The Family Solution Finder

Study Guide & Workbook w/video's

"Certificate of Completion Course"

PHASE III

"Getting Organized"

Seminar # 14

12 Key Issues a Family Faces in Substance use Disorders

Issue # 5 of 12 key issues: Emergency Medical Services Intervention

Introduction

The family will be traveling on a path that many before them have taken. Each family is different and the circumstances they face are rarely identical. However, there are many aspects by category which remain common to all. So, it is reasonable to assume, the family would benefit to know what is likely to happen prior to it coming up in their journey. We know what will happen, but there is no one to bill for taking the time to tell the family. This is why, to date the family has been left out of the dialog. These seminars are created to fill this GAP of KNOWLEDGE. These are the 12 key issues a family is likely to face and need to prepare for in their journey. We will present them in three parts: 1. The Issue (define it clearly), 2. The issues obstacle, things that will likely come up when the family addresses the issue, 3. Solution to both the issue and its obstacle. The issues are presented in the Study Guidebook, the Obstacle and Solutions are presented in the Workbook. Please read both and watch the assigned video.

An Example: The Legal System will likely be a part of the family journey, and the issue that will come up is "Drug Court". The Drug Court has a specific process which each family will follow, and this information can be presented and learned in advance. By learning this information in advance, the result for the family is EMPOWERMENT THROUGH KNOWELDGE.

Learning these issues in advance reduces stress of the unknown, saves time, allows the family to budget their expenses, and gives them room to gather the needed resources.

THESE 12 KEY ISSUES ARE A "CERTIFICATE OF COMPLETION COURSE SEMINARS.

They are essential to a family members knowledge base in becoming empowered to address each issue in their journey with substance use disorders.

The next 12 seminars will address each of the 12 key issues a family faces in their journey with addiction. It is our goal to break these issues into three parts for each issue:

Issues the Family Faces

This will clearly explain the issue and by using the F.T.R. model allow the family to break it down into a solution.

Obstacle the Family Faces

These are obstacle the family faces when trying to address each issue.

Solutions to Issues & Obstacles

Each of these will be presented in the 12 Key Family Issues.

The 12 Key Issues a Family Faces

ISSUE # 1. Enabling vs. Consequences

GOAL: To use this seminar content as a foundation towards *building denial techniques* that do not enable substance misuse. Also learn the consequences of enabling and denial that disables the positive habits of successful recovery. How communication makes a safe place for the family.

ISSUE #2. Addiction Behavior

GOAL: To learn the *behavior traits of substance use disorder*. To understand how boundaries work to create change over time. Also, learn how to responds to these behaviors.

ISSUE #3. Family Intervention

GOAL: Gain a practical understanding of the *5 Stages of Change* theory. Be able to apply the motivational interview (family level) work sheet for each stage.

ISSUE #4. The Police Intervention

GOAL: To learn the typical steps needed when the police intervein. Create a *missing person's report* in advance. Learn the options and paths this intervention might take. Be able to bridge from the police intervention to the next level of intervention.

ISSUE #5. The Emergency Medical Services Intervention

GOAL: Learn what to do in the case of a medical emergency. Understand what to expect at an Emergency Room. Be prepared to make the needed decisions required at this part of the journey.

ISSUE #6. The Legal System Intervention

GOAL: Learn how to navigate the court system. What is the requirement for drug court and other options?

ISSUE #7. The Treatment Center Intervention

GOAL: Learn what the treatment center will do and what it will not do. How to select the right treatment center using a criterion check list.

ISSUE #8. The County, State, Federal Agencies

GOAL: Learn how to create a family Resources Plan by using a *Family Resources Plan of Action Work Sheet.* Using the list of available agencies to properly match the agency with the needs of the family.

ISSUE #9. Relapse

GOAL: Learn how to create a *Getting Back to Work Plan*. Using the Getting Back to Work Planning Guide match each step with the proper agency or program.

ISSUE #10. Successful Lifelong Recovery

GOAL: Learn how to create a supportive and safe space for the family and the loved one in recovery.

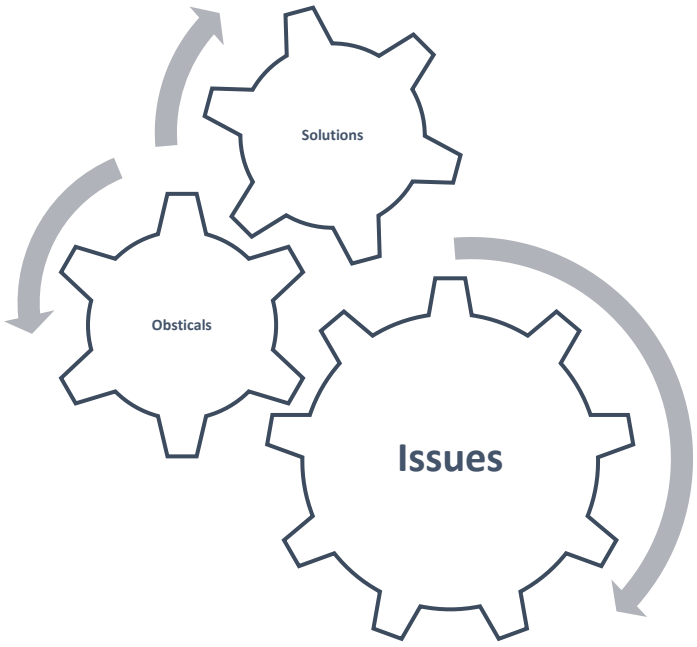
ISSUE #11. Bereavement

GOAL: Learn how to navigate the journey of grief and all that life give us in these times.

ISSUE # 12. Faith, Spiritual Practices

GOAL: How to create a new State Certified Addiction Counselor position at your place of worship. Open Doors to Open Hearts May 5th call for universal inter-faith prayer across NE Ohio. 2-4pm

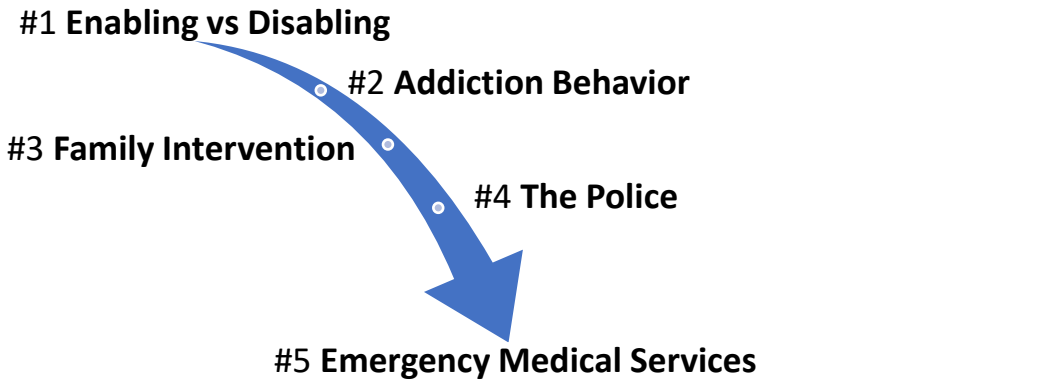
An Issue has obstacles, before the solution can be obtained

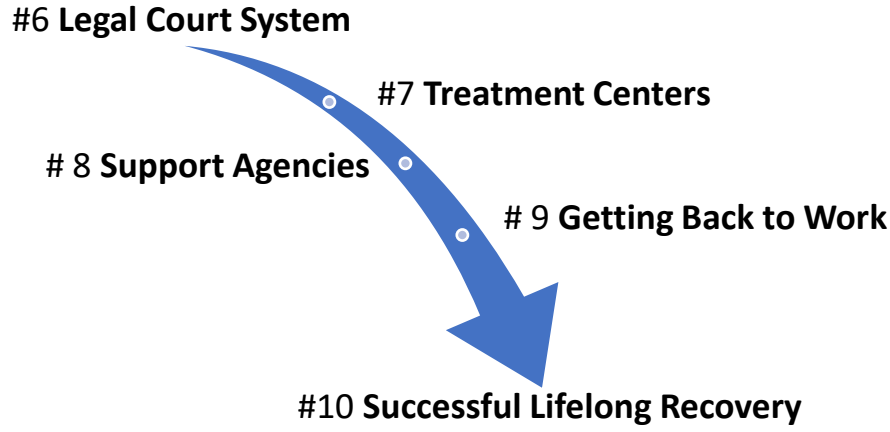


Plan to Address All Three

Sequence (consider relapse occurrences)

The 12 Key Issues a Family Faces





#11 **Bereavement (Learning how to move forward)**

#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

Family Transformational Response Model (F.T.R.)

Instruction: Take the issue and in clear details define what the issue is, then state how this issue will impact the family, then identify what steps your family can take to prepare or respond to this issue, then find those organizations/professionals who can help the family in dealing with this issue**. This model creates a known expectation for the outcome. This model/tool is part of the family's empowerment response.**

The F.T.R. Model:

I. Define the Issue?

II. How does this issue impact the family?

III. What steps can the family take to prepare and respond to this issue?

IV. Creates of list of who can help and assist the family in their response?

V. What should the family expect as their outcome?

The F.T.R. Model Worksheet

I. Define the Issue?

- ❖ Clearly State what happened or will happen.

_____

_____

_____

- ❖ Identify who is involved or should be involved.

_____

_____

_____

- ❖ What would you like to have happened, or like to see happen?

_____

_____

_____

II. How does the issue impact the family?

- ❖ Who in the family?

_____

_____

_____

- ❖ In what way?

_____

_____

_____

- ❖ What is needed to move forward?

_____

_____

_____

III. What steps can the family take to prepare and then respond to the issue?

- ❖ What needs to be done, prioritize the list.

_____

_____

_____

- ❖ Who needs to be involved?

_____

_____

_____

- ❖ What will it look like when completed?

_____

_____

_____

IV. Who can help and assist the family in their response?

- ❖ How to search for an organization to help.

_____

_____

_____

- ❖ What to ask from them?

_____

_____

_____

- ❖ What to expect?

_____

_____

_____

V. What should the family expect as their outcome?

- ❖ Timeline.

_____

_____

_____

- The expenses/cost involved in this issue.

  _____

  _____

  _____

- Required changes to successful respond to this issue.

  _____

  _____

  _____

Use the F.T.R. model for every issue, to find your best solution.

The Family Solution Finder

Study Guide

PHASE III

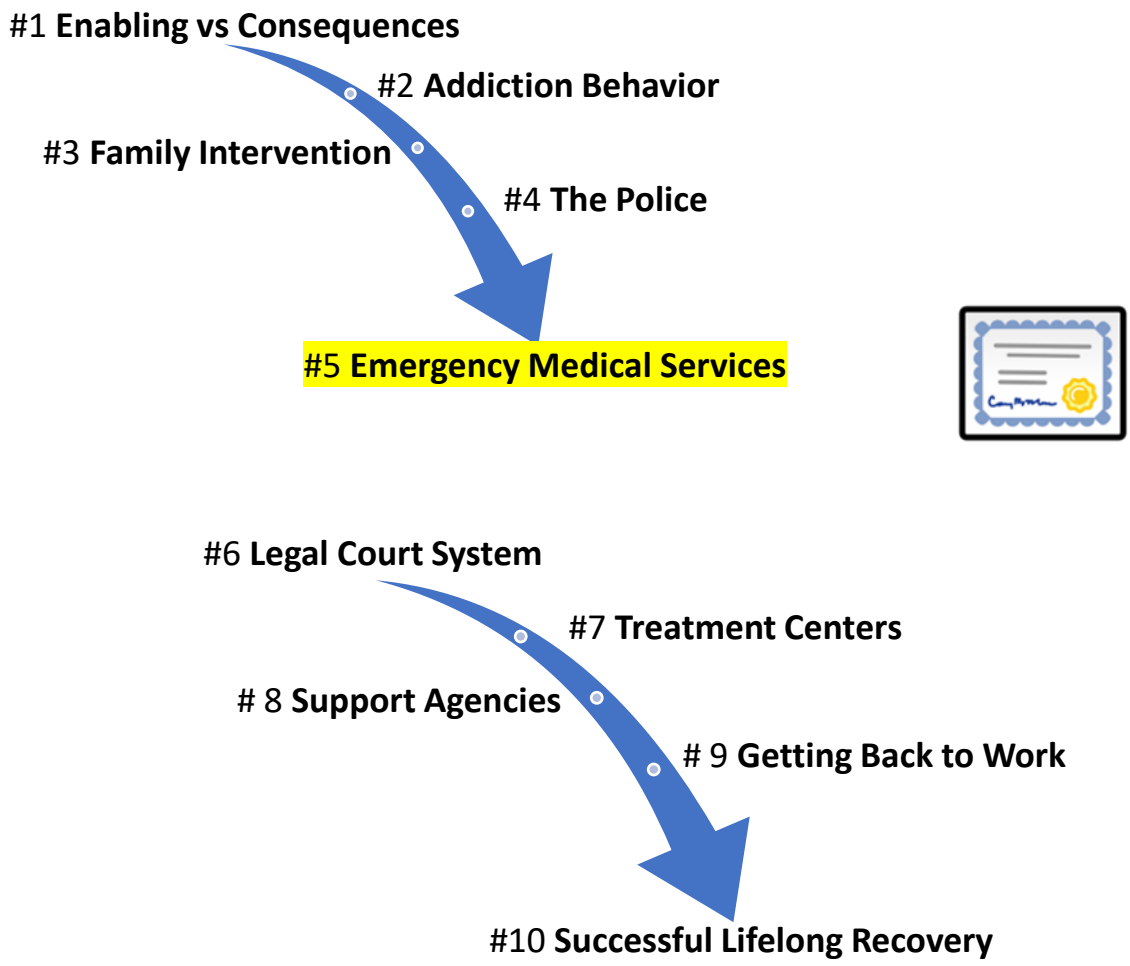
"Getting Organized"

Seminar # 14

12 Key Issues a Family Faces in Substance use Disorders

Issue # 5 of 12 key issues: Emergency Medical Services Intervention

The 12 Key Issues a Family Faces



#11 **Bereavement (Learning how to move forward)**
#12 **Faith, Spiritual Practices (It's His will first and in all ways)**

Introduction: The Emergency Medical Services Intervention

Make no mistake about it, when the stages of this disease reach a need for medical intervention, you are at

a new phase in the family journey. This is the sever stage and now is not the time to learn about what will happen next and how you need to respond. Fortunately, you are taking this seminar and can start the learning process to be prepare for this likely future event.

This is an intervention and can be a critical turning point at getting your loved one to accept treatment. However, it can go either way; it may yield a successful next step or may be a temporary and frightening experience in the continuation in self-use. It may also be the end of their journey in life.

Signs of OVERDOSE, which is a life-threatening emergency, include the following:

 The face is extremely pale and/or clammy to the touch.

 The body is limp.

 Fingernails or lips have a blue or purple cast.

 The person is vomiting or making gurgling noises.

 The person cannot be awakened from sleep or cannot speak.

 Breathing is very slow or stopped.

 The heartbeat is very slow or stopped.

CALL 911

There are four phases to the "Emergency Medical Service Intervention":

1. Paramedic First Response Phrase.
2. Hospital Emergency Room Visit.
3. Hospital Intensive Care Unit Admissions or Discharge.

The reality of this experience is a hospital will not going to take ownership of seeing your loved one through their next steps into recovery. That is going to be your job, not theirs. We need to keep our expectations in line with what is most likely to happen.

The hospital will treat them for their condition, (which is what they are there for) and release them. If your loved one is referred to a Peer to Peer coach, great. They may also be seen in follow up visits with behavioral health, admitted to a treatment center or discharged to the custody of the police. All of these are not the responsibility of the hospital to follow after that point, it is not their concern, it is yours and yours alone.

But by knowing the steps in an “Emergency Medical Services Intervention”, you can stay one step in front of their process and set up the best next choices for your loved one.

The family members need to:

1. Get Educated on the process.
2. Get Organized to be ready should this occur.
3. Get Networked in advance, to know who is here to help.

Get Educated, Include the Family Members

Get Educated

What is your budget for this expense?
Nothing is free. You will get a bill for transportation to the Emergency Room and it is likely not covered by insurance. The emergency room patients are likely to get a surprise hospital bill from the radiology, medical transport and other specialty groups such as cardiology departments**.**

They don’t necessarily have your back in follow-up.
A new study found that fewer than 10% of ED patients treated for opioid overdoses received medications to treat their substance use disorder. In the years after their overdose, only 10% of those overdose patients received mental health counseling. Experts say a lack of training among health professionals undermines what happens after the overdose patient is stabilized. However, the family members could have prevented this by getting their loved one to the right level of care.

How can the family respond for best results?
We should be doing everything we can to get them plugged into treatment. By comparison to someone who came into the emergency room with a heart attack. It's taken for granted that the patient would leave with heart medication and a referral to a cardiac specialist. Similarly, you would think patients who come in with an overdose to start buprenorphine in the hospital and leave with a referral to other forms of treatment. The family needs to understand that a lack of training and understanding among health professionals continues to undermine what happens after the overdose patient is stabilized. The emergency rooms are not particularly well trained to be able to help people in a situation like this. So, it is up to the family to get educated on what treatments are best practice for their loved one upon discharge from the ER. McEvoy, M. Naloxone: Drug Whys. EMS1. 2015, October 22.

For this reason, your family is needed in the ER, to advocate for the right level of assessment, treatment and especially follow-up care.

Check list of events which may occur

Para-Medic

Stablize and Transport

- Stablize VItal Signs for respiratory, cardiac and neurogolgy (brain fuctioning)
- Transport to the ER, non-cobative

Hospital ER Visit

Triage, Assess, Treat, Discharge

- Triage Vitals is the hospitals first priority
- Assess Severity, what drugs are identified, is referral to ICU required?
- Treat condition and Co-Mobidities, stablize condition, treat other identified co-mobidities.
- Discharge to Police, Treatment Center, Peer to Peer Coach or Home.

Hospital ICU Admission or Discharge

Stablize, Improve Condition, Discharge

- Intesive Care Unit (ICU)
- Plan of Treatment
- Discharge

Para-Medic, First Responder (NOTE: This is not for the family members to use, it is only for the family members to understand what the clinicians are doing as you observe). Do not take any of these steps unless you are a license professional in this field.

A Case Simulation:
The Emergency responders arrive. An assessment of the patient's vital signs reveals a heart rate of 123 beats per minute, blood pressure of 122/86 mmHg, and an oxygen saturation of 98% with assisted ventilation (his room air oxygen saturation was 66%). His initial end tidal CO2 is 70 mmHg and his blood glucose is 269 mg/dL. The patient's skin is pale, dry and cold to the touch. After establishing IV access and starting a normal saline bolus, the crew administers 0.4 mg of IV naloxone (Narcan).

After five minutes, his spontaneous respiratory effort improves and he becomes agitated and combative. The patient's movement isn't purposeful and he isn't able to speak. The patient is placed on high flow oxygen via non-rebreather mask. Reassessment of vital signs reveals a heart rate of 140 beats per minute, a blood pressure pf 134/83 mmHg, a SpO2 of 99%, a respiratory effort of 30 breaths per minute, and an EtCO2 of 34 mmHg. The patient now has a Glasgow coma score of 8.

One of the first responders suggests an additional dose of naloxone because the patient is still obtunded. Though the patient continues to exhibit decreased mentation, he's breathing adequately, so there's no indication to give additional naloxone. The crew captures an ECG which is unremarkable and prepares the patient for transport to the hospital.

While enroute to the receiving facility, the patient becomes increasingly combative and the crew is forced to sedate him with midazolam (Versed). After two 2.5 mg of IV midazolam, the patient is appropriately sedated. The patient doesn't experience any respiratory depression and the rest of the transport is uneventful.

Upon arrival at the ED, the patient is transferred to staff, and the crew starts to get their gear back together for the next call. The patient's urine drug screen is found to be positive for opioids as well as cocaine, and his core body temperature is 84 degrees F. Active rewarming is initiated in the ED and the patient is admitted to the ICU.

Hospital Emergency Room Visit

Stabilization of vital signs is the hospital first concern. The cardiac, respiratory and neurological (brain) is closely assessed for conditions of decline.

One of the protocols is the use of Naloxone. This may also be the response used on site with the first responders.

With any overdose that results in admission, the first few hours determine not only the outcome, but also the pace at which patients recover.

The key is to identify the important clinical effects. That means figuring out if the overdose is activating (or deactivating) the central nervous system, causing cardiac arrhythmias or depressing myocardial function, or causing anion gap acidosis. The heart.

"Those are the really big ones you need to be concerned about early on," says Dr. Heard, who is on the faculty at the University of Colorado School of Medicine.

The recognizing of exactly what drug was used isn't necessarily as important as recognizing the severity of patients' symptoms and responding to them. With a drug that deactivate the CNS as Opioids, the most common reason people die is because they lose their airway. By managing the patients' airway, they're likely going to survive.

This means ventilation is important, when ER or First Responders overdose the short-acting sedatives to calm the patient with a drug like midazolam or propofol, patients may experience longer ICU course because someone gave them multiple doses of lorazepam. They're overly sedated when they might have been ready to extubate.

Naloxone in the ER

1. Opioids cause respiratory compromise and naloxone can reverse it

All opioids stimulate specific receptors in the brain, which decreases perception of pain and causes a feeling of euphoria. When overstimulated, opioid receptors desensitize the brainstem to rises in CO2, which causes respiratory depression, creating a loss of protective airway reflexes and respiratory arrest. Cardiac arrest from opioid overdoses is usually secondary to respiratory arrest. Both are critical and life threatening.

Naloxone reverses narcotic overdoses by binding to opioid receptors in the neuronal channel, which blocks stimulation from the opioid substance. If administered in time, this restores the patient's airway reflexes, respiratory drive and level of consciousness.

The major drawback of naloxone is that it can trigger withdrawal symptoms in patients addicted to narcotics, including agitation, tachycardia, vomiting and pulmonary edema. Withdrawal symptoms are usually mild and short lasting, but some patients can become violent after receiving naloxone. Violent reactions are usually after intravenous naloxone is administered at too high a dose or too quickly [2].

Remember the goal of treatment is to restore respiratory drive and airway reflexes, prevent respiratory and cardiac arrest, and avoid causing severe opioid withdrawal [1].

2. Address circulation and ventilation before administering naloxone

Initial care for patients with a suspected narcotic overdose is the same as for any other patient with decreased mental status. They may present drowsy, even falling asleep mid-sentence, and require frequent verbal or tactile stimuli for arousal. They may also be unconscious with slow or agonal respirations, diaphoretic and cyanotic. Opioid usage also causes pupils to constrict, but taking of another substance or anoxic brain injury may cause pupils to dilate. Once respiratory depression occurs, assisted ventilation and naloxone are vital to prevent permanent brain damage or death [2].

The pulse is first checked of an unconscious patient. If a pulse is not detected they start chest compressions and attach the defibrillator. The 2015 American Heart Association guidelines recommend standard ACLS practices for cardiac arrest secondary to opioid overdose, and makes no recommendation regarding the administration of naloxone [1].

For unconscious patients with a pulse, they will open the airway, assess respiratory rate and assist ventilation with a bag-valve mask.

They will assess pulse-oximetry to guide ventilation rate and to determine if ventilations are effective. The amount of carbon dioxide (CO2) in exhaled air at the end of each breath (end-tidal CO2, or ETCO2) will be monitored.

2. When giving naloxone, think intranasal administration first

Naloxone can be administered intravenously (IV), intramuscularly (IM), intranasally (IN), subcutaneous (SQ), endotracheal and via nebulizer. The most common routes for EMS administration are intranasal, intramuscular and intravenous, which has several advantages over the other routes for the initial dose.

Patients respond approximately 80 percent of the time to both intravenous and intranasal naloxone, but the onset of intranasal naloxone is longer, the recovery is more gradual, and there is less risk of patient agitation and withdrawal symptoms.

Because ventilation and oxygenation is addressed before naloxone administration, other benefits of intranasal administration outweigh the added time needed to restore spontaneous respiration and airway reflexes. A higher dose of naloxone may be needed to reverse longer-lasting oral or transdermal opioids than for heroin. Even if a second intravenous dose is needed later, there is no downside to giving an initial dose intranasal before attempting intravenous access.

Approximately 20 percent of opioid overdose patients do not respond to naloxone. This may be from a high opioid dose, brain damage after a prolonged downtime, or use of other medications.

References:

1. Lavonas EJ, Drennan IR, Gabrielli A, Heffner AC, Hoyte CO, Orkin AM, Sawyer KN, Donnino MW. Part 10: special circumstances of resuscitation: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Cardiovascular Care. *Circulation.* 2015;132(suppl 2):S501–S518.

Hospital Admission to ICU or Discharge

Hospital Admission to ICU

This admission is not about the drug, it is to address the damaged caused by the drug.

Admission into the Intensive Care Unit (ICU) will be assessed in the emergency room. Note: the death rate among overdose patients treated in ICUs averaged 7% in 2009 and increased to 10% in 2015.

Patients admitted to ICUs due to overdoses have several common comorbidities including aspiration pneumonia (25%), septic shock (6%), rhabdomyolysis (15%) and anoxic brain injury (8%). Ten percent of patients who overdosed needed mechanical ventilation.

A typical length of stay is 3-4 days.

Hospital Discharge

St. Paul's MN Hospital, Early Discharge Rule was derived to determine which patients could be safely discharged from the emergency department after a 1-hour observation period following naloxone administration for opiate overdose. The rule suggested that patients could be safely discharged if they could mobilize as usual and had a normal oxygen saturation, respiratory rate, temperature, heart rate, and Glasgow Coma Scale score. Validation of the St. Paul's Early Discharge Rule is necessary to ensure that these criteria are appropriate to apply to patients presenting after an unintentional presumed opioid overdose in the context of emerging synthetic opioids and expanded naloxone access

Dr. Yngvild Olsen, medical director for the Institutes for Behavior Resources/REACH Health Services in Baltimore, says the study confirms what many in the addiction medicine field have known for a long time: There's a need for interventions beyond what she calls the "usual standard of care, which has been to hand people a phone number or pamphlet and say 'Here. Good luck.' "

Olsen says such interventions are in the works. She points to a 2015 study by researchers at the Yale School of Medicine who tested three interventions for opioid-dependent patients who came to the emergency department for medical care.

The first group was given a handout with contact information for addiction services. The second group got a 10- to 15-minute interview session with a research associate who provided information about treatment options and helped the patient connect with a treatment provider, even arranging transportation. The third group got the same interview, plus a first dose of buprenorphine, additional doses to take home and a scheduled appointment with a primary care provider who could continue the buprenorphine treatment within 72 hours.

Dr. Corey Waller, who trained in emergency medicine and is now senior medical director for the National Center for Complex Health and Social Needs, says medical teams often lack basic knowledge.
"The professionals that are supposed to be able to refer and treat don't have the training to know how and

what to do," Waller says, pointing out that as a resident, he received less than one hour of instruction in addiction treatment.

Another problem, he says, is that emergency departments treat an opioid overdose as a toxicological problem, not unlike dealing with a patient who took too much Tylenol.

"But what that completely ignores are the psychological aspects of [addiction]," Waller says. "When you ignore that, you are fully ignoring the disease. And you're looking at the patient like a toxicological problem and not a human."

He says it's important to remember that opioid addiction changes people's brains in ways that keep them from making logical decisions, such as seeking out treatment after an overdose. "They're not putting a pros and cons list on the refrigerator," he says. "They're just reacting to a situation that feels very much like survival."

The study found that 78 percent of patients in the third group — the group that got a dose of buprenorphine in the hospital — were still in treatment 30 days later, compared with 45 percent in the group that only got the interview and 37 percent who only got the handout.

Based on the study, hospitals across the country are now discussing incorporating buprenorphine into emergency department care for patients who have overdosed, Olsen says. Several Baltimore hospitals have begun doing so. She is hopeful that such a system could provide new paths to treatment for people who need it, while not overburdening emergency department staff who are already stretched thin.

"Conceptually, it makes so much sense," Olsen says. "It is, in my mind, one of those landmark studies that really addresses how to take advantage of those missed opportunities that the JAMA research letter describes."

The initial assessment and treatment of patients attending an emergency department (ED) for suspected drug poisoning takes place in the emergency room, where the busy physicians must rapidly decide on the level of therapeutic measures and disposal. Decontamination procedures for drug overdose are recommended under specific circumstances by the American Academy of Clinical Toxicology and by the European Association of Poison Centres and Clinical Toxicology in a joint position statement,1 but their efficacy is questioned. The most important measure is a correct management of individual patients, according to their clinical status and hospital resources. In unstable patients, lifesaving support is mandatory, independently of laboratory results, whereas in uncomplicated, stable, slightly drowsy patients, with no specific symptoms of drug poisoning, the diagnosis may be uncertain, and there is no definite consensus on treatment and disposal. These patients are a special challenge for the emergency physicians.

A pure clinical approach, without confirmatory laboratory results, makes diagnosis and decision making highly uncertain. Some patients need only a brief period of observation in ED, while others may need care in a high dependency unit (HDU) or in intensive care unit (ICU), in relation to worsening clinical status or long acting drug overdose.

Comprehensive drug screenings have been proposed to document and confirm any acute drug overdose in patients for suspected poisoning.

2 A screening procedure is operative in our unit, permitting the determination of over 900 drugs and their metabolites in a turnaround of 20 to 60 minutes. Its usefulness has however been questioned

3 In most cases the results do not change, the decision being mainly based on clinical parameters.

4 Drug screening, limited to life threatening drugs selected on the basis of the clinical suspect, is currently considered a cost effective diagnostic tool.
The aim of this study was to evaluate the effects of comprehensive drug screening in decision making strategies of patients with suspected drug poisoning. In particular, we aimed to determine whether the results of such screening improved the agreement in an expert panel of emergency physicians and changed the decision on patients' disposal, potentially saving hospital resources.

REF: Comprehensive drug screening in decision making of patients attending the emergency department for suspected drug overdose A Fabbri, G Marchesini, A M Morselli-Labate, S Ruggeri, M Fallani, R Melandri, V Bua, A Pasquale, A Vandelli

Get Organized

RESOURCES FOR OVERDOSE SURVIVORS AND FAMILY MEMBERS

Survivors of opioid overdose have experienced a life-changing and traumatic event. They have had to deal with the emotional consequences of overdosing, which can involve embarrassment, guilt, anger, and gratitude, all accompanied by the discomfort of opioid withdrawal. Most need the support of family and friends to take the next steps toward recovery.

While many factors can contribute to opioid overdose, it is almost always an accident. Moreover, the underlying problem that led to opioid use—most often pain or substance use disorder—still exists and continues to require attention.

The individual who has experienced an overdose is not the only one who has endured a traumatic event. Family members often feel judged or inadequate because they could not prevent the overdose. It is important for family members to work together to help the overdose survivor obtain the help that he or she needs.

FINDING A NETWORK OF SUPPORT

As with any health condition, it is not a sign of weakness to admit that a person or a family cannot deal with overdose and its associated issues without help. It takes real courage to reach out to others for support and to connect with members of the community to get help. Health care providers, including those who specialize in treating substance use disorders, can provide structured, therapeutic support and feedback.

If the survivor's underlying problem is pain, referral to a pain specialist may be in order. If it is addiction, the patient should be referred to an addiction specialist for assessment and treatment by a physician specializing in the treatment of opioid addiction in a residential treatment program or in a federally certified opioid treatment program.

In each case, counseling can help the individual manage his or her problems in a healthier way. The path to recovery can be a dynamic and challenging process, but there are ways to help. In addition to receiving support from family and friends, overdose survivors can access a variety of community-based organizations and institutions, such as: ♣ Health care and behavioral health providers. ♣ Peer-to-peer recovery support groups such as Narcotics Anonymous. ♣ Faith-based organizations. ♣ Educational institutions. ♣ Neighborhood groups. ♣ Government agencies. ♣ Family and community support programs.

The Personal Attaché Organized Binder

Because your next step will require request for new information it is best to organize these document into a Binder. You will complete this exercise in "The Family Solution Finder Workbook" under this section: The Emergency Medical Services Intervention.

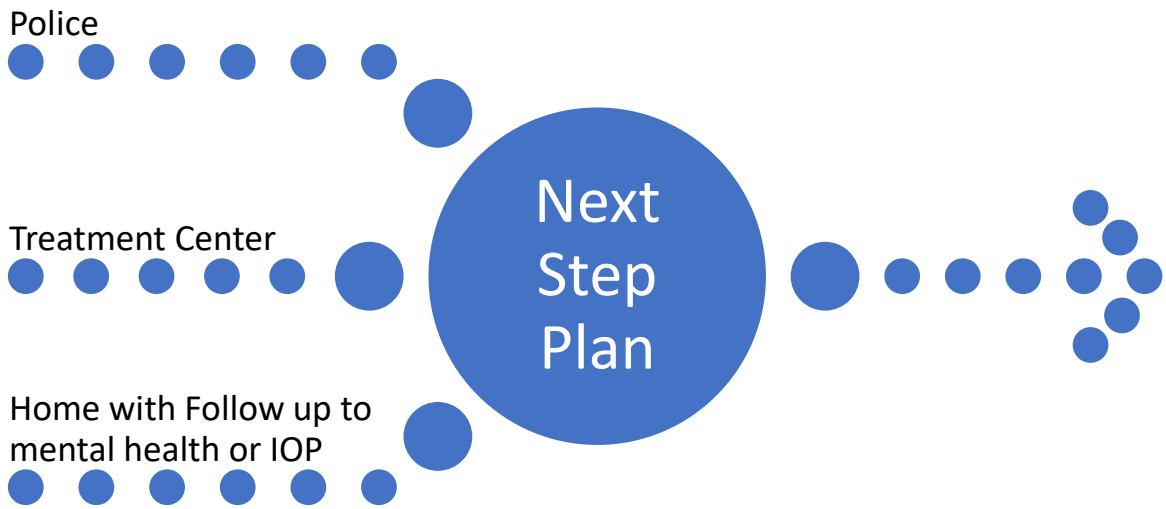
There are a number of steps a family will go through when using a hospital for the care of their loved one. Most of these require documents, billing information, healthcare history information and current health status updates. This can all be contained by the family in a "Family Personal Attaché Binder", which the family assembles prior to needing this level of information.

The Family Personal Attaché is a binder system that contain important documents and information about the persons life that are requested by professional service in order for them to provide their services. In the Binder System there are four parts:

1. The Legal Section
2. The Medical Section
3. The Financial Section
4. Spiritual/Social/Community Networking Sections

All these sections are filled in with specific documents and information about the persons status, history and future. In the case of completing this family binder for the person with a substance use disorder the medical section is the part that will be most frequency used and updated.

Your Family Plan of Action After Discharge:



Each of the above categories can be learned prior to the event taking place. It will be a great value to the family members if they get educated about each option and then create a plan of action on that topic to pre-determine the choices the family will need to consider.

Because each case is unique it will be difficult to determine all the steps that will be needed. However, having a mutual base understanding will assist the family in communicating, making stronger decision and in the end save time and money for improved outcomes.

Next Steps Following Emergency Medical Services Intervention

At this point, the hospital visit is over and now the next steps will require new decisions and choices of which path to take.

This scenario plays out in emergency departments across the country, where is the next step — unfortunately the means to divert addicted patients into treatment — remains elusive, creating a missed opportunity in the health system. A recent study of Medicaid claims in West Virginia, which has an opioid overdose rate more than three times the national average and the highest death rate from drug overdoses in the country, documented this disconnect.

Researchers analyzed claims for 301 people who had nonfatal overdoses in 2014 and 2015. By examining hospital codes for opioid poisoning, researchers followed the patients' treatment, seeing if they were billed in the following months for mental health visits, opioid counseling visits or prescriptions for psychiatric and substance abuse medications.

They found that fewer than 10 percent of people in the study received, per month, medications like naltrexone or buprenorphine to treat their substance use disorder. (Methadone is another option to treat substance use, but it isn't covered by West Virginia Medicaid and wasn't included in the study.) In the month of the overdose, about 15 percent received mental health counseling. However, on average, in the year after the overdose, that number fell to fewer than 10 percent per month.

"We expected more … especially given the national news about opioid abuse," said Neel Koyawala, a second-year medical student at Johns Hopkins School of Medicine in Baltimore, and the lead author on the study, which was published last month in the Journal of General Internal Medicine.

It's an opportunity that's being missed in emergency rooms everywhere, said Andrew Kolodny, the co-director of Opioid Policy Research at the Heller School for Social Policy and Management at Brandeis University outside Boston. "There's a lot of evidence that we're failing to take advantage of this low-hanging fruit with individuals who have experienced a nonfatal overdose," Kolodny said. "We should be focusing resources on that population. We should be doing everything we can to get them plugged into treatment."

He compared it to someone who came into the emergency room with a heart attack. It's taken for granted that the patient would leave with heart medication and a referral to a cardiac specialist. Similarly, he wants patients who come in with an overdose to start buprenorphine in the hospital and leave with a referral to other forms of treatment.

Kolodny and Koyawala both noted that a lack of training and understanding among health professionals continues to undermine what happens after the overdose patient is stabilized.

“Our colleagues in emergency rooms are not particularly well trained to be able to help people in a situation like this,” said Dr. Margaret Jarvis, the

It was clear, Angerer said, that her doctors were not equipped to deal with her addiction. They didn’t know, for instance, what she was talking about when she said she was “dope sick,” feeling ill while she was going through withdrawal. “They were completely unaware of so much, and it completely blew my mind,”

Ref: Journal of General Internal Medicine June 2019, Volume 34, Issue 6, pp 789–791| *Cite as Changes in Outpatient Services and Medication Use Following a Non-fatal Opioid Overdose in the West Virginia Medicaid Program*

Plan of Care as follow up:
According to a news report report, 79% of overdose victims in Delaware died in private homes. Fifty-two percent of overdose deaths occurred within three months of a visit to an emergency room. Most exhibited signs of substance abuse disorder during those ER visits. That’s according to a new report from the Delaware Drug Overdose Fatality Review Commission, which was created to better understand the state’s overdose death epidemic.

It is absurd that we don’t voluntarily offer the best care we have to anyone who wants it in the aftermath of an overdose, on the spot.

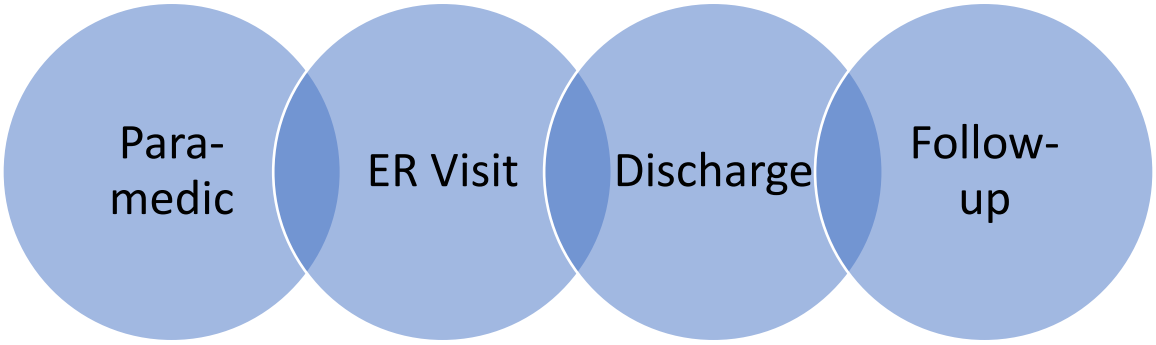
A strategy of offering immediate medication treatment has been studied in a randomized clinical trial published in the *Journal of the American Medical Association* in 2015. 329 patients were included. Of this group, 104 were simply provided a referral to further treatment, 111 were given referrals along with a brief motivational therapy aimed at encouraging them to follow through and enter care and 114 were prescribed buprenorphine right then and there.

Not surprisingly, the buprenorphine patients were twice as likely as those who were simply offered treatment referrals to still be in treatment a month later, and they reduced their illegal opioid use from an average of five days a week to an average of just one.

While 78% of them were still in treatment, fewer than half of the other two groups remained engaged—and their drug use was reduced by far less than in the group who got buprenorphine immediately, according to Dr. Gail D’Onofrio, lead author of the study, and a professor of emergency medicine at Yale.

“Immediate treatment in the emergency room with buprenorphine for a patient withdrawing or after an overdose is critical to save more lives and engage more people in treatment, but only if the 100 patient limit is eliminated and people have somewhere to go for maintenance,” says Dr. Molly Rutherford, a family doctor who treats addiction in Kentucky, which is one of the hardest hit states. She also notes that many E.R. doctors may also be unaware that they are legally able to provide emergency maintenance.

Of these four, Follow up is the most often neglected and creates the greatest loss in opportunity to move forward.



So often is the case where the patient leaves the ER, says they are fine and months go by. Then it happens again. Over and over again.

Stop the cycle by using the ER as a launch into follow up services, know the resources now before you need them. Because, it is very likely you will need them.

NOTES:

The Family Solution Finder

Workbook

PHASE III

"Getting Organized"

Seminar # 14

12 Key Issues a Family Faces in Substance use Disorders

Issue # 5 of 12 key issues: Emergency Medical Services Intervention

Going Forward

We are going to begin with this video. Stop reading and view the recommending link. Afterward, you will now understand more about what is likely to happen. So, do you want to know how you can learn and be ready to respond so that when this is done you can act in a way that takes the most advantage of a bad situation. The emergency medical services intervention is the first place where everything stops and the focus demands their attention. It typically does not last long, and when over is the point that a family has the opportunity to make a difference.

VIDEO ONE

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: Opioid rescue in action (simulation)

UMass Medical School

This dramatization depicts a simulated emergency room encounter for the management of an opioid overdose. The individuals in this simulation are real medical professionals acting in the roles they serve in a real-world emergency room setting.

Published on May 4, 2018

Link:
https://www.youtube.com/watch?v=kuIOltSBOMU&list=PLK9_yWbpBidoFLIz1znyWKebChhCVJktl&index=37&t=0s

The Emergency Medical Services is an Intervention

Issues the Family Faces

. **INTRODUCTION TO SBIRT**

Because emergency medical services are an intervention and assessment is a matter of course and procedure, this will happen in a sequence according to those that respond to your call for help. However, it is equally important to the family members that what is done next includes their participation. This is often not the case because family members are not aware to the choices involved or decisions that need to be made.

The family being included is a matter of advocatory activist. Your family members need to become Advocatory Activist in order to address your family needs in a manner that will make a difference. We are sorry to tell you this, but you will need to stick up for yourself and make this industry do for your, that which needs to be done.

Therefore, you will need to know more about "best practices" that are being provided elsewhere and set up the same model to serve you and your family. This may seem un-necessary in going to such extremes, but consider the alterative, you know nothing, your being told nothing and therefore you can do nothing. If nothing is not an option you want, then learn what is possible, that is proven to work, and be an advocatory activist by learning and speaking up for yourself and your loved one. This level of knowledge is empowering.

SBIRT stands for Screening Brief Intervention and Referral Treatment. Nothing gets done in this industry until an Assessment Tool is given stating the treatment is needed. Therefore, get the assessment screening completed and move forward to the referral for treatment phase.

HERE IS WHERE THE FAMILY MEMBERS CAN LEARN MORE: **Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services**, Fact Sheet, created by CMS, provides education on substance abuse structured assessment and brief intervention (SBIRT). It includes an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. **Why SBIRT?** is a primer developed by the Colorado SBIRT initiative to acquaint readers with SBIRT.

Foundations of SBIRT is a 1.5-hour course developed by the **Pacific Southwest ATTC** that helps familiarize health professionals with the SBIRT process.

The BIG (Brief Intervention Group) Initiative SBIRT Education is a national organization of individuals and organizations founded by Drs. Eric Goplerud and Tracy McPherson that promotes routine screening for hazardous alcohol use and brief solution-focused counseling in the workplace. Access a comprehensive training on SBIRT or view the webinar series on SBIRT implementation in various settings and populations.

The Substance Use in Adults and Adolescents: Screening, Brief Intervention and Referral to Treatment (SBIRT) **free online SBIRT course** through Medscape addresses the basic principles of SBIRT as well as coding and reimbursement for the implementation of SBIRT in practice.
** A free membership to Medscape is required to view the training.

An extension of SBIRT - Implementing Care for Alcohol and Other Drug Use in Medical Settings.

GENERAL RESOURCES The **SBIRT App**, developed at Baylor College of Medicine to support the use of SBIRT by physicians, other health workers, and mental health professionals is free to download. The app provides evidence-based questions to screen for alcohol, drugs and tobacco use. If warranted, a screening tool is provided to further evaluate the specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient based on motivational interviewing.

The Annals of Internal Medicine journal article **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement** provides a good overview of ways to improve long-term health outcomes, the harms of screening and behavioral health counseling interventions, and influences from the health care system that promote or detract the effectiveness of screening and counseling interventions for alcohol misuse.

Care for hospitalized patients with unhealthy alcohol use: A Narrative Review
The review summarizes the major issues involved in caring for patients with unhealthy alcohol use in the general hospital setting, including prevalence, detection, assessment of severity, reduction in drinking with brief intervention, common acute management scenarios for heavy drinkers, and discharge planning.

TAP 33: Systems-Level Implementation of SBIRT
This SAMHSA Technical Assistance Publication (TAP) is a compilation of research and experience from over a decade of federally-funded work on SBIRT. It includes specific implementation models, details about reimbursement and sustainability and case studies from across the nation.

SBIRT in a Radically and Rapidly Changing Environment is a powerpoint that highlights SBIRT in the context of healthcare reform. The webinar which was conducted by the Altarum Institute for SAMHSA can be found below.

The Addiction Technology Transfer Center (ATTC) created an guide: **SBIRT: A Resource Toolkit for Behavioral Health Providers to Begin the Conversation with Federally-Qualified Healthcare Centers.** This resource provides behavioral health providers with information to engage their local FQHC and community health centers in conversations around implementing SBIRT.

Frequently Asked Questions by Healthcare Providers developed by the Colorado Clinical Guidelines Collaborative provides answers to questions commonly asked by providers when beginning to implement SBIRT. Since 2003, SAMHSA has funded 17 Medical Residency Cooperative Agreements, 15 State Cooperative Agreements, and 12 Targeted Capacity Expansion Campus Screening and Brief Intervention (SBI) Grants. Learn more about **SAMHSA's SBIRT grantees**. A presentation for HRSA grantees discusses **SBIRT implementation in Ryan White settings**.

NIAAA's **Helping Patients Who Drink Too Much: A Clinician's Guide** focuses on implementing alcohol screening and intervention in any healthcare setting. A SAMHSA Treatment Improvement Protocol (TIP), **TIP 24: A Guide to SA Services for Primary Care Clinicians** provides guidelines to primary care clinicians for caring for patients with alcohol and drug abuse problems. TIP 24 discusses screening, assessment, brief intervention, medication-assisted treatment, and legal issues of patient confidentiality.

The American Public Health Association manual, **Alcohol Screening and Brief Intervention: A guide for public health practitioners**, provides public health professionals such as health educators and community health workers with the information, skills, and tools needed to conduct screening and brief intervention to help at-risk drinkers limit or stop drinking. SAMHSA's **TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders** provides substance abuse providers with updated information on co-occurring substance use and mental disorders and advances in treatment for these individuals. TIP 42 discusses terminology, assessment, and treatment strategies and models.

The **"Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse"** booklet announces that effective with dates of service on and after October 14, 2011, the Centers for Medicare & Medicaid Services (CMS) will cover annual alcohol screening, and for those that screen positive, up to 4, brief, face-to-face behavioral counseling interventions annually for Medicare beneficiaries, including pregnant women.

EMERGENCY ROOMS Reducing Patient At Risk Drinking developed by the Emergency Nurses Association guides nurses and other healthcare professionals through implementation of SBIRT in emergency room settings. The Institute for Research and Education in the Addictions developed **SBIRT Screening, Brief Intervention and Referral to Treatment** , which provides an array of useful information for emergency departments.

TRAUMA CENTERS Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide The CDC's **Screening and Brief Interventions for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers** helps Level I and II trauma centers plan and implement the American College of Surgeon's Committee on Trauma's alcohol-screening and brief intervention requirements.

Obstacle the Family Addresses

The four common barriers to substance abuse treatment were:

- **Patient Eligibility.** Healthcare providers often find it difficult to determine whether or not patients meet the criteria for admission to certain treatment centers.
- **Knowledge of Treatment Options.** Providers that make referrals may not understand the different types of addiction treatment options available and how to make recommendations to patients for choosing the right type of addiction treatment.
- **Treatment Capacity.** When patients are eligible for services, providers may not be able to get timely information on space availability at certain treatment centers.
- **Communication.** There may exist some difficulty in communication between the providers that refer to addiction treatment services, patients, and the facilities that can deliver the care.

Referral to treatment is a critical yet often overlooked component of the SBIRT process. It involves establishing a clear method of follow-up with patients that have been that have been identified as having a possible dependency on a substance or in need of specialized treatment.

The referral to treatment process consists of assisting a patient with accessing specialized treatment, selecting treatment facilities, and helping navigate any barriers such as treatment cost or lack of transportation that could hinder treatment in a specialty setting. The manner in which a referral to further treatment is provided can have tremendous impact on whether the client will actually receive services with the referred provider.

RESOURCES

Bridging the Gap Between Primary Care and Behavioral Health - Referral Forms
Community Care of North Carolina, in partnership with other stakeholders, has developed a set of three referral forms (below) for primary care and behavioral health providers to facilitate easier consultation and communication.

Form #1 – Behavioral Health Request for Information – this form is for behavioral health providers who begin working with a new consumer or identify a potential medical need, and wish to make contact with the PCP.
Form #2 – Referral to Behavioral Health Services Section I – this form is for PCPs to make a direct referral to a behavioral health provider for an assessment and/or services.
Form #3 – Behavioral Health Feedback to Primary Care Section II – this form is to be used in conjunction with the 2nd form listed above. It is for behavioral health providers to complete and send back to the PCP after receiving a referral.

Sample Warm Hands-Off Scripts and Procedures was created by California's Integrated Behavioral Health Project and provides several examples of scripts that can be used to make a "warm handoff" referral.
SAMHSA Treatment Locator is a searchable directory of drug and alcohol treatment programs by location.
SAMHSA Mental Health Treatment Locator provides professionals, consumers and their families, and the public with comprehensive information about mental health services and resources across the country.

Sample Business Association Contract from the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) that provides details of the privacy related information that could be included in a contractual agreement between a health clinic and a behavioral health organization.

Sample MOU from the Wisconsin Initiative to Promote Healthy Lifestyles (WIPHL) is an example of what types of information may need to be included in a Memorandum of Understanding between to a community health organization and a behavioral health organization to deliver SBIRT services.

Enhancing the Continuum of Care: Integrating Behavioral Health and Primary Care through Affiliations with FQHCs this document walks providers through the process of setting up a formal partnership between an FQHC and a Community behavioral health organization.

For more information on Contracts and MOU please refer to the Center for Integrated Health Solutions page. **REF:** https://www.integration.samhsa.gov/clinical-practice/sbirt/referral-to-treatment

VIDEO TWO

ASSIGNMENT VIDEO: On www.youtube.com/

Search Title: RaffertyWeiss Media | SBIRT - "Substance Abuse Screening"

Published on May 4, 2018

Link: https://www.youtube.com/watch?v=aaUm4qgk7kg

Duration: 5:17hrs.

So why view this video? The answer is just because your hospital does not provide the Behavioral Referral does not mean your family con not take this as their next step. By being prepared for this intervention, the family can ask a local mental health network to complete the follow up steps you have determined are needed.

Pay close attention to the title of the screening assessment tools., These will be administered several times each year in order to stay ahead of any changes that occur with your loved one. The objective is to respond to their changes in a timely and level appropriate level.

What we are asking of the family is to take charge and participate in the plan of care, what is provided, frequency and appropriateness. You are now a consumer of healthcare service, because this is an emergency medical service intervention.

Solutions to Issues & Obstacles

The primary solution it to move forward after the emergency medical services are finished and your loved one prepares to be discharged from the hospital. To take the time now, gather together the critical documents which will be asked of you to provide as you seek the help from those in the different service fields that understand your journey. They will need certain pieces of information which you can prepare now to provide, by having them in a binder broken into specific categories.

Personal Attaché, For Substance Use Disorders

In the Personal Attaché for Substance Use Disorders Binder the family will find a selection of categories to assist in getting organized. The purchase of the "It's Time to Get Organized in the Substance Use Disorder Journey workbook, is strongly recommended.

Table of Content for the workbook:

Exercise # One:

1. Purchase the "**The Substance Use Disorder Journey, It's Time to get Organized" Critical Documents Binder**.

2. Take the time to create your own Family Substance Use Disorder Binder, with all the required critical documents.

3. Go to the "It's Time to Get Organized" workbook and complete the exercise for each chapter in the binder.

Buy On Line: The Substance Abuse Disorder Journey, It's Time to Get Organized. By Roy P. Poillon www.amazon.com

Another activity is “Assessment & Screening” . This is implemented to ensure the right level of services are provided for our loved one. These two screening tools are those which are typically used in conjunction with other assessments. We are providing these two tools so your family members have an idea of what an assessment looks like. Ask your case worker, counselor to explain results and build your knowledge, ask what you and your family members can do to positively impact the results going forward.

Practical Exercise # One: Standard Screening Tools

Drug Screening Questionnaire (DAST)

Patient name:
Date of birth:
Which recreational drugs have you used in the past year? (Check all that apply)
□ methamphetamines (speed, crystal)
□ cocaine
□ cannabis (marijuana, pot)
□ narcotics (heroin, oxycodone, methadone, etc.)
□ inhalants (paint thinner, aerosol, glue)
□ hallucinogens (LSD, mushrooms)
□ tranquilizers (valium) □ other

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

1. Have you used drugs other than those required for medical reasons? No Yes

2. Do you abuse (use) more than one drug at a time? No Yes

3. Are you unable to stop using drugs when you want to? No Yes

4. Have you ever had blackouts or flashbacks as a result of drug use? No Yes

5. Do you ever feel bad or guilty about your drug use? No Yes

6. Does your spouse (or parents) ever complain about your involvement with drugs? No Yes

7. Have you neglected your family because of your use of drugs? No Yes

8. Have you engaged in illegal activities in order to obtain drugs? No Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? No Yes

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? No Yes

Do you inject drugs? No Yes
Have you ever been in treatment for a drug problem? No Yes

I	II	III	IV
0	1-2	3-5	6

Alcohol screening questionnaire (AUDIT)

Patient name:
Date of birth: _
One drink equals: 12 oz. Beer 5 oz. wine 1.5 oz. Liquor (one shot)

1. How often do you have a drink containing alcohol?
Ans: Never Monthly or less 2 – 4 times a month, 2 – 3 times a week, 4 or more times a week.

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
Ans: 0 - 2 3 or 4, 5 or 6, 7 – 9, 10 or more

3. How often do you have five or more drinks on one occasion?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost daily

4. How often during the last year have you found
that you were not able to stop drinking once you
had started?
Ans: Never Less than monthly, Monthly, Weekly, Daily or almost Daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
Ans: Never Less than monthly, Weekly, Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?
Ans: Never Less than monthly, Weekly, Daily or almost daily

9. Have you or someone else been injured because of your drinking?
Ans: No__ Yes, but not in the last year, Yes, in the last year

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?
Ans: No__ Yes, but not in the last year, Yes, in the last year

11. Have you ever been in treatment for an alcohol problem
Ans: Never, Currently, In the past

Scoring and interpreting the audit

1. Each response has a score ranging from 0 to 4. All response scores are added for a total score.

2. The total score correlates with a risk zone, which can be circled on the bottom left corner.

Score Zone Explanation

I - Low Risk 0-3
"Someone using alcohol at this level is at low risk for health or social complications."
Counselor Action: Positive Health Message – describe low risk drinking guidelines 4-9

II – Risky: 4-9
"Someone using alcohol at this level may develop health problems or existing problems may worsen."
Counselor Action: Brief intervention to reduce use 10-13

III – Harmful: 10-13
"Someone using alcohol at this level has experienced negative effects from alcohol use."
Counselor Action: Brief Intervention to reduce or abstain and specific follow-up appointment (Brief Treatment if available) 14+

IV – Severe: 14
"Someone using alcohol at this level could benefit from more assessment and assistance."
Counselor Action: Brief Intervention to accept referral to specialty treatment for a full assessment.

Positive Health Message, an opportunity to educate patients about the NIAAA low-risk drinking levels and the risks of excessive alcohol use.

Brief Intervention to Reduce Use: Patient-centered discussion that uses Motivational Interviewing concepts to raise an individual's awareness of his/her substance use and enhance his/her motivation to
change behavior.

Brief interventions are typically 5-15 minutes, and should occur in the same session as the initial screening. Repeated sessions are more effective than a one-time intervention. The recommended behavior change is to cut back to low-risk drinking levels unless there are other medical reasons to abstain (liver damage, pregnancy, medication contraindications, etc.).

Brief Intervention to Reduce or Abstain (Brief Treatment if available) & Follow-up: Patients with numerous or serious negative consequences from their alcohol use, or patients who likely have an alcohol use disorder who cannot or are not interested in obtaining specialized treatment, should receive more numerous and intensive BIs with follow up.

The recommended behavior change is to cut back to low-risk
drinking levels or abstain from use.

Brief treatment is 1 to 5 sessions, each 15-60 minutes. Refer for brief treatment if available. If brief treatment is not available, secure follow-up in 2-4 weeks.

Brief Intervention to Accept Referral: The focus of the brief intervention is to enhance motivation for the patient to accept a referral to specialty treatment. If accepted, the provider should use a proactive process to facilitate access to specialty substance use disorder treatment for diagnostic assessment and, if warranted, treatment. The recommended behavior change is to abstain from use and accept the referral.

More resources: www.sbirtoregon.org

* Johnson J, Lee A, Vinson D, Seale P. "Use of AUDIT-Based Measures to Identify Unhealthy Alcohol Use and Alcohol
Dependence in Primary Care: A Validation Study." Alcohol Clin Exp Res, Vol 37, No S1, 2013: pp E253–E259

THE STORY

VIDEO THREE

ASSIGNMENT VIDEO: On www.youtube.com/
Search Title: How to file a missing person report: What to do when a person is missing

Published on Sep 28, 2018

Justice for the Missing
114 subscribers
SUBSCRIBE
If you need to know what to do when someone goes missing, watch this video. I answer the question, "do i have to wait 24 hours to file a missing person report?" I talk about when to file a missing person report and how to file a police report to find your missing loved one. If you are looking for a missing person report example, contact you local authorities. We also talk about what to do if someone goes missing. Whether you are looking to find a missing person for free, how to track down a missing person, or missing person cases in general you will want to subscribe to this channel. We talk about missing person cases that are solved, police missing person procedures, solved missing person cases, and unsolved missing person cases Contact us at justicefordaniellebell@gmail.com Facebook: https://www.facebook.com/missingdanie... Twitter: @JusticefortheM2 Instagram: Justice for the missing Ensure your case is listed on these sites. https://api.missingkids.org/missingki... http://charleyproject.org/ Search and Rescue Nonprofit http://klaaskids.org/pg-leg/

Search Link: https://www.youtube.com/watch?v=yoepCbMfAzQ

Duration: 7:41

MASTER FAMILY PLAN OF ACTION FOR: "FAMILY IS A SYSTEM"

Complete answers and move to "Master Family Plan of Action" found in back of workbook.

1. Our family will identify the steps of receiving emergency medical services as an intervention of our loved one.
2. Our Family will use the workbook: The Substance Use Disorders Journey, It's Time to Get Organized and complete it now, in advance of needing it during an emergency.
3. As part of the Master Family Plan of Action we will complete the review of setting boundaries and seek professional counseling, legal advise and financial advice depending on our findings in organizing these documents. We want to be assured to have all the necessary documents in an easy to find binder.