debunking the myth. *Resource Links.* Retrieved December 2, 2008, from http://nattc.org/resPubs/pubCat/details.asp?keyword=meth&offset=20&ID=1660

- This is a one hour training documentary that highlights methamphetamine manufacturing, use, abuse and trafficking in Bay County, Florida.

  Multijurisdictional Counterdrug Task Force Training. (2005, September 29). *Ice age II: Lessons learned from Bay County, Florida methamphetamine awareness/training documentary.* Retrieved February 22, 2008, from http://ncadi.samhsa.gov/multimedia/webcasts/w.aspx?ID=421

- The goal of this broadcast is to educate the public about a drug free workplace.

  Multijurisdictional Counterdrug Task Force Training and Community Anti-drug Coalitions of America. (2004, October 21). *Drugs and society: The true cost to YOU! Drug endangered children.* Washington, D.C.: United States Department of Health and Human Services, Substance Abuse and Mental Services Administration, National Clearinghouse on Alcohol and Drug Information. Retrieved January 9, 2008, from http://ncadi.samhsa.gov/multimedia/webcasts/w.aspx?ID=271

- This monograph identifies eight essential components of a successful Clandestine Laboratory Enforcement Program; outlines a 5-stage strategic planning process to developing and implementing a CLEP; provides worksheets to assist policymakers and program planners with planning process; and includes models of forms and procedures that State and local agencies can use to develop their own CLEP. (PDF - 944 KB)

  United States Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. (2000, July). Developing a strategy for multiagency response to clandestine drug laboratories. *Bureau of Justice Assistance Monograph.* (Original work published June 1993). Retrieved January 9, 2008, from http://www.ncjrs.org/pdffiles/clan.pdf

- This comprehensive approach to address methamphetamine abuse has a specific focus on empowering local communities using toolkits. Oregon Partnership also offers Tackle Meth training. Retrieved February 28, 2008, from http://www.orpartnership.org/web/tacklingmeth.asp

  - Oregon Partnership. (n.d.). *Tackling meth toolkit: A community education tool.*

  - Oregon Partnership. (n.d.). *Tackling meth toolkit: A community action guide.*

- The State of Tennessee sets forth policies and procedures for all Tennessee Department of Children's Services CPS employees. (132 – KB)

  Tennessee Department of Children's Services. (2007, December 1). *Work aid – 4 – Protocol for CPS investigations involving methamphetamine.* Retrieved December 3, 2008, from http://www.state.tn.us/youth/dcsguide/policies/chap14/WA4.pdf

- These recommendations are based on draft guidelines developed by the California Department of Justice Bureau of Narcotics Enforcement.

  University of Arizona, College of Public Health, Community, Environment and Policy Division. (n.d.). *Recommendation of work practices to maintain officer safety.* Retrieved January 9, 2008, from http://www.publichealth.arizona.edu/Divisions/CEP/Documents/Officer%20Saftey.swf

- This training program provided participants with the knowledge and skills necessary to maintain their safety and well-being when working with methamphetamine involved individuals. (PDF - 84 KB)

  Webber, J.R. (2006). *Working with methamphetamine abusers: Personal safety recommendations and procedures.* Bloomington, IL: Chestnut Health Systems, Lighthouse Institute. Retrieved January 9, 2008, from http://www.drugfreeinfo.org/PDFs/strengthensupervision.PDF

Training on Clandestine Labs

- A guidance document on general cleanup has been prepared to assist property owners, contractors and local authorities. (PDF – 251 KB)

  Minnesota Department of Health and Minnesota Pollution Control Agency. (2007, April 3). *Clandestine drug lab general cleanup guidance.* Retrieved January 9, 2008, from http://www.health.state.mn.us/divs/eh/meth/lab/guidance0407.pdf

- This guide provides information for police on prevention and how to improve overall response to incidents involving clandestine drug labs. (PDF - 792 KB).

  Scott, M.S. & Dedel, K. (2006, August). *Problem-oriented guides for police series, Problem-specific guide series, No. 16: Clandestine methamphetamine labs, 2nd edition.* Washington, D.C.: United States Department of Justice, Office of Justice Programs, Office of Community Oriented Policing Services. Retrieved December 3, 2008, from http://www.popcenter.org/problems/meth_labs/

- This webcast features panelists from Drug Enforcement Administration and law enforcement who provide training information on understanding and responding appropriately to clandestine labs.

  Substance Abuse and Mental Health Services Administration, Community Anti-Drug Coalitions of America and Multijurisdictional Counterdrug Task Force Training. (2004, April 22). *Ice age: Fighting the war on meth.* Retrieved February 4, 2008, from http://ncadi.samhsa.gov/multimedia/webcasts/w.aspx?ID=253

Past Conferences and Training Events

- The CATES is a series of one-day trainings designed to provide in-depth information to individuals working with substance using populations with support from Pacific Southwest ATTC and UCLA Integrated Substance Abuse Programs.

  - *California Addiction Training and Education Series I: Methamphetamine.* March 30, 2004 in Pasadena, CA. Retrieved December 4, 2008, from http://www.psattc.com/events/cates/I/presentations/index.html

  - *California Addiction Training and Education Series II: Methamphetamine.* June 11, 2004 in San Francisco, CA. Retrieved December 4, 2008, from http://www.psattc.com/events/cates/II/presentations/index.html

  - *California Addiction Training and Education Series III: Methamphetamine.* August 20, 2004 in Sacramento, CA. Retrieved December 4, 2008, from http://www.psattc.com/events/cates/III/presentations/index.html

- *California Addiction Training and Education Series VI: Methamphetamine treatment.* June 28, 2005 in San Diego, CA. Retrieved December 4, 2008, from http://www.psattc.com/events/cates/IV/presentations/index.html

- *California Addiction Training and Education Series VI: Methamphetamine treatment.* June 30, 2005 in Sunnyvale, CA. Retrieved December 4, 2008, from http://www.psattc.com/events/cates/V/presentations/index.html

■ The conference was sponsored by the Administration for Children and Families' Children's Bureau and Child Care Bureau, and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. The conference proceedings, including Power Point Presentations and handouts are available.

Methamphetamine: The child welfare impact and response. May 8-9, 2006 at the Hyatt Regency in Crystal City, VA. Retrieved February 22, 2008, from http://www.ncsacw.samhsa.gov/conferences/conference-meth.aspx

■ The Montana Methamphetamine Cleanup Program organized this conference, which is focused on the environmental risks and dangers of methamphetamine labs and its impact on community members.

Methamphetamine: Hazards to your health and home. March 3-4, 2008 at the Red Lion Colonial in Helena, MT. Retrieved February 28, 2008, from http://deq.mt.gov/meth/ConfAgenda_files/conf032008.mcpx

■ This two-day conference brings together local agencies to tackle methamphetamine in Southern Illinois.

- *Southern Illinois meth awareness conference.* May 15-16, 2007 at John A. Logan College in Carterville, IL. Retrieved February 22, 2008, from http://www.jalc.edu/cbi/methconf07/presentations.html

- *Southern Illinois meth and other drugs awareness conference: Breaking the chains, building bridges.* April 1-2, 2008 at John A. Logan College in Carterville, IL. Retrieved February 22, 2008, from http://www.jalc.edu/cbi/methconf08/index.html

■ National Alliance for Model State Drug Laws held regional methamphetamine legislative conferences, which resulted in each region developing a compilation of recommendations and priorities and a memorandum of recommendations for a regional methamphetamine strategy. Retrieved December 3, 2008, from http://www.namsdl.org/methconf.htm

- *South/Southeast methamphetamine legislative and policy planning conference.* July 13-14, 2006 in Birmingham, AL.

- *West/Southwest methamphetamine legislative and policy planning conference.* October 5-6, 2006 in Salt Lake City, UT.

- *Midwest/Great Lakes methamphetamine legislative and policy planning conference.* February 1-2, 2007 in Des Moines, IA.

Identifying and Serving Children Affected by Methamphetamine

Prenatal Methamphetamine Exposure

- This document discusses the development of treatment care plans for drug-exposed infants until age 3 that provide effective and developmentally appropriate interventions with successful outcome potential.

  Shah, R. Z. (2000). *Second chance kids: Providing development focused care for drug-exposed infants.* Retrieved February 11, 2008, from http://www.addictionrecov.org/paradigm/P_PR_SP00/cont_shah.htm

- This article explores the neonatal growth effects of prenatal exposure to methamphetamine in the Infant Development, Environment and Lifestyle study.

  Smith, L.M., LaGasse, L.L., Derauf, C., Grant, P., Shah, R., Arria, A., Huestis, M., Haning, W., Strauss, A., Grotta, S.D., Liu, J., and Lester, B.M. (2006). The infant development, environment, and lifestyle study: Effects of prenatal methamphetamine exposure, polydrug exposure, and poverty on intrauterine growth. *Pediatrics, 118*(3). Retrieved February 11, 2008, from http://pediatrics.aappublications.org/cgi/content/full/118/3/1149

- This paper describes the health risks to pregnant women and infants caused by methamphetamine use during pregnancy.

  Wells, K. (n.d.). *Methamphetamine and pregnancy.* Retrieved January 9, 2008, from http://www.colodec.org/decpapers/methandpregnancy.htm

National Drug Endangered Children Materials and Protocols: Children Found in Methamphetamine Labs

- This is intended as a guide for managing health issues of children who are found at methamphetamine lab sites. (PDF - 34 KB)

  Carver County. (2006, April 11). *Minnesota medical protocols for children found at methamphetamine lab sites.* St. Paul, MN: Minnesota Department of Health. Retrieved January 9, 2008, from http://www.health.state.mn.us/divs/eh/meth/ordinance/carverchild.pdf

- The national protocol is designed to inform law enforcement, child protective services, medical personnel and the emergency department about the critical steps needed to assist children found in drug labs. (PDF - 93 KB)

  National Alliance for Drug Endangered Children. (2004, June). National protocol for medical evaluation of children found in drug labs. *Community Links.* Retrieved January 9, 2008, from http://www.colodec.org/decpapers/Documents/DECNationalProtocol.pdf

- Nebraska provides the Children Exposed to Methamphetamine Labs protocol for children exposed to methamphetamine labs, which was developed by a Medical Working Group as part of the Midwest High Intensity Drug Trafficking Area (HIDTA) Program. (PDF - 799 KB)

  Protocols. (n.d.). Lincoln, NE: Nebraska Alliance for Drug Endangered Children. Retrieved January 9, 2008, from http://www.nebraskadec.org/protocols.html

- This article discusses the dangers posed by methamphetamine labs and provides information on what is being done to help children. (27 – KB)

  Reed, C. (2004, November). *Children in meth labs: Risky business.* Washington, D.C.: United States Department of Justice, Office of Community Oriented Policing. Retrieved December 3, 2008, from http://www.nationaldec.org/user_files/3549_1662737.pdf

- This provides an overview of methamphetamine production and trends, discusses the dangers to children living in methamphetamine labs and outlines recommendations for a multidisciplinary team approach.

  Swetlow, K. (2003, June). Children at clandestine methamphetamine labs: Helping meth's youngest victims. *OVC Bulletin.* Washington, D.C.: United States Department of Justice, Office of Justice Programs, Office for Victims of Crimes. Retrieved February 11, 2008, from http://www.ojp.usdoj.gov/ovc/publications/bulletins/children

- These papers provide answers to frequently asked questions about clandestine methamphetamine labs and removal of children from these labs.

  - Wells, K. (n.d.). *Clandestine methamphetamine labs FAQ #1.* Retrieved January 9, 2008, from http://www.colodec.org/decpapers/clandestinelabfaq1.htm

  - Wells, K. (n.d.). *Medical evaluation of children removed from clandestine labs FAQ #2.* Retrieved January 9, 2008, from http://www.colodec.org/decpapers/childmedevalfaq2.htm

  - Wells, K. (n.d.). *How to care for children removed from a drug endangered environment FAQ #3.* Retrieved January 9, 2008, from http://www.colodec.org/decpapers/careforchildrenfaq3.htm

State Drug Endangered Children Materials and Protocols: Children Found in Methamphetamine Labs

- The following papers are written by members of the DEC Alliance and are made available through Colorado Alliance for Drug Endangered Children. Retrieved January 9, 2008, from http://www.colodec.org/decpapers/decpapers.htm

  - This is a set of 8 forms compiled for Colorado that other states may modify for their efforts. (PDF - 357 KB)

Colorado Alliance for Drug Endangered Children. (n.d.). *Drug endangered children: Initial response forms.*

- National Jewish Hospital and Research Center describes the study beginning in 2003 on the harmful effects of methamphetamine labs to first responders and children.

  Martyny, J.W., Arbuckle, S.L., McCammon, C.S., Esswein, E.J., & Erb, N. (n.d.). *National Jewish Research Center methamphetamine research synopsis.*

- This Memorandum of Understanding between Larimer County Department of Human Services and Larimer County Drug Task Force is a collaborative effort to assist in the identification, investigation and removal of Drug Endangered Children.

  Larimer County, Colorado. (2003, April 1). *Memorandum of understanding.*

- This protocol provides a screening guide for child welfare workers and law enforcement in Larimer County, Colorado.

  Larimer County, Colorado. (n.d.). *Protocol for investigating child protection referrals involving the operation of clandestine labs.*

- In Arizona, a multidisciplinary team developed this protocol for child protective services, law enforcement, medical services and prosecution to develop safety procedures involving methamphetamine laboratories. (PDF - 342 KB)

DEC Task Force. (2003, September 30). *Arizona Drug Endangered Children (DEC) multidisciplinary/integrated protocol.* Phoenix, AZ: Office of the Arizona Attorney General. Retrieved January 9, 2008, from http://www.azag.gov/DEC/docs/DEC_protocol.pdf

- This resource presents the mission, goals and logic model of the Georgia Alliance for Drug Endangered Children. (166 – KB)

Georgia Alliance for Drug Endangered Children. (2006). *Georgia Alliance for Drug Endangered Children strategic plan 2006.* Retrieved January 23, 2008, from http://www.georgiadec.org/docs/strat_plan_logic.pdf

- The purpose of this study was to identify local procedures for handling drug-endangered children cases and to compare these procedures to the steps recommended by Washington's We Care plan.(2,397 – KB)

Governor's Council on Substance Abuse. (2006, September). *Survey of policies and procedures for drug endangered children in Washington State.* Olympia, WA: State of Washington, Department of Community, Trade and Economic Development. Retrieved January 23, 2008, from http://www.cted.wa.gov/_CTED/documents/ID_3547_Publications.pdf

- This resource provides guidance in the establishment of local DEC programs. (323 – KB)

  Iowa Alliance for Drug Endangered Children. (2007, February). *Building a DEC team: Guide to help Iowa communities launch DEC programs.* Retrieved January 23, 2008, from http://www.iowadec.net/uploads/Guide_to_Launching_a_DEC_Program_in_Iowa.pdf

- Kentucky's Drug Endangered Child Training Network provides posters, brochures, videos, presentations and online courses informing children, family members, community members and professionals about the dangers of methamphetamine.

  - Kentucky's Drug Endangered Child Training Network. Retrieved January 23, 2008, from http://www.drugendangeredchild.org/Publications.htm

  - Kentucky's Drug Endangered Child Training Network. Retrieved January 23, 2008, from http://www.drugendangeredchild.org/Videos.htm

  - Kentucky's Drug Endangered Child Training Network. Retrieved January 23, 2008, from http://www.drugendangeredchild.org/courses.htm

- This report provides background information on Arizona's drug endangered children program and highlights program activities and results. (2,021 – KB)

  Office of the Arizona Attorney General. (2006, December). *Arizona Alliance for Drug Endangered Children Program annual report 2006.* Retrieved January 23, 2008, from http://www.azag.gov/AnnualReports/2006AnnualReport.pdf

- There are five counties in Tennessee that formed a collaboration team as well as an agreement stating their operating policies in response to drug endangered children.

  Tennessee Alliance for Drug Endangered Children. (n.d.). *DEC protocols.* Retrieved January 9, 2008, from http://www.tadec.org/Protocols/countyprotocols.htm

- Washington State Department of Health has a Drug Endangered Children Program listing resources from Washington State, other U.S. states and nationwide. Retrieved February 11, 2008, from http://www.wadecalliance.org/

  - This publication describes the *We Care* plan involving six elements to address the immediate needs of the drug-endangered child. (PDF - 251 KB)

    Washington Governor's Methamphetamine Coordinating Committee. (2004, August). Washington, D.C.: United States Department of Justice, Washington State Methamphetamine Initiative. *Washington's endangered children's assessment and response: We care, recommended best practices addressing the needs of drug endangered children.*

- This document describes the phases of site processing a clandestine lab, which involves a multi-agency response. (PDF – 28 KB)

  Washington State, Stevens County Sheriff's Office. (2003, June). *Sheriff's office inter-agency notification.*

- This is specific DEC protocol using one CPS worker in Pierce County. (PDF – 14 KB)

  Washington State, Pierce County. (n.d.). *Drug endangered children's (DEC) protocol.*

County, State and Federal Reports and Resources

County and Local Reports and Resources

- These reports summarize the activity during the 1st and 2nd quarters submitted by each Arizona County that received funds from HB 2554 to support increased methamphetamine interdiction efforts including investigation, training, prosecution, abuse treatment, or education programs. (PDF – 200 KB) Retrieved February 29, 2008, from http://www.azcjc.gov/ACJC.Web/Pubs/Home/MethInterdiction3rdQuarterFY2008.pdf

  - Arizona Criminal Justice Commission. (2007, November 30). *Methamphetamine interdiction summary report: 1st quarter FY 2008 summary report.*

  - Arizona Criminal Justice Commission. (2008, February 28). *Methamphetamine interdiction summary report: 2nd quarter FY 2008 summary report.*

- This report provides results of an assessment of the methamphetamine situation in Laramie County, Wyoming. Recommendations are also presented. (2,545 - KB)
  Datacorp. (2007, February 8). *Cheyenne-Laramie County methamphetamine assessment project.* Retrieved January 28, 2008, from http://www.cheyennecity.org/DocumentView.aspx?DID=1216

- The National Association of Counties offers a research study and monthly newsletters focused on methamphetamine topics.

  - This study is the sixth in a series of studies surveying 500 county law enforcement officials on the impact of methamphetamine abuse on the nation's counties.
    National Association of Counties. (2007, August). *The meth epidemic: The changing demographics of methamphetamine.* Washington, D.C.: National Association of Counties, Research Division. Retrieved January 30, 2008, from http://www.naco.org/Template.cfm?Section=Publications&template=/ContentManagement/ContentDisplay.cfm&ContentID=24797

- Since November 2006, National Association of Counties has offered monthly newsletters that provide information gathered from many sources on methamphetamine.

  National Association of Counties. (n.d.). *NACo's Methamphetamine* Newsletter. Retrieved February 22, 2008, from http://www.naco.org/Template.cfm?Section=Meth_Action_Clearinghouse&template=/ContentManagement/ContentDisplay.cfm&ContentID=22797

- This resource describes the estimated cost of one methamphetamine related criminal case to San Diego taxpayers. (48 – KB)

  San Diego Association of Governments Criminal Justice Research Division. (2006, October). Meth use has many costs. *Criminal Justice Fax: Research findings from the criminal justice research division, 8*(10). Retrieved January 30, 2008, from http://www.sandag.org/programs/public_safety/comprehensive_public_safety_projects/fax/cj_fax_vol8iss10.pdf

- This article summarizes the data presented May 2006 at the Substance Abuse Research Consortium meeting in Pasadena, California.

  Burke, C. (2007, November). Methamphetamine use among San Diego County arrestees. *Journal of Psychoactive Drugs,* 337-346.

- This article investigates drug use trends and treatment admission rates for Los Angeles County funded programs between 2001 and 2005.

  Crevecoeur, D., Rutkowski, B., & Rawson, R.A. (2007, November). The rise in treatment admissions for methamphetamine use in Los Angeles County from 2001 through 2005. *Journal of Psychoactive Drugs,* 383-392.

- This article discusses the indicators of methamphetamine use and abuse in San Diego County, California and emphasizes the importance of multiple data sources.

  Pollini, R.A. & Strathdee, S.A. (2007, November). Indicators of methamphetamine use and abuse in San Diego County, California: 2001-2005. *Journal of Psychoactive Drugs,* 319-326.

- This study examines psychosocial and behavioral correlates of depressed mood in 146 females who use methamphetamine in San Diego, California.

  Semple, S.J., Zians, J., Strathdee, S.A., & Patterson, T.L. (2007, November). Psychosocial and behavioral correlates of depressed mood among female methamphetamine users. *Journal of Psychoactive Drugs,* 353-366.

State Reports and Resources

- Arizona developed a strategic action plan with 10 recommendations to eradicate methamphetamine use within the State to build healthy and safe communities. (2,013 – KB)

  Arizona Methamphetamine Task Force. (2007). A plan for action: *Addressing the methamphetamine crisis in Arizona – policy recommendations for a comprehensive statewide strategy to combat methamphetamine.* Phoenix, AZ: The Governor's Office for Children, Youth and Families. Retrieved January 23, 2008, from http://gocyf.az.gov/SAP/documents/050407_MethFullReport.pdf

- This bulletin demonstrates how key indicators can be used to measure, monitor and evaluate the extent and nature of methamphetamine abuse in Illinois. (PDF - 636 KB)

  Bauer, R. (2003, January). Methamphetamine in Illinois: Examination of an emerging drug. *Research Bulletin, 1*(2). Chicago, IL: Illinois Criminal Justice Information Authority. Retrieved February 4, 2008, from http://www.icjia.state.il.us/public/pdf/bulletins/meth.pdf

- This chapter illustrates how the nonmedical use of the prescription drug form of methamphetamines varies from each State.

  Colliver, J.D., Kroutil, L.A., Dai, L., & Gfroerer, J.C. (2006, September). *Misuse of prescription drugs: Data from the 2002, 2003, and 2004 National Surveys on Drug Use and Health.* (DHHS Publication No. SMA 06-4192, Analytic Series A-28). Rockville, MD: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Retrieved February 4, 2008, from http://www.oas.samhsa.gov/prescription/Ch7.htm#7.6

- This study uses the SF-8 health survey to assess the mental and physical health status of 249 adults in Ohio reporting use of a stimulant.

  Falck, R.S., Wang, J., & Carlson, R.G. (2007, November). Health status of illicit stimulant drug users in rural Ohio. *Journal of Psychoactive Drugs,* 401-406.

- This report provides recommendations in 7 fundamental categories that are intended to serve as the basis for a comprehensive strategy to address methamphetamine use in Tennessee. (PDF - 746 KB)

  The Governor's Task Force on Methamphetamine Abuse. (2004, September 1). *The Governor's Task Force on methamphetamine abuse: Final report.* Retrieved January 9, 2008, from http://kci.org/meth_info/methreport.pdf

- The purpose of this Preliminary Report is to provide the Nevada Governor and 2007 Legislature with information and recommendations to address the negative impacts methamphetamine use and distribution are having on the State.

  Governor's Working Group. (2007, April 1). *Preliminary report: Governor's Working Group on methamphetamine use.* Carson City, NV: Nevada Department of Health and Human Services. Retrieved January 23, 2008, from http://dhhs.nv.gov/DO-Meth.htm

- This resource highlights the efforts of Indiana agencies and organizations to address methamphetamine in the state. (124 – KB)

  Indiana Criminal Justice Institute. (2007, January). *Meth-free Indiana action plan.* Retrieved December 3, 2008, from http://www.in.gov/cji/2853.htm

- The purpose of this report is to understand the impact of methamphetamine on the child welfare system in Arkansas. (446 - KB)

  Kelly, P. (2007, January). *Poison, problem and perspective: The impact of methamphetamine on the Arkansas child welfare system.* Little Rock, AR: Arkansas Advocates for Children and Families. Retrieved January 23, 2008, from http://arkadold.aristotle.net/_images/pdfs/AACF_Meth&ChildWelfare.pdf

- Minnesota Department of Health has several links on its home page ranging from methamphetamine labs, on-scene safety and laws and ordinances. Retrieved January 9, 2008, from http://www.health.state.mn.us/divs/eh/meth/index.html

  - Minnesota laws, sample city and county ordinances, medical protocols, methamphetamine lab cleanup letters, and other resources are provided in this section.

    Minnesota Department of Health. (n.d.) *Methamphetamine and meth labs: Laws and ordinances.*

  - Minnesota Department of Health provides results from the 2 Statewide surveys on methamphetamine lab discoveries.

    Minnesota Department of Health. (2006, June). *Meth labs discovered in Minnesota in 2005.*

    Minnesota Department of Health. (2006, October). *Meth labs discovered in Minnesota in 2005 and January to June, 2006.*

- This documentary chronicles the impact of methamphetamine on Minnesota and includes interviews with individuals in recovery, medical professionals, law enforcement, and others familiar with methamphetamine.

  Minnesota County Attorneys Association. (2007, February). *Revealing meth in Minnesota.* [DVD]. Retrieved January 30, 2008, from http://www.revealingmeth.com/dvd1.htm

- This report summarizes results from the 2007 Montana Youth Risk Behavior Study.

  Montana Office of Public Instruction. (2007, September 18). *Significant reduction in high school meth use summary report.* Retrieved December 3, 2008, from http://opi.mt.gov/PDF/superintendent/MMO091807MethSummary.pdf

- This report assesses trends and patterns of methamphetamine use and crime in Montana.

  Montana Attorney General's Office and The Meth Project. (2007, January). *Methamphetamine in Montana: A preliminary report on trends and impact.* Retrieved December 3, 2008, from http://www.doj.mt.gov/news/releases2007/20070124preliminarymethreport.pdf

- This report documents the process and initial results of Washington State's methamphetamine initiative using a collaborative team approach. (PDF - 324 KB)

  National Crime Prevention Council and Drug Enforcement Administration. (2002, September). *Responding to Methamphetamine: Washington State's promising example.* Retrieved February 4, 2008, from http://www.ncpc.org/cms/cms-upload/ncpc/files/RespondtoMeth.pdf

- This issue of Children's Services Practice Notes, a quarterly newsletter published by the North Carolina Division of Social Services, is devoted entirely to helping child welfare workers respond to the impact of methamphetamine on families and children. (287 – KB)

  North Carolina Division of Social Services. (2005, April). Meth and family-centered child welfare practice. *Children's Services Practice Notes, 10*(2). Retrieved January 28, 2008, from http://www.practicenotes.org/vol10_n2/cspnv10n2.pdf

- This assessment outlines methamphetamine use, provides information and data regarding methamphetamine related criminal activities and highlights Washington State efforts to address methamphetamine. (981 - KB)

  Northwest High Intensity Drug Trafficking Area. (2006, March). *Methamphetamine and related crime: The impacts of methamphetamine abuse.* Retrieved January 28, 2008, from http://www.mfiles.org/publications/Methandrelatedcrime.pdf

- This site highlights a series of TV, radio and online programs to help Oregonians by providing more information on methamphetamine.

  Oregon Public Broadcasting. (2007). *Meth: The Oregon front.* Retrieved http://www.opb.org/meth/

- The Criminal Justice Research Division of the San Diego Association of Governments conducted this study on methamphetamine use and its consequences among arrestees in Los Angeles, Phoenix, Portland, San Diego and San Jose. The study used data from the Arrestee Drug Abuse Monitoring program. (PDF - 421 KB)

Pennell, S., Ellett, J., Rienick, C., & Grimes, J. (1999, April). *Meth matters: Report on methamphetamine users in five western cities.* Washington, D.C.: United States Department of Justice, Office of Justice Programs, National Institute of Justice. Retrieved January 23, 2008, from http://www.ncjrs.org/pdffiles1/176331.pdf

- This report provides information about methamphetamine, its effects, and the impact on North Dakota communities. (699 – KB)

Rural Crime and Justice Center. (2007, March). *Methamphetamine: The Impact on North Dakota.* Retrieved January 23, 2008, from http://warp6.cs.misu.nodak.edu/rcjc/pdf/MethamphetamineTheImpactonNorthDakota.pdf

- These annual reports provide information about Colorado's Methamphetamine Task Force and the priorities and expectations identified by the Task Force. Retrieved December 3, 2008, from http://www.coloradodec.org/coloradostatemethtaskforce111.html

State of Colorado Methamphetamine Task Force. (2007, January). *Methamphetamine Task Force first annual report.* Denver, CO: Colorado Attorney General.

State of Colorado Methamphetamine Task Force. (2008, January). *Methamphetamine Task Force second annual report.* Denver, CO: Colorado Attorney General.

- This study examines rural stimulant use, specifically methamphetamine use in 225 adults in Kentucky.

Stoops, W.W., Tindall, M.S., Havens, J.R., Oser, C.B., Webster, J.M., Mateyoke-Scrivner, A., Wright, P.B., Booth, B.M., & Leukefeld, C.G. (2007, November). Kentucky rural stimulant use: A comparison of methamphetamine and other stimulant users. *Journal of Psychoactive Drugs,* 407-417.

- As part of Oregon's Target Meth Project, this guide provides information on effective methamphetamine and other drug prevention practices, techniques for organizing a neighborhood response to drug use, and strategies to involve the community. (597 - KB)

Target Meth. (2007). *Community Action Guide: Assisting You to Take Action and Reduce Drug Use in Your Community.* Retrieved January 28, 2008, from http://www.adp.ca.gov/Prevention/pdf/Meth_Resource_Guide.pdf

- This report to the legislature provides information about methamphetamine in Vermont and describes the efforts of Vermont's public information campaign. (287 – KB)

  Vermont Department of Health. (2007, January 15). *Vermont 2007: Methamphetamine public information campaign.* Retrieved January 28, 2008, from http://healthvermont.gov/admin/legislature/documents/Methamphetamine_leg_report.pdf

- This article offers an overview of the challenges and highlights some of the promising practices that practitioners can consider. (2,316 – KB)

  Virginia Department of Social Services, Child Protective Services Unit. (2007, Spring). Methamphetamine and child maltreatment. *Virginia Child Protection Newsletter 79.* Harrisonburg, VA: James Madison University. Retrieved January 28, 2008, from http://psychweb.cisat.jmu.edu/graysojh/volume%2079.pdf

Federal Reports and Resources

- This publication presents national estimates of drug-related visits to hospital emergency departments for 2005, based on data from the Drug Abuse Warning Network. (915 – KB)

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007, March). *Drug abuse warning network 2005: National estimates of drug-related emergency department visits.* Retrieved February 4, 2008, from http://dawninfo.samhsa.gov/pubs/edpubs/

- This report examines trends and patterns in rates of methamphetamine use among males and females, age 12 and older.

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007, January 26). *The NSDUH Report: Methamphetamine use.* Retrieved February 4, 2008, from http://www.oas.samhsa.gov/2k7/meth/meth.cfm

- Survey responses about methamphetamine use, abuse and dependence retrieved from National Surveys on Drug Use and Health are compiled into this report. (205 – KB)

  United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2005, September 16). *The NSDUH Report: Methamphetamine use, abuse, and dependence: 2002, 2003, and 2004.* Rockville, MD. Retrieved February 4, 2008, from http://www.oas.samhsa.gov/2k5/meth/meth.pdf

- This report acknowledges that some survey respondents may fail to recognize and report their methamphetamine use in the core stimulants module. (586 – KB)

  Ruppenkamp, J., Davis, T., Kroutil, L., & Aldworth, J. (2006, August). *2005 National Survey on Drug Use and Health: Methamphetamine analysis report.* Rockville, MD: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Retrieved February 4, 2008, from http://www.oas.samhsa.gov/nsduh/2k5MRB/meth2k5.pdf

Tribal

- This explores methamphetamine use in Indian country by surveying tribal professionals from three Western tribal communities about their perceptions on methamphetamine use and implications for children in their communities. (817 - KB)

  Bubar, R., Winokur, M., & Bartlemay, W. (2007, January). *Perceptions of methamphetamine use in three western tribal communities: Implications for child abuse in Indian Country.* Washington, D.C.: United States Department of Justice, Office for Victims of Crime, Tribal Law and Policy Institute. Retrieved January 23, 2008, from http://www.tribal-institute.org/download/Final%20Meth%20Article%20for%20Printing%206-07.pdf

- This article describes the role of methamphetamine use and its impact on child welfare in tribal communities. (98 – KB)

  Bubar, R. & Payne, D. (n.d.). *Methamphetamine and child abuse in Native America.* Retrieved February 22, 2008, from http://www.ncai.org/ncai/Meth/Methamphetamine_and_Child_Abuse_in_Native_America_Article.pdf

- Indian Health Services provides sources for methamphetamine prevention initiatives. This document offers a list of conferences, training and other methamphetamine related activities in Arizona, Oklahoma, Aberdeen, Montana, and in the Navajo area.

  Indian Health Services. (n.d.). *Methamphetamine activities in Indian country.* Retrieved December 3, 2008, from http://www.ihs.gov/Medicalprograms/Behavioral/index.cfm?module=BH&option=Meth

- This is a compilation of preliminary recommendations reported by the facilitated workgroups at the Summit.

  National Alliance for Model State Drug Laws. (August 1, 2007) *Regional Methamphetamine Legislative Conferences: ONDCP Tribal Methamphetamine Summit.* Phoenix, AZ. Retrieved February 22, 2008, from http://www.namsdl.org/methaz.htm

- The National Congress of American Indians provides methamphetamine related resources, including reports, treatment efforts, conferences, and legislative action. Retrieved January 30, 2008, from http://www.ncai.org/Meth_in_Indian_Country_Initiat.192.0.html

  - Methamphetamine educational materials are provided to fight methamphetamine abuse in Indian Country.

    National Congress of American Indians. *Methamphetamine toolkit for tribes.*

  - This resource provides information and data showing the impact of methamphetamine on tribal communities, highlights solutions that have been created to address methamphetamine and provides the Tribal leader methamphetamine contacts for members of the press. (157 – KB)

    National Congress of American Indians. (2006, November 30). *Methamphetamines in Indian Country: An American problem uniquely affecting Indian Country.*

  - There are 8 congressional testimonies and a witness list available.

    United States Senate Hearing on the problem of methamphetamine use in Indian Country. (2006, April 5). *Congressional testimonies from the Senate Indian Affairs Committee: Oversight Hearing on Methamphetamine.*

  - *3rd annual Great Plains regional summit on methamphetamine.* May 30 – June 1, 2007 at the Spirit Lake Resort and Casino in Spirit Lake Tribe, ND.

  - *NCAI meth task force meeting.* June 10, 2007 at the Egan Convention Center in Anchorage, AK.

  - *NCAI meth task force meeting.* November 11, 2007 at the Hyatt Regency at the Colorado Convention Center in Denver, CO.

- This conference is presented by National Indian Child Welfare Association with a focus on the role with Indian children and families.

  26th annual protecting our children national American Indian conference on child abuse and neglect. April 20-23, 2008 at the Sheraton Bloomington Hotel in Minneapolis, MN. Retrieved December 2, 2008, from http://www.childwelfare.gov/calendar/materials/nicwa_08.cfm

- *1st annual mothers against methamphetamine conference: Opening doors to recovery.* April 10-12, 2008 at the Hilton Bella Harbor in Dallas, TX. Retrieved February 28, 2008, from http://www.mamasite.net/visit/index.php?main_page=product_info&cPath=73&products_id=184

- National Alliance for Model State Drug Laws held this summit, which resulted in each region developing a compilation of recommendations and priorities for a regional methamphetamine strategy.

Office of National Drug Control Policy tribal methamphetamine summit. August 1, 2007 in Phoenix, AZ. Retrieved February 22, 2008, from http://www.namsdl.org/methaz.htm

Policy and Legislation

- The provisions of the Child and Family Services Improvement Act of 2006 are outlined in this briefing paper and represent an important step toward providing $40 million annually towards services to children and families, improving the workforce and addressing substance abuse, specifically methamphetamine abuse. (92 – KB)

Conway, T. & Hutson, R.Q. (2007, January 19). *In-depth summary of the Child and Family Services Improvement Act of 2006.* Center for Law and Social Policy. Retrieved January 30, 2008, from http://www.clasp.org/publications/summary_cfsia.pdf

- The Methamphetamine Remediation Research Act of 2007 enacted by the U.S. House of Representatives instructs the Environmental Protection Agency to develop guidelines to help state and local authorities clean up former methamphetamine lab sites.

Methamphetamine Remediation Research Act of 2007, Public Law No: 110-143. (2007). Retrieved January 28, 2008, from http://www.govtrack.us/congress/bill.xpd?bill=h110-365

- National Alliance for Model State Drug Laws offers a list of State legislative resources pertinent to ephedrine/pseudoephedrine, drug endangered children and methamphetamine trafficking. Retrieved December 3, 2008, from http://www.namsdl.org/resmethinfo.htm

National Alliance for Model State Drug Laws. (2007, January). *State child endangerment Bill status update.*

National Alliance for Model State Drug Laws. (2007, April). *Offenses and penalties related to methamphetamine trafficking citation list.*

- This report surveys the effects of anti-methamphetamine activities in all 50 States and compares State laws to the Federal standard enacted in September 2006 as part of the Combat Methamphetamine Epidemic Act of 2005. (1,335 - KB)

Office of National Drug Control Policy. (2006, November). *Pushing back against meth: A progress report on the fight against methamphetamine in the United States.* Retrieved January 30, 2008, from http://www.ncjrs.gov/ondcppubs/publications/pdf/pushingback_against_meth.pdf

- The Synthetics Strategy set goals to reduce synthetic drug use at a rate of approximately 5 percent each year and outlines a strategy for reducing past month methamphetamine use by 15 percent over three years, past-month prescription drug abuse by 15 percent over three years and domestic methamphetamine laboratories by 25 percent over three years.

  Office of National Drug Control Policy. (2006, May). *Synthetic drug control strategy: A focus on methamphetamine and prescription drug use.* Washington, D.C.: Executive Office of the President. Retrieved January 30, 2008, from http://dhs.alabama.gov/pdf/info/synthetic_strategy.pdf

- These materials provide more information on California's Proposition 36, which is the Substance Abuse and Crime Prevention Act of 2000.

  - An overview of Proposition 36, reports and data, press releases and frequently asked questions are available on this website.

    Drug Policy Alliance. (n.d.). *California Proposition 36: The substance abuse and crime prevention act of 2000.* Retrieved December 4, 2008, from http://www.prop36.org/

  - This includes the full text of California's Proposition 36.

    Proposition 36: The Substance Abuse and Crime Prevention Act. (2000). Retrieved March 14, 2008, from http://www.drugreform.org/prop36/fulltext.tpl

- Governor of South Dakota signed House Bill 1178 allowing an intensive methamphetamine treatment program for women in the State correctional facilities.

  State of South Dakota, 83rd Session Legislative Assembly. (2008). *House Bill 1178.* Retrieved February 28, 2008, from http://legis.state.sd.us/sessions/2008/Bills/HB1178P.htm

- This training guide is developed for regulated sellers of non-prescription drug products containing ephedrine, pseudoephedrine, and phenylpropanolamine in compliance with the Combat Methamphetamine Epidemic Act of 2005, Title VII of Public Law 109-177. (527 – KB)

  United States Department of Justice, Drug Enforcement Administration, Office of Diversion Control. *Training required to sell drug products containing ephedrine, pseudoephedrine, and phenylpropanolamine.* Retrieved January 30, 2008, from http://www.deadiversion.usdoj.gov/meth/trg_retail_081106.pdf

Additional Web Sites

- This site, sponsored by the White House Office of National Drug Control Policy, the Department of Justice, and the Department of Health and Human Resources, provides various resources on methamphetamine, including information on publications and research, upcoming conferences, policies and legislation, technical assistance and training, and more.

  http://www.methresources.gov

- The Meth Awareness and Prevention Project of South Dakota offers information geared towards different populations in the community to create awareness about methamphetamine.

  http://www.mappsd.org/

- Stop Drugs is implemented by the California Department of Justice and offers a methamphetamine overview, prevention efforts, treatment strategies and other topics.

  http://www.stopdrugs.org/

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