RECOVERY MANAGEMENT WITH METHAMPHETAMINE ADDICTS IN RURAL AMERICA

By Mark Sanders, LCSW, CADC

The keynote speaker for an addictions conference I recently attended in a Southwestern state was an Attorney General. This was striking to me; in the twenty-seven years I have been an addictions counselor, this was the first time a law enforcement agent keynoted a conference I attended. These conferences are usually keynoted by academians, researchers, seasoned addictions speakers, or CSAT and NIDA administrators. The Attorney General stated: “Methamphetamine use is the number one drug problem, legal problem, cause of rural files, public health problem, and problem in our child welfare system throughout the state.” At the same conference another speaker stated, “Methamphetamine use in the rural part of our state will make crack cocaine look like candy.”

The use of methamphetamine is ravaging rural America, causing a great deal of damage to the user and to society (California Department of Alcohol and Drug Programs, 2007). Many authors (T. Sim et al., 2002; B.B. Hoffman & R.J. Lefkowitz et al., 1993; R. Gonzales et al., 2006; W. C. Holton, 2001) have described the impact of methamphetamine. These impacts include:

Damage to the User

- Paranoia
- Depression
- Extreme anxiety
• Hallucinations – producing symptoms that resemble paranoid schizophrenia
• Suicidal ideation
• Suicide
• Memory problems – This impairment resembles the early stages of Alzheimer’s disease.
• Legal problems
• Health problems – Meth use increases the risk of heart attacks, convulsions, strokes, Hepatitis C, and dental decay.

Damage to the Community
• An increase in crime
• An increase in violence
• Family deterioration
• Contamination – For every pound of methamphetamine manufactured, approximately six pounds of toxic waste is deposited into back yards, parks, roadsides, motels, and water. This can increase risk of poisoning, burns, lung irritation, organ damage, and cancer.
• Risks to children – A common method of dealing with meth use is raids by law enforcement. A new term emerging is, “Meth orphans,” referring to children brought into the child welfare system during meth raids.

Recovery management is an emerging approach geared toward treating addiction, similar to how other chronic and progressive illnesses, such as cancer and diabetes, are treated (W. White, E. Kurtz, & M. Sanders, 2006). This
treatment is usually longer term and often anchored in the client’s natural environment. There are three phases of recovery management, which makes it an ideal approach with methamphetamine users in America. The phases include:

1. **Pretreatment recovery support.** This phase often involves the use of recovery coaches (individuals in recovery) who engage clients in their natural environments prior to treatment, with the goal of motivating them to seek help for their addiction. In spite of the fact that methamphetamine use is a continuous crisis in rural America, meth users constitute only 8% of all U.S. treatment admissions (SAMHSA E-Network, 2009). Their symptomatology, i.e., apathy, feelings of depression, isolation, involvement with destructive peer groups, and physical deterioration, makes it difficult for methamphetamine addicts to reach out for help (California Department of Alcohol and Drug Programs, 2007). I recently heard a CSAT administrator state, “If they’re not coming in, we’ll have to go out and get them.”

2. **In-treatment recovery support.** Approximately 50% of chemically dependent clients leave treatment prematurely (*GLATTC Bulletin*, 2005). Methamphetamine addicts have biopsychosocial challenges (California Department of Alcohol and Drug Programs, 2007) that make completing primary treatment even more difficult. These challenges include:
   - Memory deficit – which makes it difficult to grasp materials presented in treatment.
• Intense craving – sending clients rushing out the door, against medical advice, to purchase methamphetamines.
• Depression – causing a lack of energy to participate in treatment.
• Heightened emotionality and anger – which can lead to outbursts and a tendency to leave treatment early or to get administratively discharged.

One study indicated that 50% of methamphetamine addicts drop out of inpatient treatment prematurely and 70% drop out of outpatient treatment (California Department of Alcohol and Drug Programs, 2007). A promising approach is the use of recovery coaches to engage clients while they are in primary treatment in order to encourage and motivate them to complete primary treatment. These recovery coaches can also serve as a link to the outside world, as 80% of clients who relapse do so within ninety days of completing treatment (GLATTC Bulletin, 2005). The State of Connecticut uses recovery coaches to meet with clients voluntarily while they are in primary residential treatment, to provide recovery support while they are there, then volunteering to contact them once a week by phone for twelve weeks for early recovery support upon discharge. Research reveals that 80% of these clients are still sober at the 90-day period (W. White, 2008).

3. Post primary treatment recovery support. Methamphetamine addicts face many difficulties upon discharge that make staying sober a challenge (J.L. Ojbert, 2000). These challenges include:
• Criminal record – Methamphetamine users are more likely to be under criminal justice supervision than other clients, making it difficult to secure employment.

• Intense cravings – This often lures meth users back to active addiction.

• Depression and anhedonia – For approximately one-and-a-half months following discontinuing use, meth addicts often feel depression and have difficulty achieving pleasure from anything other than drug use. This increases the chance of relapse.

• Difficulty with memory and cognitive impairment

Clients requiring the greatest recovery support include those with the highest problem severity and lowest recovery capital, i.e., internal and external assets that aid in recovery efforts (W. White & W. Cloud, 2008). According to Brecht (2005) these include:

• Those who live in rural communities where there are often fewer resources and for which they have to travel long distances to access.

• Clients with less education than a high-school diploma.

• Those with co-occurring disorders.

• Those with histories of sexual trauma.

• Those who started using methamphetamines at an early age.

• Those with greater severity of meth use.

• Those who inject methamphetamines.

Recovery coaches can provide a range of supports to these clients in early recovery. These supports include:
• Social recovery support.
• Transportational recovery support – help in traveling to and from needed resources.
• Vocational and occupational recovery support.
• Symptom management support.
• Help with problem solving and decision making.
• Help with disengagement from drug cultures.
• Help with linkages into communities of recovery.
• Support around family reintegration.

Rarely, in modern history has a drug had such a stronghold in rural American in such a short period of time. Recovery management offers clients, families, and communities a great deal of recovery support before, during, and after primary treatment.
REFERENCES


Methamphetamine Treatment: A Practitioner’s Reference (2007). California Department of Alcohol and Drug Programs, Sacramento, CA


http://oas.samhsa.gov/TEDS2k7highlights/TOC.cfm

W. White (2008) Perspectives on Systems Transformations. Chicago, IL:

Great Lakes ATTC.


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