Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

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Children's Services Practice Notes is a publication for child welfare workers produced four times a year by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!
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METH AND FAMILY-CENTERED CHILD WELFARE PRACTICE

Chances are you have heard horror stories about what methamphetamine is doing to families and children. Stories about an addiction so powerful that parents lose any interest in their kids. About poisonous, explosive homemade labs. About an epidemic rapidly spreading across the state.

Frightening stories. True stories.

Confronted by this new challenge it is only natural that child welfare workers should be concerned for their safety and the safety of the children and families they strive to protect and support, only natural for them to ask:

- Why is meth so dangerous?
- How can I keep everyone safe? (including *myself!*)
- What can we do to help these families?

This issue of *Practice Notes* will attempt to answer these questions and explain how you can respond to meth in an effective, family-centered way. ◆

The challenge is to respond to meth-involved parents in a way that protects children and expresses our desire for partnership.

METHAMPHETAMINE: WHAT YOU SHOULD KNOW

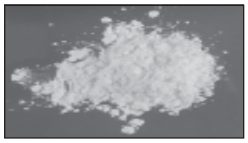
To protect and support families, child welfare workers need to know what methamphetamine is and how it affects users.

WHAT IS METH?

Meth is methamphetamine, a powerful central nervous system stimulant. A highly addictive drug, meth comes in different forms; most often it is a powder that dissolves easily in water, though it can also come in clear, chunky crystals called "ice." Meth can be swallowed, snorted, injected, or smoked. It is known by many names, including speed, meth, crystal, crank, biker's coffee, and chalk (ONDCP, 2003; Shaw, 2004).

Although known primarily as an illegal drug, methamphetamine does have legitimate medical uses. It is sometimes prescribed for the treatment of narcolepsy, attention deficit disorders, and obesity (NIDA, 2002). Medical methamphetamine is sold in the U.S. under the trade name Desoxyn (Narconon, 1998).

Yet the legal use of meth is almost entirely eclipsed by growing tide of illegal production and abuse. Nationally, four times as many people sought treatment for meth addiction in 1998 than in 1992 (NCPC, 2002). Meth is also showing up in the workplace. Between 1999 and 2003, the percentage of positive workplace drug tests containing amphetamines doubled, from 4.5% to 9.3% (CESAR, 2004). During 2000, 4% of the U.S. population reported trying meth at least once in their lifetime (NIDA, 2002).


Meth in powder form

Child welfare agencies may see a much higher incidence of meth use, just as they see more domestic violence and mental illness than are present in the general population. One western North Carolina county we spoke with said that the majority of CPS reports it has received so far in 2005 have involved meth.

EFFECTS ON USERS

Users are drawn to meth because when they first take the drug they get an intense rush of pleasure followed by a sense of euphoria, energy, and elevated self-esteem lasting up to 8 hours (Swetlow, 2003). Asked by a child welfare worker what taking meth was like, a user responded: *cont. p. 2*

BASIC FACTS ABOUT METH *continued from page 1*

"Imagine the most pleasurable experience you have ever had. Now multiply that times ten."

Users also like meth because it helps with weight loss and acts as a sexual stimulant (Shaw, 2004). Another draw is meth's relative affordability. Whereas $100 will hardly buy enough crack cocaine to get a user through the night, for the same amount a meth user can stay high for days (Shaw, 2004).

Because of severe depression and other negative effects that begin when the drug starts to wear off, users try to avoid sobering up. They may binge to stay high—and awake—for many days at a time and then use other drugs, such as alcohol or depressants, to help them sleep. Meth users who binge commonly crash and sleep for days afterwards. When chronic users stop taking meth they experience depression, anxiety, fatigue, paranoia, aggression, and an intense craving for the drug (NIDA, 2002).

According to the US Drug Enforcement Agency (2005), "methamphetamine has a phenomenal rate of addiction, with some experts saying users can get hooked after just one use." Once a person becomes addicted, explains Agent Van Shaw of the North Carolina State Bureau of Investigations (SBI), "home maintenance, personal health and hygiene, and parenting all suffer" as the drug becomes the person's only focus (Shaw, 2004).

Using meth can have many immediate physical side effects, as indicated in the sidebar below. Long-term negative physical effects of chronic use include lung and nerve damage, heart attack, kidney failure, extreme weight loss, tooth loss and cavities, stroke, seizures, and death (Mason, 2004; McFadden, 2003). Because they may engage in risky behaviors, there is also a higher rate of hepatitis, HIV, and STDs among meth users (NIDA, 2002).

The psychological side effects of meth use include hostility, impulsivity, irritability, insomnia, paranoia, and behaviors such as skin picking, pacing, chattering, and repetitive movements. Long-term psychological effects of chronic meth abuse can include delusions, hallucinations, homicide, suicide, psychosis, and bizarre and violent behaviors (Mason, 2004).

In addition to the physical and psychological effects, meth users are at risk for negative outcomes such as unemployment and criminal activity. Meth use and meth labs are linked to increases in crime, especially car thefts, forgeries, identity theft (NCDOJ, 2004), and domestic violence (Shaw, 2004).

USER PROFILE

In North Carolina, most meth users are "young, white, small-town residents with limited education and a blue collar-career" (Lacour & Gregory, 2004). As with most drugs, the majority of users are men (McWhirter & Miller, 2004). Yet many women find the drug attractive. Today women account for 47% of all treatment admissions for meth—a much higher percentage than for most other drugs (Vaughn, 2003).

SIGNS OF METH USE

- Grinding of teeth
- Light sensitivity due to pupil dilation
- Dry mouth
- Rapid heartbeat and breathing
- Sweating and increased temperature
- Euphoria
- Hyperactivity
- Tremor (shaking hands)
- Rapid/pressured speech
- Depression (when drug wears off)
- Irritability, paranoia, suspiciousness
- Hallucinations
- Presence of drug paraphernalia

source: Mason, 2004; Crowell & Webber, 2001

10 Years of Meth: A meth user at age 31 (L) and age 41 (R).
Images courtesy of the North Carolina State Bureau of Investigation.

Anecdotal reports suggest that a significant percentage of the friends and family of parents arrested for cooking meth also use the drug. Though these reports do not have the weight of empirical evidence, they underscore the importance of thorough assessments before placing children.

CHILD MALTREATMENT

Compared to other children, children whose parents use drugs or alcohol are three times more likely to be abused and four times more likely to be neglected (Wells & Wright, 2004). This increased risk certainly seems to apply in the case of meth.

Pregnancy. Meth use during pregnancy can result in prenatal complications, low birth weight, birth defects, increased rates of premature delivery, and abnormal infant behavior (NIDA, 2002; Wells & Wright, 2004). Children born to meth-addicted mothers go through painful withdrawal for weeks or months (Lacour & Gregory, 2004). Long-term, most children prenatally exposed to meth function normally as they get older, though some may have "subtle impairments" that negatively affect regulation of emotions and ability to concentrate, which could put them at risk for behavioral and learning difficulties (Matthias, 2001).

Neglect. When parents use or make meth, their children often do not have necessities such as food, water, and shelter, and they frequently lack adequate supervision and *cont. p. 3*

continued from page 2

medical care, including proper immunizations and dental care (NDIC, 2002). In addition, the cycle of meth abuse has a built-in phase when parents usually "crash" and are unable to look after their children (Wells & Wright, 2004). Children in meth-using families may also face hazards such as used hypodermic needles and razor blades (Swetlow, 2003).

Abuse. Exposure to parents intoxicated by meth may compromise child safety: when high, users often exhibit poor judgment, confusion, irritability, paranoia, and increased violence. Given the effects it has on libido, children of meth-using parents may be at greater risk for sexual abuse (Swetlow, 2003; Riverside DEC, 2005), either by parents themselves or by other adults coming in and out of the home (NCDOJ, 2004).

Brain changes brought on by chronic meth use can impair cognitive function long after a person stops using the drug. Experiments indicate that for up to six months after they stop using, addicts recovering from sustained, heavy meth use may have trouble processing information and may experience anhedonia (inability to experience even the simplest pleasures), depression, and anxiety. On the bright side, research finds that meth users' brains show signs of recovery after 12 to 14 months of abstinence (Wells & Wright, 2004).

TREATMENT FOR METH

Although many people are pessimistic about the future of those addicted to meth, experts say that treatment for meth is just as effective as for other drugs, with 50% to 60% of patients recovering (Worth, 2005).

Predictions of low recovery rates, experts say, often arise in communities with little or no experience with crack, cocaine, or heroin abuse, where substance abuse professionals are unprepared for the challenges of meth addiction (Sommerfield, 2004). Thus, the problem is not that treatment doesn't work with meth, but that the most effective treatment models can be hard to find (Szalavitz, 2005).

One approach that has been proven to work with meth is the Matrix model, which combines elements from relapse prevention, motivational interviewing, and other programs (Larimer County, 2004). One key difference between this model and others is its duration: whereas many programs last 30 or fewer days, Matrix lasts up to six months. This fits better with what we know about how long it takes the brain to shake off the effects of meth.

Thanks to a federal grant, the NC Division of Mental Health, Substance Abuse Services, and Developmental Disabilities is making the Matrix model more widely available in North Carolina. Through its Methamphetamine Treatment Initiative, North Carolina hired a Matrix consultant to train treatment clinicians from New River Behavioral Healthcare (Watauga and Ashe Counties), Western Highlands LME (Buncombe and Rutherford Counties), and Foothills LME (Caldwell and McDowell Counties).

If you are interested in bringing the Matrix model to the mental health LME in your area, contact Smith Worth, manager of the Methamphetamine Treatment Initiative, at smith.worth @ncmail.net.

CHILD WELFARE POLICY

In North Carolina, child welfare policy dictates that allegations of children exposed to meth labs must be investigated by DSS in cooperation with law enforcement. In Multiple Response System (MRS) counties, if the allegation concerns meth use (but no lab), the individual county DSS may respond to the report using either the family assessment or the investigative assessment approach. ◆

WORKING SAFELY WITH METH USERS

Possible Danger Signs

- Signs of methamphetamine use (see description, page 2)
- Client is extremely irritable or argumentative, or there is an escalation of irritability
- Regular client does not appear to know who you are
- Evidence of paranoid thinking, delusions
- Client verbalizes implicit or explicit threat against you
- Presence of knife, firearm, or other weapon in the immediate vicinity

Safety Tips

- Inform supervisor/co-workers you will be visiting a client with a history of making or using methamphetamine
- Follow agency safety protocols and suggestions made in *Practice Notes* issue on worker safety (vol. 3, no. 2)
- Ask permission if you want to go to another area of the client's dwelling or look in cabinets (e.g., to ensure food is in the house)
- Watch for:
  - Symptoms of stimulant use
  - Paraphernalia for using meth such as glass smoking pipes, syringes, straws and razor blades on mirrors or other surfaces
  - Signs that client is becoming upset, angry, or suspicious
  - Scratch marks or scabs, particularly on hands and arms, could be evidence of tactile hallucinations and indicate a prior episode of stimulant psychosis
  - Evidence of hallucinations
  - Strong chemical odor (may indicate manufacturing of meth)

Adapted from Crowell & Webber, 2001

METH LABS AND THEIR IMPACT

What are meth labs and how do they affect the safety and well-being of children?

METH LABS

For many years illegal methamphetamine was made almost exclusively in large batches in "superlabs" on the West Coast and in Mexico. These labs usually used a production process that required hard-to-obtain ingredients and someone with chemistry expertise.

Then, in the late 1980s, new production methods were discovered that made it possible for users without a chemistry background to make meth in small batches in improvised "labs," using readily-available ingredients. These ingredients often include cold medicine, matches, drain cleaner, and paint thinner. Soon these small-time meth "cooks" were teaching others to make the drug. These "Mom and Pop" or "Beavis and Butthead" labs quickly spread.

Today, although most of the illegal meth sold in the U.S. is still produced in superlabs, most of the labs found by law enforcement are of the smaller variety; of the 8,290 clandestine meth labs seized in 2001, only 303 were superlabs (ONDCP, 2003). As of this writing, all the meth labs seized in North Carolina have been small.

Photo Illustration

Children were found in 25% of North Carolina meth labs in 2003.

In North Carolina makeshift labs have been found in "homes, apartments, hotel rooms, inside vehicles, and in close proximity to schools and youth organizations" (Wagoner, 2004). These labs are highly mobile; some fit into a duffle bag or the trunk of a car. Some cooks use a method requiring no heat source so they can work in uninhabited areas (Locke, 2001).

Clandestine labs, which can produce the drug in as few as six to eight hours (Swetlow, 2003), generate between five and seven pounds of toxic waste for every pound of methamphetamine (Butterfield, 2004; NCDOJ, 2004). Statistics from California indicate that most "cooks" make meth 48 to 72 times a year (Riverside DEC, 2005).

EFFECTS ON CHILDREN

According to the National Drug Intelligence Center (2002) the number of children found at seized meth *cont. p. 5*

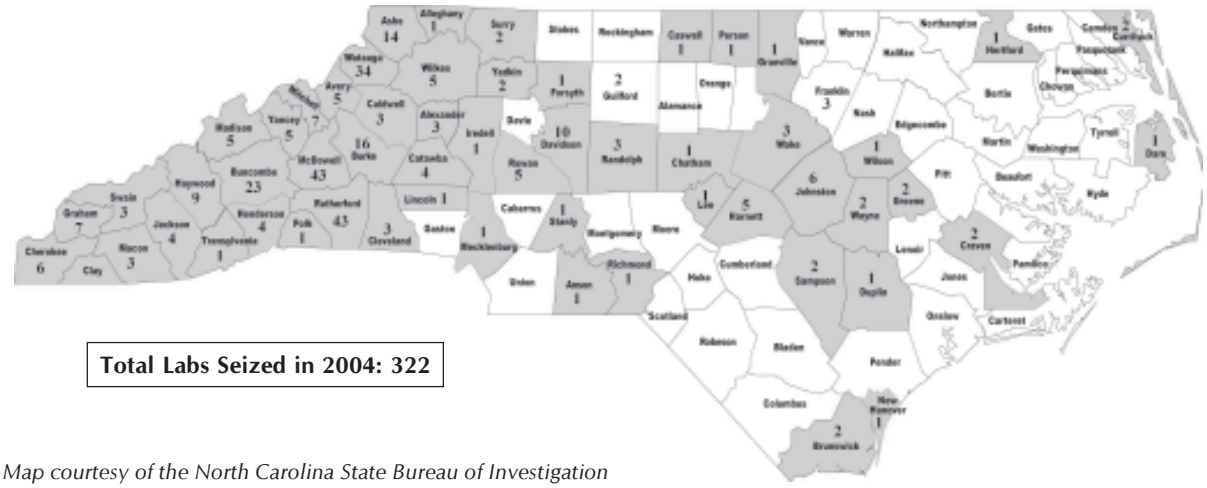
METH AND METH LABS IN NORTH CAROLINA

Meth lab seizures in North Carolina increased twenty-fold in the last four years (NCDOJ, 2004). In 2001, 34 meth labs were found; in 2002 there were 98; in 2003 there were 177; in 2004 there were 322 (Shaw, 2004). North Carolina is doing what it can to combat this trend (see page 8) because it can get much worse: some states seize more than 2,000 meth labs a year.

Rural communities are particularly at risk. Teens aged 12 to 14 who live in smaller towns are 104% more likely to use meth than those who live in larger cities (DEA, 2005). Meth "cooks" often site their labs in rural areas to hide the odors produced during manufacture (KCI, 2005).

The trend is for labs to spread from rural to suburban to urban areas. Relatively few labs have been found in larger cities such as Charlotte and Raleigh, but they are becoming more common in small towns in western and eastern North Carolina (Shaw, 2004).

METH LABS SEIZED IN NORTH CAROLINA COUNTIES, 2004



Total Labs Seized in 2004: 322

Map courtesy of the North Carolina State Bureau of Investigation

continued from page 4

labs in the U.S. more than doubled between 1999 and 2001. Children are found in between 20% (one in five) and 30% (one in three) of meth labs (DEA, 2005; NJMRC, 2004; NCDOJ, 2004). The threats faced by children found in these lab environments include the following.

Chemical contamination. One of the first studies of the exposures faced by the people living in meth labs was conducted by the National Jewish Medical and Research Center. Researchers gathered data from three controlled "cooks" done in a scientific laboratory, a house, and a motel room, as well as from 15 suspected meth lab sites. One of the study's authors says, "The chemicals spread throughout the house. The methamphetamine is deposited everywhere, from walls and carpets to microwaves, tabletops and clothing. Children living in those labs might as well be taking the drug directly" (NJMRC, 2004).

Indeed, approximately 35% of children found in meth labs test positive for toxic levels of chemicals in their bodies, including meth (NDIC, 2002; Shaw, 2004). This is probably an underestimate, since "many states do not keep records on children present at laboratory sites or medically evaluate them for the presence of drugs or chemicals" (NDIC, 2002). Many meth lab chemicals can damage vital body organs or cause cancer (Swetlow, 2003).

Mason (2004) explains that children are at increased risk from exposure to the chemicals in meth labs for a number of reasons:

- Some fumes/gases are heavier than air and so will sink down to the children's level, increasing their exposure
- Their skin isn't as thick as an adult's, which means they absorb chemicals faster
- Their metabolisms are higher (faster breathing and heart rates), so they take in and activate toxins faster
- Children are more inclined to put things in their mouths and to use touch to explore the world
- Their developing nervous systems are less able to withstand exposure to chemicals

Children most commonly come into contact with meth lab chemicals through inhalation and absorption through the skin. The most dangerous method of contact is ingestion, which can prove fatal (NDIC, 2002). Long-term medical complications of exposure to meth lab toxins can include damage to the lungs, kidneys, liver, eyes, skin, and neurological system (NDIC, 2002; McFadden, 2004).

It is not uncommon for children removed from meth labs to have chemically-induced asthma or pneumonia that often clears up after the children are out of the lab (Shaw, 2004).

Fires and explosions. Experts report that approximately one in every six meth labs seized by authorities is discovered because of a fire or an explosion caused by careless handling and overheating of volatile, hazardous chemicals and waste *cont. p. 6*

SIGNS OF A METH LAB

Although not in and of themselves conclusive evidence, the following could signal the presence of a meth lab.

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

IF YOU SUSPECT A METH LAB

Seventy-five percent of meth labs found in North Carolina have been "stumbled upon" (NCDSS, 2005). If you suspect a meth lab take these steps:

- Remain calm. Give yourself time to think.
- Do NOT approach suspects. They are often armed and may be dangerous.
- Do NOT enter the lab area. Discarded containers, waste, and other materials remaining from a meth lab can be highly toxic and dangerous. Do no try to clean up the area. Evidence should remain undisturbed for investigation by law enforcement.
- If you are in the lab already, find an excuse to leave immediately. Never use touch or smell to try to identify unknown substances.
- Keep a safe distance. Hazardous materials may ignite or the fumes may overcome you (Mason, 2004; NCDSS, 2005).
- Promptly notify local law enforcement and follow all NCDSS policies regarding meth labs.

Source: Mason, 2004; Shaw, 2004

METH LABS *continued from page 5*

and unsafe manufacturing methods (Mason, 2004; Riverside DEC, 2005). Based on an analysis of its local data, the Drug Endangered Children (DEC) Program in Riverside County, California found:

- The typical meth cook will experience a lab fire at some point within a 36-month period. One-third of cooks experience multiple lab fires.
- If a fire starts there is a 1 in 5 chance neighbors won't know; at least 20% of lab fires go unreported.
- If a lab fire starts, suspects may flee without warning anyone, even their own children.
- The most likely time for meth production in North Carolina is between 9 p.m. and 6 a.m. (Shaw, 2004)

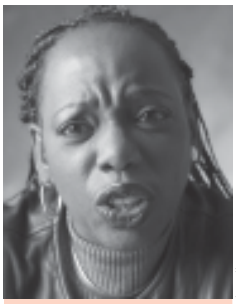


Photo Illustration

Every child welfare worker should be able to recognize a meth lab.

Other risks. Children in meth labs are at significant risk for abuse and neglect. In addition, loaded firearms are found in easy-to-reach locations in the vast majority of meth labs (Shaw, 2004). Dangerous animals and booby traps designed to protect illegal meth labs pose added physical hazards. Children may even be involved in the manufacturing process, but receive no protective gear (Riverside DEC, 2005).

EFFECTS ON COMMUNITIES

Meth labs have a tremendous impact on communities. Typical cleanup costs for a meth lab are between $4,000 and $10,000 (NCDOJ, 2004). These costs must be absorbed by property owners and local and state government. "Cleanup sometimes involves tearing down a house and hauling it away for incineration" (Lacour & Gregory, 2004). North Carolina has already made it clear that insurance companies will not be responsible for damage caused by meth labs (McFadden, 2003).

Unlike other drugs, meth creates little revenue for law enforcement agencies. Instead of seizing homes and other valuables that can offset interdiction costs, officials are left with costly cleanup and ruined properties.

Meth labs also pose a threat to the general public and the environment. Because clothing and other articles are so easily contaminated by meth production, toxins can quickly spread from one place to another, requiring involved clean-up. Meth cooks often dispose of lab waste by burning it, dumping it in streams, fields, and down toilets, or by simply leaving it behind in hotels, on roadsides, and in other public areas.

THE CHILD WELFARE RESPONSE

When it comes to child welfare practice around meth labs our goal should be to provide a measured, realistic response that simultaneously takes into account the serious threats posed by meth production AND reflects our fundamental respect for the family and our concern for its well-being and future.

It may sound difficult, but some agencies say that planning and carrying out such a response in the midst of a SWAT-style police raid really is possible.

The new NCDSS children's services policy covers the many details agencies must take into account in making such a response, including intake screening of meth lab reports, procedures for conducting assessments at lab sites, follow-up interventions, worker safety, and placement provider preparation and safety. The policy also contains numerous assessment tools specifically for responding to a meth lab.

You can find it online at found at <http://info.dhhs.state.nc.us/olm/manuals/dss/>. ◆

WHEN IS IT SAFE TO REOCCUPY A DWELLING THAT HAS BEEN USED TO MAKE METH?

In January 2005 North Carolina passed a law (NCGS 130A-284) stating that property owners may not occupy or cause to be occupied (i.e., rent) a residence formerly used as a meth lab until it has been decontaminated in accordance with the rules established by the NC Department of Health. NCDSS policy states that "Prior to any child's return to the home where the meth lab was located, the home must have been decontaminated in accordance with the rules in N.C.G.S. 130A-284 effective January 1, 2005." These rules have been developed and can be found online at <http://www.epi.state.nc.us/epi/oii/meth/>.

The point of these rules is to prevent a "potential nightmare scenario—one that has occurred in other states—of unsuspecting renters or homebuyers developing inexplicable health problems after living in a house or apartment formerly used to produce meth" (McFadden, 2003).

These rules require every county health department in North Carolina to maintain a list of local properties contaminated by meth. Health departments must keep record of these properties for at least three years. Renters, homebuyers, and child welfare agencies should be sure to call their local health department to find out if a prospective dwelling is safe to reoccupy.

CRAFTING A SAFE, FAMILY-CENTERED RESPONSE TO METH

Recently Chad Slagle, a North Carolina CPS worker from a county affected by meth, travelled to a national conference about the drug. Although the event taught him some useful things, there was one "lesson" he made a conscious decision not to take back home.

According to Slagle, most of the child welfare professionals from other states he spoke with said they don't attempt to keep the family together or reunify them when they find children in a meth lab. "They go straight for TPR (termination of parental rights)," he says.

Despite having seen firsthand the terrible effects meth has had in his own community, Slagle was appalled. He says, "My response to this was, 'We're not doing this.' Kids deserve their families. Families deserve more."

The state of North Carolina strongly agrees. As it clearly expresses in its children's services policy, North Carolina believes that although the safety of the child is always our first concern, the presence of meth use or a meth lab should be a signal to agencies to conduct a thorough, strengths-based assessment and to make a robust attempt to ensure family members receive the treatment and support they need to stay together or to reunify if at all possible.

Like everyone else, families involved with meth have strengths to build on.

As a practice community we are in the process of trying to understand exactly how to do this. It is an incremental journey that is happening county by county, worker by worker, family by family. As you and your agency participate in this effort there are guidelines that you can follow. A good jumping off place is North Carolina's new child welfare policy on responding to meth labs, which can be found at <http://info.dhhs.state.nc.us/olm/manuals/dss/>.

We hope the box below, which is drawn from our discussions with practitioners and a review of the literature on meth and child welfare, is also useful to you as you work to protect and support families struggling with meth. ◆

SUGGESTIONS FOR CHILD WELFARE PRACTICE

- **Safety**. Know about the dangers posed by meth use and meth labs. Knowing how to recognize the signs of meth intoxication is important, since it is linked to violent and unpredictable behavior. Follow your agency's safety protocols. Never do anything to endanger yourself or others.
- **Family Engagement**. Attempts to join with meth-involved parents can be frustrating. Because the drug heightens energy and inflates self-esteem, some meth users feel so "on top of the world" that they are genuinely unable to see any reason for DSS involvement with their family. Yet it is important to avoid pre-judging or demonizing meth users. Assess each family individually. Families involved with meth also have strengths. Help the family find these and build on them.
- **Case Decisions**. Parental substance abuse alone does not constitute child maltreatment. When substantiating or finding a family in need of services, it is important to fully document the negative impact of parental behaviors on the children.
- **Collaboration**. Collaborate with law enforcement by reporting suspected meth use and by jointly approaching families when meth use is known. A close working relationship with substance abuse, medical, and mental health professionals will help you support families. If your community doesn't have an active Drug Endangered Child task force, start one. If it does, join it.
- **Placement**. Placement in foster care should never be automatic, even in the case of a lab. Thoroughly assess kin and others before placing children: meth use is sometimes a problem for extended families. Consulting with law enforcement can help prevent risky placements. NCDSS meth lab policy contains a useful guide for preparing resource families.
- **In-home Services**. Effective addiction treatment is essential. Identify and or/help develop meth treatment resources in your community. Develop realistic plans with families, plans that can accommodate episodes of relapse.
- **Court**. To respond effectively to meth, child welfare agencies need to have access to experts (toxicologists, chemists, chemistry professors) who can testify in court for them. Meth cases typically require more preliminary preparation.
- **Permanence**. Because of the time needed to recover from intense, sustained meth use, and because users may be involved with the criminal justice system, it can be a challenge to achieve family reunification for meth-involved families within ASFA timeframes.
- **Education**. Make sure foster parents and other team members are fully informed about meth use. Educate the schools so they will know how to recognize the signs of meth lab exposure in children. Also, thoroughly educate birth families about the effects and dangers of meth use and production. Carefully document that they have received this information. This can enhance child safety after reunification, or it can provide persuasive evidence in court if reunification is not possible.

NORTH CAROLINA'S RESPONSE TO METH

Our state has responded to the spread of methamphetamine by taking a number of steps, including the following.

Obtaining Federal Funds. North Carolina received a grant through the federal Drug Endangered Child program; Watauga, Johnston, Ashe, and Harnett counties received a total of $312,000 to fund meth-response efforts.

Meth Summit. Attorney General Roy Cooper convened a group of experts in October 2003 to develop a comprehensive strategy to fight meth. The summit's final report is available at <http://www.ncdoj.com>.

New Laws and Funding. Several new laws to fight meth were proposed and passed in 2004 (Eisley, 2004):

- Penalties for making meth increased greatly, from likely probation to a mandatory five to 17 years behind bars
- Additional penalties for making meth in the presence of children, or if someone is injured while seizing the lab
- If someone consumes meth you made and dies of overdose, you can now be charged with murder
- Possessing ingredients in quantities sufficient to make meth can be punished with up to five years in prison, if prosecutors can prove intent to manufacture meth
- Funding for additional SBI mobile clandestine lab response units
- Funding for CPS policy development and training. The new policy is online at <http://info.dhhs.state.nc.us/olm/manuals/dss/csm-65/man/CSs1000.htm>. Meth training will be offered 20 times in spring 2005.

Photo illustration

The number of meth labs seized in NC in the last four years has increased twenty-fold.

Limiting Precursors. California, which has a long history fighting meth, found that legally restricting the sale of chemical precursors needed to manufacture meth is one of the most effective ways of combating the drug's spread. After that state enacted laws restricting the sale of key ingredients such as ephedrine and pseudoephedrine, lab busts were cut in half, from 2,090 in 1999 to 1,130 in 2002 (Gregory & Lacour, 2004). In North Carolina, Attorney General Cooper hopes we can achieve the same results by asking retailers to apply restrictions voluntarily. Currently many retail chains voluntarily restrict sales of products containing ephedrine or pseudoephedrine (Gregory & Lacour, 2004).

Cooper told the *Charlotte Observer* in 2004 that we will know soon enough whether this voluntary approach works. If it doesn't, the state could seek a legislative solution (Gregory & Lacour, 2004). One example of a community effort to get retailers to limit the sales of precursors is happening in Rowan County, where they have formed the "Rowan County Meth Watch." Visit the group's website at <www.rowanmethwatch.com>. ◆

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Children's Services Practice Notes

Family & Children's Resource Program
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