HELPING PEOPLE ADDICTED TO METHAMPHETAMINE

A Creative New Approach for Families and Communities

Nicolas T. Taylor, Herbert C. Covey

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NICOLAS T. TAYLOR AND
HERBERT C. COVEY

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This book is dedicated to the families, friends, parents, children, treatment providers, judges, teachers, counselors, law enforcement officers, employers, members of faith-based organizations, elected officials, and communities that care enough about those addicted to methamphetamine to take positive action. We also want to acknowledge our families and especially our spouses Teresha Taylor and Marty Covey who supported us throughout this endeavor. Special thanks to Marty Covey, who provided editorial suggestions and helped greatly in writing this book. Her contribution was immense. Thanks also to Senior Editor Debbie Carvalko of Praeger Publishers, who provided excellent guidance and displayed great patience with the authors. She has been a valuable partner in seeing this book come to fruition.

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Preface

Methamphetamine has impacted families and communities in such a way that for the past 10 years treatment programs and judicial systems have struggled with how to intervene and to provide the right kind of rehabilitative help. While not entirely different from other substances of abuse, meth is unique enough to challenge these systems to come up with the most effective ways of helping people not only stop using the drug but also stop hanging around other people who continue to use it. At one point the most devastating cases of communities being impacted by meth were limited to the western regions of the nation. That has changed, and with the exception of only the eastern seaboard states, really, meth has penetrated every community, both urban and rural, and has crossed almost all ethno- and demographic boundaries.

Treatment for meth addiction must involve the broad sober community in which the addict lives; otherwise it becomes almost impossible for people who are trying to stop using meth to separate themselves from groups of people who use it. What this book provides is the description of a creative new approach to treating meth addiction that can be used to guide a true community-based intervention. The key to this intervention is the practice of carving out a niche within the sober community so that people recovering from meth have a place to go as well as the necessary support to break ties with other meth users.

Families and community leaders are invited to consider the principles and practices described in the pages of this book as they develop treatment plans and strategies for individual people addicted to meth as well as broad groups of people accessed through social service and judicial referral systems. We know for certain that there is neither a magic potion nor a silver bullet that

could be used to help every addict. Instead, there are general principles of practice that stem from an informed awareness of those things that make meth unique. It is those principles that we have attempted to present in this book as part of our general treatment approach. In this way, we hope to help enhance what is being attempted by people who generally care to see people addicted to meth move toward living a sober lifestyle.

We are often asked why we would focus so much energy on the treatment of addiction to just one substance of abuse when there are literally millions of other people around the nation who either struggle with addiction to different chemicals, other than meth, or are family members of people addicted to other drugs. The answer to this question is twofold. First, people addicted to meth present as a unique challenge to treatment systems because of the detrimental effects associated with meth, specifically. This uniqueness does necessitate consideration of a treatment approach for meth. Second, the true community-based intervention we have attempted to describe, while effective in treating meth addiction, introduces creative new treatment concepts that can be employed by families and communities for the treatment of other substances of abuse as well.

Very little that is good has come from the widespread use of meth across this nation. However, if we consider what the impact of meth has done to improve the treatment systems and practices of communities hardest hit by meth, we may see that dealing with so many people addicted to meth has helped us to improve how we prevent meth use and how we treat as communities those addicted to it.

CHAPTER 1
Introduction

THE METH EPIDEMIC

Drug epidemics are not new to the United States. The abuse of patent medicines around the turn of the 20th century is estimated to have affected more than a million Americans when it was at its peak. When it was discovered that the primary "curative agents" in these snake-oil-type medications were highly addictive chemicals, such as heroin and cocaine, the Pure Food and Drug Act was passed in 1906. This law required drug companies to indicate on the labels of all medicines the exact nature and amounts of addictive substances found in their products (Hanson, Venturelli, and Fleckenstein 2004).

Alcohol, although sometimes not considered a drug, was at the center of a very unique epidemic during the period of prohibition. The use of alcohol among the general population appears to have declined during this period of American history. However, the illegal production and distribution of alcohol by moonshiners and bootleggers and its sale in underground bars, known as speakeasies, spread across the nation and spurred violence between law enforcement and organized crime. Police corruption, violence, and the growth of organized crime were the primary reasons prohibition was repealed in 1933 (Hanson, Venturelli, and Fleckenstein 2004).

Other drugs, including heroin in the 1930s, hallucinogens in the 1960s, and crack cocaine in the 1980s, have all been described as reaching epidemic-like proportions during periods of highest use. Then there is meth.

An epidemic is defined as a rapid spread or increase in the occurrence of something. Epidemics are typically thought of as a temporary prevalence;

a wave of occurrence, if you will, that seems to have an onset, a peak, and then a period of recovery. The use of methamphetamine throughout the United States, and especially in the midwestern and western states, first started getting the attention of law enforcement, treatment providers, and public policy makers in the late 1980s and the early 1990s. Even at that time, there was talk in these circles that the way the drug seemed to be affecting people and the numbers of new users from small communities suggested the start of an epidemic. By the mid-1990s, there really was no denying the issue. It seemed that this illegally manufactured drug was taking over the lives of the people who started using it and they did not seem to be getting much better, even with strong legal consequences, having children taken away, and negative effects on their appearance, health, and general lifestyle.

Meth quickly became known as the "walk-away drug" because people who used it seemed to walk away not only from their families, jobs, and responsibilities but also from other drugs of abuse. Once individuals started using meth, it seemed to take over their lives. They may use other drugs, but these other drugs were often either to prepare for or enhance the effects of meth or to help recover from the use of it.

Time magazine in a 1998 article followed a group of meth users in Billings, Montana and documented some of the unique characteristics of the people who use the drug and of the meth-using culture. The article referred to the new "crank epidemic," and pretty much from that time on, the floodgates were opened for popular media; governmental publications, too, referred to the rising meth epidemic. People believed that because this was an epidemic and since all epidemics are only temporary increases in the prevalence of something, meth would eventually reach its peak and decline. This decline would occur, they reasoned, because it was so detrimental to the health and well-being of users. After meth diminished, the U.S. population could then begin bracing itself for whatever drug du jour would be coming next.

It has now been more than 10 years since meth use in the United States was first popularly labeled an epidemic. Every indicator of prevalence seems to suggest that we are nowhere near the climax. In fact, if anything, the trend still seems to be rising. Treatment admissions for people addicted to meth, arrests for use or possession of the drug, the numbers of people testing positive for meth at the time of arrest for any crime, the numbers of children removed from the care of meth-using parents, hospital discharges for medical problems associated with meth use, emergency room admissions for meth intoxication, and coroner reports for meth-related fatalities have all been on the rise and seem to show no sign of leveling off. Meth, once thought of as primarily a rural

western/midwestern drug, has made its way across the Mississippi river and is even beginning to show signs of increased use in the eastern seaboard states, where it has always been thought it could never supplant the drugs of choice in those regions, such as heroin and crack cocaine.

While meth has always seemed to have been used by a greater proportion of women compared to other drugs, it was thought to have some racial, ethnic, and cultural boundaries that it did not frequently cross. Once labeled "red-neck heroin" and "poor man's cocaine," meth was thought to be primarily the drug of choice of people pejoratively called "white trash," apropos its widespread use among predominantly poor Caucasian populations. Now it seems to have spread into other populations as well. Those hardest hit include not only poor Caucasian men and women but also Native Americans living on reservations, Alaskan Natives, homosexual men from all parts of the country, Hispanic men and women from the Southwest, people from Hawaii and the pacific island nations, and Asians. Perhaps the only major ethnic group that has not yet experienced an increase in meth use to any great extent is the African American population, but that may change as meth becomes more widespread in the southern and eastern states, which have a much higher percentage of African Americans.

Traditionally, meth use has been highest among adults ages 20 to 40. A collective sigh of relief was breathed nationwide when it appeared that meth use was actually declining among adolescent populations. Then, however, it was noted that the surveys being used to measure drug use trends among teenagers were administered primarily through school systems. Since, presumably, teens who use meth are not likely to still be in school, these estimates of decreased use among teenagers are probably hopeful, but not totally accurate. This seems to be the case, especially since anecdotal evidence actually suggests more teenagers are trying meth and are becoming addicted. Furthermore, when interviewed most meth users report that their initial use began sometime during their teenage years.

The use of meth in the United States seems to have endured longer than was expected and it seems to have impacted more people than was anticipated. Because of the geographic spread of meth, some authors have started referring to its use across the nation as a pandemic, meaning that it is an epidemic that has spread over a large area. However, as was mentioned, the spread of meth has not just been to new states and regions. It has also crossed into populations, cultures, and communities not previously affected by it. Because of this, the transitory nature of the meth epidemic is questionable. Perhaps a new epidemiologic term can be invented just for meth. Maybe that term should be metapandemic, or even methapandemic.

SOLUTIONS?

The most logical step to begin addressing the "methapandemic" is prevention. It really makes no sense trying to address a problem until we figure out a way to keep the problem from escalating in the first place. Prevention means to intervene, to keep those who have never tried meth from even trying it once. It also means working to keep those who have tried meth from using it again. However, unless prevention efforts start before a problem has really grown into anything significant, they do nothing about existing cases. While prevention is important to keep the meth epidemic from becoming even bigger and affecting even more people and communities, the real solution lies in knowing how to help the millions of people already addicted to meth.

While only about 60,000 people are admitted each year to substance abuse treatment centers for methamphetamine addiction, approximately 12.5 million Americans, ages 12 and over, report having tried meth sometime during their life. About 3 million report having used meth in the past year, and about 900,000 admit to having used it sometime during the past month (SAMHSA 2005a). While recent use is not necessarily an indication of a severe meth abuse problem, if it is conservatively assumed that half of the approximately 900,000 people who admitted to having used meth in the past month are addicted and need treatment, then current treatment admission suggests that less than 15 percent of them actually end up engaging in treatment. Of this small percentage who do wind up in treatment, even fewer take maximum advantage of the treatment they do receive by establishing and maintaining long-term abstinence from the drug.

So, is there any hope? For families and communities whose lives have been touched personally by people who have become addicted to meth, hope can be hard to come by. The high rate of relapse and the difficulty of getting someone addicted to meth to go to treatment in the first place make the idea of long-term recovery seem unlikely and bleak. The situation is not helped at all by false and sensationalized reports in the media of people who "once they become addicted to meth are hooked for life" and the false claim that less than 6 percent of people who ever use meth recover.

This book is not intended to build up false hope among people whose lives have been devastated by meth either because they use the drug or because they are close to someone who uses it. However, to suggest that people cannot recover from meth use or that it is so difficult that almost no one is able to stop doing it once they have started is a tremendous disservice and dishonor to the thousands of people who have been able to successfully stop using meth after becoming severely addicted. There do seem to be many

people who are using meth, and that number does seem to be increasing. But the "chicken little" type hysteria about the ravages of meth throughout the nation does not bring us any closer to a solution either. What this book does provide is a factually based, honest appraisal of what meth is and what it really takes for someone to stop using it. In that way, this book could really be considered a treatment manual since a theory for meth addiction is posited and then, based on this theory, a community-based approach for treating meth addiction is described.

However, this is not a treatment manual in that it is not written for treatment professionals specifically. Instead, it is intended for communities and families dealing with meth addiction. So much of what makes meth such a unique drug has to do with the distasteful subculture associated with people who use meth. Meth truly is a community drug, and it requires community solutions. The motivation and desire for sobriety of the addicted individual is, of course, paramount. But there is much that can and must be done by sober communities throughout the country to assist with treatment. Communities can help the increasing numbers of people who are becoming addicted to meth have what it takes to stop using the drug and to distance themselves from other people who do use it.

This book describes how communities and families can participate in the treatment of people addicted to meth in a way that truly addresses the reasons why meth is so addicting and why people continue to use it in spite of the fact that it causes them such serious problems. A traditional view of treatment is that it is something provided by a trained professional, often while the addicted person is out of the community, and in an inpatient, residential, or hospital-based rehabilitation program. While removal from the community is sometimes required for treatment to be most effective, especially in the beginning stages of recovery, it is our position that treatment is most effective when it is accomplished while the addicted person is living in their home community. Even for people whose severe addiction requires that they begin their treatment with a medically monitored detoxification or a structured inpatient experience, they will still need a successful outpatient treatment experience at some point if they are going to someday be successful at remaining sober while living in their home community, wherever that might be.

A well-trained competent substance abuse treatment provider is an indispensable part of the treatment a meth-addicted person needs to receive. However, families and communities have traditionally been relegated to the role of adjunct participants in the therapy, and there often is little guarantee they will be involved in the therapy, if at all. This is a critical flaw when it comes to treatment of meth addiction. With other substances of abuse or

psychological disorders, it may be the case that the primary vehicle for the treatment is the exclusive, private, confidential, and personal relationship with a trusted therapist. However, with meth addiction, important as the relationship with the therapist might be, it is really the client's relationship with their community that requires the greatest focus.

This is partially because addicted individuals have most likely distanced themselves almost to the point of complete exclusion from their sober communities but also because people addicted to meth have little hope of living soberly without this important source of support. Involvement of family and the community in outpatient treatment is also critical because an important part of treatment, as will be explained later in this book, is helping the addicted individual get to the point at which the person can feel pleasure because of things that are naturally pleasurable as opposed to using meth to feel good. These "pleasure recalibration exercises" require the involvement of family and community members to be most effective. The inherent difficulty of this kind of work lies in the fact that many people addicted to meth may not have ever even learned to associate feelings of pleasure with events, situations, people, or objects that are naturally pleasurable, such as fun activities with family members or engaging experiences with sober friends. This may be because from an early age, they begin associating good feelings or the removal of bad feelings primarily through the use of drugs and alcohol from their own use or because that was what was modeled for them by other people in their lives.

Community-based efforts are not new solutions to social problems. The tragic Columbine school shooting in 1999 and other acts of violence on school campuses have forced law enforcement, school officials, mental health professionals, students, and families to work together to determine effective prevention and interdiction efforts. The issue is simply too broad and complex to be effectively dealt with by one community agency or entity. Helping people who are addicted to meth is no different. The demands of the treatment effort are often so involved that it is really more than any one individual, one family, or one agency can provide. For this reason, perhaps more than a guide to meth recovery, this book is designed to provide families and community treatment teams with needed strategies and collective approaches to maximize the effectiveness of their efforts to help people stop using meth.

In discussing strategies and techniques, theories, and practices to effectively help people stop using meth, it is important to not lose sight of the individuals whose lives have been ruined by the drug. A community-based approach to treating meth addiction assumes that the addicted individual has been, and can once again be, a valued community member. As community

members, their individual stories and circumstances are important to consider. For this reason, we will begin with two stories of people who have experienced extreme addiction to meth. The stories are not just about the people but also about their families and communities who were impacted by their addiction as well.

The first is the story of Sasha. It is a true story in that it is made up of bits and pieces of several real stories we have become aware of over the last 10 years that we have been working closely with people addicted to meth. The conclusion of the story, however, is the actual account of what happened to a young woman we had seen professionally, whom Sasha most resembles. It is in her memory and in the hope of helping other addicts and their families that this work is dedicated. Chris's story is that of a real and truly courageous individual who has now become a beacon of hope for people addicted to meth and for families and communities trying to help them. This work is also dedicated to his life and to helping others find what he has found.

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CHAPTER 2

Two Meth Stories and the Important Role of Community

Case histories can teach us important lessons about meth use and how family and community dynamics can play out. The following are two case histories of meth use and the role it plays in the lives of users, family members, friends, and those trying to serve them. The names of the individuals have been changed to protect identities. The stories shed light on some of the patterns found with meth use and the struggles of overcoming this drug. The first story is that of Sasha and the second, of Chris.

SASHA'S STORY

Sasha was a vivacious, fun-loving 15-year-old who used her good looks and outgoing personality to get whatever she wanted. She loved adventure and was not afraid to seek out those in her world who could provide her with excitement. She was skilled at using her charm to get whatever she wanted from people, especially her father. She had her father wrapped tightly around her little finger and he would do anything she wanted to keep her happy.

Her father had emigrated from another country and quickly opened a small business in town. He soon met and married her mother, whose family had