

RESOURCE LINKS

VOLUME 5 • ISSUE 1 • WINTER 2006



SPECIAL ISSUE

METHAMPHETAMINE: DEBUNKING THE MYTH



NORTHEAST
attc

The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

DEAR COLLEAGUES:

Three reasons emerge for this edition of *Resource Links* titled “Methamphetamine: Debunking the Myths.” Methamphetamine is emerging as an ever-more-popular drug of abuse with far reaching ramifications for society and in particular the addictions field.

The general public has seen as many myths as facts about Methamphetamine abuse, treatment and recovery. The intense media focus can alarm us or numb our sensibilities. Often, we don’t always get a true picture or we get an overload that overwhelms us to a degree that we cannot process it at all so we just dismiss it.

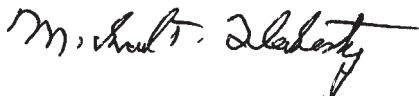
The NeATTC applauds the rapid response of many to deploy forces against Methamphetamine abuse, helping to prevent its emergence throughout the country.

Interdiction and law enforcement agencies in our region have done an outstanding job in mobilizing against the advance of the abuse of a drug whose purchase price belies its costly impact on individual users and society as a whole. Unlike cocaine and heroin, though devastating in their own ways, meth’s harm is insidious, often ubiquitous.

This issue of *Resource Links* is a collaborative effort. National experts present our “cover story.” Then, the NeATTC went to authorities in our three states to get a snapshot of our region’s experiences. The NeATTC ambassadors—many of you, our readers—submitted dozens of commonly asked questions that we culled for our experts to address. The issue contains numerous resources for additional information as well.

Resource Links is one way that the NeATTC enhances the quality of addiction treatment and recovery services within the region, providing policymakers, providers, consumers and other stakeholders with state-of-the-art information through technology translation and transfer. Visit www.neattc.org for the range of services available to you.

As always, your comments in this continuing dialogue are most welcome at flaherty@ireta.org.



Michael T. Flaherty, Ph.D.

NeATTC

METHAMPHETAMINE ADDICTION: DOES TREATMENT WORK?

**Thomas. E. Freese, Ph.D., Rachel Gonzales, MPH and
Richard Rawson, Ph.D.**

S **Scope of the Methamphetamine Problem**

Methamphetamine (MA), known on the street by meth, speed, crystal, crank, and ice, has emerged as the most dangerous home grown and one of the most widely used drugs in America. Worldwide, the United Nations Office of Drug Control estimates that over 42 million individuals regularly use amphetamines around the world, more than any other illicit drug, except for cannabis (United Nations, 2005). In the United States, MA ranks as one of the most highly abused illicit drugs in urban and rural areas of the West, Midwest and South. Epidemiologic indicators show that while MA continues to grow as a problem in these areas, it is also being used with increasing frequency in the Eastern US as well. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), national treatment admission rates for MA abuse increased by more than 420 percent for persons 12 years or older during the past decade (SAMHSA 2000a, 2000b).

Physiology of Methamphetamine & Associated Health Effects

MA stimulates the central nervous system. The euphoria (“high”) produced by MA use is immediate and powerful and is directly linked to the release of dopamine. The powerful stimulant effects (i.e., increased energy, confidence, talkativeness, sex drive, decreased fatigue, and depression) last for 10-12 hours. Advances in brain imaging techniques have shown major abnormalities and deficits associated with MA use in certain parts of the brain that are responsible for feelings of pleasure and other emotions, as well as memory and judgment. Research has also demonstrated the impact of MA on certain kinds of information processing (Paulus, 2002), motor tasks and memory (Volkow et al., 2001). Despite these effects producing great impact on the functioning of users during the many months of recovery, it does appear that most are reversible.

The substantial health problems associated with MA addiction include severe weight loss, sleep disorders, damage to the cardiovascular system, and stroke as well as severe dental and skin problems. MA use is a major factor in the spread of HIV in the gay community (Shoptaw, Reback and Freese, 2002) and has recently been shown to be highly associated with the spread of the hepatitis C virus (Freese, et al., 2005).

**The authors are with the Pacific Southwest ATTC (California, New Mexico and Arizona).
Dr. Freese and Dr. Rawson are principal investigators and Rachel Gonzales, MPH, is a
Pre-doctoral Fellow. For more information visit: www.psattc.org**

Treatment for MA Addiction

Psychosocial/Behavioral Treatments: Presently, there are two approaches that have evidence to support their efficacy for the treatment of MA dependence, but there is much larger literature on treatments that work with the other major illicit stimulant problem in the U.S., cocaine dependence. Research examining the treatment responses of MA and cocaine users suggests that cocaine and MA users have very similar outcomes when exposed to the same treatments (Hser, 2005; Rawson, et al., 2000, Simon, 2002).

Matrix Model: During the 1980s, the Matrix Institute on Addictions group in Southern California created a multi-element treatment manual with funding support from NIDA, designed for application with stimulant users on an outpatient basis (Rawson et al., 1995). The Matrix approach evolved over time, incorporating treatment elements with support from scientific evidence, including cognitive behavioral therapies (i.e., relapse prevention techniques), a positively reinforcing treatment context, many components of motivational interviewing, family involvement, accurate psychoeducational information, 12-step facilitation efforts, and regular urine testing. The approach is delivered using a combination of group and individual sessions delivered approximately three times per week over a 16-week period followed by a 36-week continuing care support group and 12-step program participation. Over 15,000 cocaine and MA users have been treated with this approach during the past 20 years. The manual and related materials have been published by Hazelden and SAMHSA. (For more details see www.Hazelden.org and www.SAMHSA.gov.)

Contingency Management (CM): Positive reinforcement is a powerful tool in increasing desired behaviors. Many existing treatment programs informally use positive reinforcement as part of their treatment milieu. Frequently, the reinforcement takes the form of verbal praise, or earning program privileges, or “graduating” to a higher level of status in the program or some other practice to acknowledge and reward progress in treatment. CM is simply the systematic application of these same reinforcement principles. In many of the studies investigating CM approaches, treatment participants can earn “vouchers” that are exchangeable for non-monetary desired items (e.g., free movie tickets, restaurant dinners, grocery vouchers, gasoline coupons, etc.). Typically the individual can earn larger valued rewards for longer periods of continuous abstinence from drugs and alcohol. The results of research over the past 30 years have provided powerful support for the efficacy of this behavioral strategy as treatment for MA abuse (see for example Rawson et al., 2005; Roll et al., 2005). People receiving CM have shown better retention in treatment, lower rates of MA use and longer periods of sustained abstinence over the course of their treatment experience.



Implications for MA Addiction Treatment: Psychosis, Route of Administration, Sex, Infectious Diseases, Women and Kids

Much of the ambivalence about MA treatment effectiveness stems from sentiments that “meth abusers are difficult to treat,” quoted by many in the field and press. Studies have identified unique characteristics of MA abusers that may pose many clinical challenges that are frequently more problematic than is seen with standard treatment populations. MA abusers come to treatment with unique demographic and health profiles. For instance, MA abusers have been consistently observed to experience severe psychiatric problems, including psychoses, hallucinations, suicidal ideation, and severe depression and cognitive impairments when presenting for treatment. (Copeland and Sorensen, 2002; Peck et al., 2005; Zweben et al., 2004). At present, it is not clear how much of the psychiatric symptomatology is directly related to the effects of the drug and what role co-morbid disorders play. Clearly, however, clinicians treating MA have to be educated about working with patients who have clinically significant levels of disordered thinking and persisting paranoia.

Smoking and particularly injecting MA appears to lead to a more difficult addiction to address. Injection users tend to report far more severe craving during their recovery and they have higher rates of depression and other psychological symptoms before, during and after treatment. They also have higher drop out rates and exhibit higher rates of MA during treatment (Rawson, unpublished data, November 2, 2005). In addition, recent reports have documented the extremely powerful relationship between MA use and sexual behavior. Individuals who use MA describe a far more powerful association between MA and sexual behavior than cocaine, heroin or alcohol users (Frosch et al., 1996; Rawson et al., 2002). Issues around sexual readjustment during sobriety are very important and can play a very big role in relapse, if not properly addressed. MA is also associated with very high risk sex and has been shown to be a huge factor in HIV transmission among gay men. Research by Shoptaw, Reback and Freese (2002) in Los Angeles has shown that MA use is the biggest threat in the gay community to producing a renewed spread of HIV.

Women use MA at rates equal to men (Brecht et al., 2004; Freese et al., 2000). Use of other major illicit drugs is characterized by ratios of 3:1 men to women (heroin) or 2:1 (cocaine). In many large data sets, the ratio for MA users approaches 1:1. Surveys among women suggest that they are more likely than men to be attracted to MA for weight loss and to control symptoms of depression. Over 70% of MA-dependent women report histories of physical and sexual abuse and are more likely to present for treatment with greater psychological distress than males (Brecht et al., 2004).

“The results of over the past 30 years research have provided powerful support for the efficacy of this behavioral strategy (contingency management) as treatment for MA abuse.”

— Rawson et al., 2005; Roll et al., 2005

CESAR Selected CESAR Publications, The Developing Methamphetamine Problem: July 1996-December 2005.

■ www.cesar.umd.edu/cesar/pubs/20051219.pdf

Congressional Caucus to Fight and Control Methamphetamine

■ www.house.gov/larsen/meth/

Drugstory.org general Information, Physical Effects and Mental Effects and many links to other resources.

■ www.drugstory.org/drug_info/methamphetamine.asp

E-Medicine includes sections on clinical, differentials, workup, treatment, medication, and follow-up for Methamphetamine.

■ www.emedicine.com/EMERG/topic859.htm

Information Tips for Teens about Methamphetamine—This site includes facts, Q&A, and referrals to SAMHSA information.

■ ncadi.samhsa.gov/govpubs/PHD861/

KCI—The Anti-Meth Site “Methamphetamine FAQs,” “Methamphetamine Facts,” and “Physical Damage of Meth.”

■ www.kci.org/

SELECTED REFERENCES

- Brecht, M.L., O'Brien, A., von Mayrhauser, C., & Anglin, M.D. (2004). Methamphetamine use behaviors and gender differences. *Addictive Behaviors* 29(1): 89-106.
- Copeland, A.L., & Sorensen, J.L. (2001). Differences between methamphetamine users and cocaine users in treatment. *Drug and Alcohol Dependence*, 62(1):91-5.
- Freese, T., Rawson, R., Pearce, V., Diaz, I., Elkashef, A., Smith E., and Other MCTG Investigators. (2005). *Hepatitis C and HIV risk among participants in medication trials for methamphetamine dependence*. Poster presentation to the 66th Annual Meeting of the College on Problems of Drug Dependence, Bal Harbor, FL.
- Freese, T.E., Obert, J., Dickow, A., Cohen, J., & Lord, R.H. (2000). Methamphetamine abuse: issues for special populations. *Journal of Psychoactive Drugs*, 32(2): 177-82.
- Frosch, D., Shoptaw, S., Huber, A., Rawson, R.A., & Ling, W. (1996). Sexual HIV risk among gay and bisexual male methamphetamine abusers. *Journal of Substance Abuse Treatment* 13(6): 483-486.
- Hser, Y.I., Evans, E., & Yu-Chuang, H. (2005). Treatment outcomes among women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment*, 28:77-85.
- Peck, J.A., Reback, C.J., Yang, X., Rotheram-Fuller, E., & Shoptaw, S. (2005). Sustained reductions in drug use and depression symptoms from treatment for drug abuse in methamphetamine-dependent gay and bisexual men. *Journal of Urban Health*, 82, 100-8.
- Paulus, M.P., Hozack, N. E., Zauscher, B.E., Frank, L., Brown, G.G., Braff, D.L., & Schuckit, M.A (2002). Behavioral and Functional Neuroimaging Evidence for Prefrontal Dysfunction in Methamphetamine-Dependent Subjects. *Neuropsychopharmacology*, 26, 53-63.
- Rawson, R., Huber, A., Brethen, P., Obert, J., Gulati, V., Shoptaw, S., & Ling, W. (2000). Methamphetamine and Cocaine Users: Differences in Characteristics and Treatment Retention. *Journal of Psychoactive Drugs*, 32(2):233-238.
- Rawson, R., Shoptaw, S., Obert, J.L., McCann, M., Hasson, A., Marinelli-Casey, P., Brethen, P., & Ling, W. (1995). An intensive outpatient approach for cocaine abuse: The Matrix model. *Journal of Substance Abuse Treatment*, 12(2): 117-127.

RESOURCES:

National Institute on Drug Abuse (NIDA) resources on Methamphetamine.

- www.nida.nih.gov/DrugPages/Methamphetamine.html

Meth Task Force Reference Materials include article links for prevention, treatment and enforcement.

- www.ocjc.state.or.us/PSReview/MTFact.php

Pacific Southwest ATTC Methamphetamine resource courses “Methamphetamine 101: Etiology and Physiology of an Epidemic” and “Methamphetamine 102: Introduction to Evidence Based Practices.”

- www.psattc.org/home.html

The Gay Center established in 1983, the Lesbian, Gay, Bisexual & Transgender Community Center has grown to become the largest LGBT multi-service organization on the East Coast and second largest LGBT community center in the world.

- www.gaycenter.org

The Methamphetamine Treatment Project This is a multi-site initiative to study the treatment of methamphetamine dependence. Jointly implemented by the UCLA Integrated Substance Abuse Programs (ISAP), and the Matrix Institute on Addictions. The project is funded by the Substance Abuse & Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT).

- www.methamphetamine.org

-
- Rawson, R.A., Washton, A., Domier, C.P., & Reiber, C. (2002). Drugs and sexual effects: role of drug type and gender. *Journal of Substance Abuse Treatment*, 22, 103-108.
- Rawson, R.A., McCann, M., Flammino, F., Shoptaw, St., Miotto, K., Reiber, C., & Ling, W. (2005). *A Comparison of Contingency Management and Cognitive-Behavioral Approaches for Cocaine and Methamphetamine Dependent Individuals*. Recently submitted to *Addiction*, 2005.
- Roll, J.M., Petry, N.M., Stitzer, M., Brecht, M.L., Pierce, J., McCann, M., Blaine, J., MacDonald, M., & Kellog, S. *Contingency Management for the Treatment of Methamphetamine Use Disorders* (being submitted, 2005).
- SAMHSA, Office of Applied Studies, 2000a. SAMHSA, Office of Applied Studies, Mid-year 1999 preliminary emergency department data from the drug abuse warning network. Department of Health and Human Services, Washington, DC (DHHS Publication SMA 003407).
- SAMHSA, Office of Applied Studies, 2000b. SAMHSA, Office of Applied Studies, Drug abuse warning network annual medical examiner data 1998. Department of Health and Human Services, Washington, DC (DHHS Publication SMA 003408).
- Shoptaw, S., Reback, C.J., & Freese, T.E. (2002). Patient characteristics, HIV serostatus, and risk behaviors among gay and bisexual males seeking treatment for methamphetamine abuse and dependence in Los Angeles. *Journal of Addictive Diseases*, 21(1): 91-115.
- Simon, S.L., Richardson, K., Dacey, J., Glynn, S., Domier, C.P., Rawson, R.A., & Ling, W., (2002). A comparison of patterns of methamphetamine and cocaine use. *Journal of Addictive Diseases*, 21(1):35-44.
- United Nations Office for Drug Control and Crime Prevention. Accessed May 25, 2005 from http://www.unodc.org/unodc/en/world_drug_report.html.
- Volkow, N.D., Chang, L., Wang, G.J., Fowler, J. S., Yee, M.L., Franceschi, D., Sedler, M.J., Gatley, S.J., Hitzemann, R., Ding, Y.S., Logan, J., Wong, C., & Miller, E.N. (2001). Association of Dopamine Transporter Reduction with Psychomotor Impairment in Methamphetamine Abusers, *American Journal of Psychiatry*, 158, 377-382.
- Zweben, J.E., Cohen, J.B., Christian, D., Galloway, G.P., Salinard, M., Parent, D., & Iguchi, M. (2004). Psychiatric Symptoms in Methamphetamine Users. *American Journal on Addictions* 13:181-190.



QUESTIONS & ANSWERS:

Commonly asked questions submitted by professionals throughout the NeATTC region.

1. To what extent is the research clear about possible neuron damage due to methamphetamine abuse?

There is evidence that over time methamphetamine causes a reduction in dopamine levels, primarily in the areas of the brain responsible for feelings of pleasure (NIDA, 1998). This can impact mood, resulting in feelings of depression, and can also cause severe movement symptoms like those observed in Parkinson's.

Research has also demonstrated there may be long-term neuronal damage resulting from methamphetamine use (Ernst et al., 2000) resulting in functional deficits in information processing (Paulus, 2002) as well as motor tasks and memory (Volkow et al., 2001). Research indicates that these deficits become less severe with time in recovery, but it is unclear at this time whether full recovery of previous function is attained.

2. Are there any medications currently being used or recommended for the detox/early recovery phase of methamphetamine use? If so, what are the functions of the medications?

Many medications have been studied through clinical trials for use in methamphetamine recovery. To date, no medications have been shown to be effective in reducing the relapse to methamphetamine use. Clinical trials continue on medications that impact the serotonin, dopamine and gaba systems. Researchers believe that useful compounds will eventually be discovered that will aid in the recovery process.

3. What's the estimate on prevalence of usage nationally? Is use higher in some regions than others?

Methamphetamine, known on the street by meth, speed, crystal, crank, and ice, has emerged as the most dangerous home grown and one of the most widely used drugs in America. Much like heroin in the 1960s and '70s and crack cocaine during the 1980s and the early '90s, the past decade has witnessed tremendous increases in methamphetamine (MA) misuse throughout much of the U.S. Worldwide, the United Nations Office of Drug Control estimates that more than 42 million individuals regularly consume amphetamines around the world, more than any other illicit drug, except for cannabis. Domestically MA ranks as one of the most highly abused illicit drugs in urban and rural areas of the West, Midwest and South. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), national treatment admission rates for MA abuse increased by more than 420 percent for persons 12 years or older during the past decade.

The questions for the Q/A section were submitted by the NeATTC regional ambassadors and are reflective of the Northeast region. The questions on pages 8-10 were selected as the most commonly asked from those submitted. While space prohibits answering every question submitted individually, many others are addressed in the articles throughout the newsletter.

4. What is the prevalence of methamphetamine use/abuse in the Northeast Region?

There are indicators that describe the impact of methamphetamine use across the country and evidence of the spread of methamphetamine into the Eastern United States through increases in the methamphetamine related emergency department admissions (Drug Abuse Warning Network-National Institute on Drug Abuse), Treatment Admissions (Treatment Episode Data Set-Substance Abuse & Mental Health Services Admin.) and Arrestee Drug Abuse Monitoring System (ADAM-National Institute of Justice). However, data collection systems are not available to indicate the specific prevalence of methamphetamine either nationally or for any specific region.

5. We are hearing that treatment is much more difficult, if not hopeless at times. Is there a bio-chemical basis in fact for such a belief?

There are many myths about treatment. It is commonly cited at national and regional meetings as evidence of the poor outcomes to be expected from treating MA users that only 5 percent (or less) of meth addicts are able to kick it and stay away. A similar picture of dismal treatment outcome was presented in the January 23, 2003 issue of *Rolling Stone Magazine* story "Plague in the Heartland" where the statement "only 6 percent of MA freaks get and stay sober, the lowest number by far for any drug" was among one of the quotes attributed to the self-interested stakeholders such as local law enforcement. In some cases, these "statistical" statements are used to support the position that money spent on treatment is wasted and that the only fruitful investment is to reduce the availability of the drug through criminal justice, supply reduction approaches. An extensive literature search has failed to find any data to provide support for these statistics.

To date, the majority of studies investigating the effectiveness of treatment for stimulant addiction have focused on cocaine abuse with fewer studies on MA. Despite differences between the two stimulants in individual health, psychological and cognitive effects, both groups tend to show comparable responses to psychosocial behavioral treatments. In one large study using the Matrix Model, 500 MA-dependent individuals were treated alongside 250 cocaine-dependent individuals at the same clinic, by the same staff, over the same time period, using the same approach. Treatment outcomes were identical both during treatment and at follow up. Similar findings have been reported from treatment studies in San Francisco and from data collected in Los Angeles County and throughout California. While there is absolutely no evidence that MA users and other drug user populations respond differently to treatment, there are multiple controlled and large scale treatment outcome studies that suggest that treatment outcomes for MA and cocaine users is very comparable. Taken together, these results tend to dispel the false beliefs about treatment effectiveness for MA addiction circulating within the public sphere.

Worldwide, the United Nations Office of Drug Control estimates that more than 42 million individuals regularly consume amphetamines around the world, more than any other illicit drug, except for cannabis.

6. What best practices treatments are available to users?

Presently, there are two approaches that have evidence to support their efficacy for the treatment of MA dependence, but there is much more literature on treatments that work with the other major illicit stimulant problem in the U.S., cocaine dependence. Although there are a number of differences in the pharmacology and physiological effects produced by MA and cocaine, these drugs have many common properties and similar effects. Research examining the treatment responses of MA and cocaine users suggests that cocaine and MA users have very similar outcomes when exposed to the same treatments. In addition, large scale treatment system evaluations have reported comparable outcomes for cocaine and MA users. To date, despite extensive examination of multiple data sources, no data have been found to support the frequently misused “statistics” mentioned earlier (page 9) or the contention of poorer treatment outcomes with adult MA users.

7. Cultural factors are important to successful recovery. Why is it even more important to be culturally aware and competent in treating methamphetamine users?

Different races, cultures, ethnic backgrounds, religions, ages, genders, sexual orientations, physical and mental disabilities give rise to a wide range of factors that may influence effective delivery of services and the way clients respond to treatment. Treatment providers should develop their understanding of how traditions, lifestyle, family and other support systems and other factors may affect compliance and ultimate treatment success.

REFERENCES

- Ernst, T., Chang, L., Leonido-Yee, M., & Speck, O. (2000). *Evidence for long-term neurotoxicity associated with methamphetamine abuse* *Neurology*, 54, 1344-1349.
- Gallon, S., & Bryan, MA. (2002). Addiction Messenger Ideas for Treatment Improvement. *Cultural Competence Issues*. Vol. 5, issues 10, 11, & 12.
- NIDA (1998). *The National Institute on Drug Abuse Research Report - Methamphetamine Abuse and Addiction: NIH Publication No. 02-4210*.
- Paulus, M.P., Hozack, N.E., Zauscher, B.E., Frank, L., Brown, G.G., Braff, D.L., & Schuckit, M.A. (2002). Behavioral and Functional Neuroimaging Evidence for Prefrontal Dysfunction in Methamphetamine-Dependent Subjects. *Neuropsychopharmacology*, 26, 53-63.
- Volkow, N.D., Chang, L., Wang, G.J., Fowler, J.S., Yee, M.L., Franceschi, D., Sedler, M.J., Gatley, S.J., Hitzemann, R., Ding, Y. S., Logan, J., Wong, C., & Miller, E.N. (2001). Association of Dopamine Transporter Reduction with Psychomotor Impairment in Methamphetamine Abusers, *American Journal of Psychiatry*, 158, 377-382.

JOHN E. PETERSON
5th District, Pennsylvania
(202) 225-5121
(202) 225-5796 FAX
<http://www.house.gov/johnpeterson>

COMMITTEES:
APPROPRIATIONS
RESOURCES
Co-Chairman
CONGRESSIONAL RURAL CAUCUS

Congress of the United States
House of Representatives
Washington, DC 20515-3805

September 26, 2005

Northeast Addiction Technology Transfer Center
425 Sixth Avenue, Suite 1710
Pittsburgh PA 15219

Dear Friends,

During my years in public office, I have been hard pressed to come across a problem as insidious as methamphetamine. This horrible drug cuts across boundaries and attacks communities, families, and lives in so many ways. From the hazardous waste that is left behind as refuse from a meth cooking to the children who are affected in so many ways from growing up in an environment where their needs for upbringing are forgotten in the wake of addiction.

All of you, the men and women who have dedicated so much time and effort to the field of drug treatment are just as much on the front lines of this fight as members of law enforcement. It is you who have to deal with the more personal effects of this drug, from the extreme paranoia to the 36 hour highs. But perhaps the most challenging is the work it has and will continue to take to overcome the myth that it is impossible to treat methamphetamine addiction. This message that is so common in society provides even those meth addicts that are dedicated to fighting their addiction the wrong sense that their condition is hopeless. You face the challenge of overcoming that perception and working with the addicts to help them fight, and hopefully overcome their problem.

I am proud to support your efforts on a national basis and have been amazed with the stories of hope that I have heard from drug treatment professionals locally in my district as they work to fight methamphetamine. Following a regional methamphetamine summit I organized in my district, one treatment facility saw their meth treatment admissions double, proving the importance of getting the word out to our communities. I know your dedication to fighting the problem of drug abuse and please know that I share that dedication and will continue to do all that I can to carry the war against methamphetamine forward in a comprehensive manner that recognizes the important role that treatment must play.

Sincerely,


John E. Peterson
Member of Congress

TITUSVILLE
127 West Spruce Street, Suite C
Titusville, PA 16354
(814) 827-3995
(814) 827-7327 (FAX)

STATE COLLEGE
1924 West College Avenue
State College, PA 16801
(814) 239-1776
(814) 239-1918 (FAX)

POINT-OF-VIEW INTERVIEWS

Representatives of the three NeATTC states (New Jersey, New York and Pennsylvania) were asked to characterize Methamphetamine use in their respective states and offer some observations based on their experience to guide other practitioners.



NEW JERSEY

John Kriger, president of Kriger Consulting, provides organizational training, management consulting, and assessment and evaluation throughout the United States and Bermuda. He is the former Acting Director and Deputy Executive Director for the N.J. Governor's Council on Alcoholism and Drug Abuse and former Deputy Director of the N.J. Office on Child Abuse Prevention.

John Kriger and his colleagues have been tracking the use of methamphetamines for 15 years. Until recently, they hadn't seen much movement from the central part of the United States. However, in the past three years they've seen more activity in Florida and the Carolinas, in upstate and central New York, and in the past 18 months or so, more in Pennsylvania, particularly western Pennsylvania.

As for his home state of New Jersey, Kriger says, "We seem to be right in the middle." Though meth use tends to surface in rural areas first and much of New Jersey is a rural state, he is beginning to see a spike in activity. He is hearing from colleges that it is infiltrating the student population as students use meth to stay awake and enhance test performance. His concern also is that use appears to be "following the interstates."

Since it just may be a matter of time, Kriger and his associates, including a colleague in Iowa, are focusing on prevention. They have offered comprehensive two-day training programs across the country that focus on history and treatment; impact on children and families; and impact on first responders.

Most troubling to Kriger is what he sees as a unique aspect of methamphetamine use. Family members and others in the same household where meth is being manufactured, particularly children, experience essentially the same effects as the user from production cast offs, residue on surfaces of the home, absorption into fabrics, etc., that do not naturally dissipate. What's more, first responders—police, firemen and paramedics—called to a meth lab incident suffer the same exposure. Social workers who are called upon to remove children from this environment also are at risk.

Calling for a realistic approach, Kriger and colleagues are working with others in New Jersey to "get ahead of" the issue in the state. They work with the state's Office of Child Abuse Prevention and others to promote the education of practitioners about the signs and symptoms to look for in children, such as respiratory and developmental problems. Children removed from parents need foster families but may be hard to place given the residual effects of meth exposure. Instruction on home decontamination procedures is recommended. First responders require specialized protective gear. Real estate agents and utility workers who have routine access to homes might be trained to spot warning signs. Legislation like that introduced in Pennsylvania and other states to limit or register sale of materials used to manufacture meth is being considered.

"In short, the issue calls for a system-wide, integrated approach," Kriger says.

New Jersey Department of Human Services Division of Addiction Services
<http://www.state.nj.us/humanservices/das/index.htm>



NEW YORK

Christopher Murray, LMSW, says look to the experience of the gay community to help prevent methamphetamine use from growing to the proportions of cocaine use in the '80s. Murray is a substance use counselor at New York City's Lesbian, Gay, Bisexual & Transgender Community Center.

"This drug (meth) connects subcultures and moves in networks in very intense ways," Murray explains. Not unlike AIDS, meth use tends to surface and spread amid very vulnerable populations—the sick, people of color, immigrants. Frightening spikes in HIV infections have been reported to follow the trail of meth use.

"A concern is that it will continue to cross from one to another niche." In New York City, Murray says, law enforcement has aggressively managed to maintain "firewalls."

While multi-day binges are sensationalized they are rare, he notes. Meth is more insidious than that. "Its powerful cheap high hits gays where we live, assuaging some of the existing homophobia, sexual abuse, depression and anxiety, and other issues."

Accurate as a laser, meth "puts you in the zone"—wherever you want that to be, to manage the day's stressor. Its adaptability—sniff, smoke, slam, etc., and availability—shipped from the West Coast, for example, when not available locally, add to meth's appealing qualities.

Murray cautions that the growing focus on prevention may be a two-edged sword: It puts dealers on notice and they flee, or worse, it drives them underground.

For all of these reasons, Murray is passionate about the need to actively engage practitioners to stem the tide, using the gay community's experience as a guide.

Cultural competence is a must, he says. Counselors need training to fully understand meth-amphetamines. He stresses the very different and critical "come down" profile: there are rhythms and cycles, it is intense and long term, and a mood can quickly turn from paranoid to psychotic. Unlike with other drugs, "tweaking" exacerbates these problems rather than quelling them. He emphasizes harm reduction, e.g., hydration and lubrication, to contain the spread of illness and disease.

But there's hope in the horror of it. The scary intensity of meth tends to discourage future use. And various treatments are showing promise, including some of the impulse control methods used in smoking cessation programs. The Contingency Model (discussed on page 4 of this newsletter) holds promise. Some outpatient programs are effectively using anti-depressants in treatment.

Resources:

Murray, C., (2005) *Meth Mess: Breaking Up With Terrible Tina*, Courier-Life Publications

Web resources:

www.thebody.com and www.Callen-Lorde.org

www.gaycenter.org/surveys/crystal

New York State Office of Alcoholism and Substance Abuse Services: Methamphetamine Electronic Clearinghouse

<http://www.oasas.state.ny.us/meth/index.htm>

Bureau of Special Populations Division of HIV Prevention AIDS Institute, New York State Department of Health: A Key to Methamphetamine-Related Literature

http://www.nyhealth.gov/diseases/aids/harm_reduction/crystalmeth/docs/meth_literature_index.pdf



PENNSYLVANIA

While the frequent news reports of exploding meth labs would lead one to believe methamphetamine use is rampant, treatment facilities are not seeing a spike. “We keep hearing that it is coming,” says Dr. Neil Capretto of Gateway Rehabilitation Center, Aliquippa. “We may be just ahead of the curve in Southwest Pennsylvania,” he says.

But it’s quite a different story for police. Often police reports are the only source of statistics on use. For example just an hour or two away in rural Titusville Officer William Dilley estimates that in this city of 6500, if budget would permit, he could use two of their 15 officers full-time on just meth cases. And it still wouldn’t be enough! Officer Dilley represents the Northwest district’s 60-80 mile area on the State Attorney General’s Drug Task Force. He acknowledges the support of agents from the State Attorney General’s office, his fellow officers and others from surrounding area police forces who work countless hours of overtime.

And cases multiply daily, he says, as more and more users become “cookers” — producing the drug themselves. And each cooker teaches 10 more they’ve found. Meth is easy to get, relatively inexpensive and mightily potent!

Meth use crosses all societal lines. Officer Dilley has known users who have squandered an entire trust fund. Kids in eighth grade are meeting suppliers under bridges. Families are completely destroyed; occasionally one is restored. He’s known parents who ransomed their children for meth money, fathers who “pimped” their daughters for the drug.

Dr. Capretto does see an increasing amount of communication and attention to meth use over the past three years. In Pennsylvania, as in other states, legislation has been introduced to monitor the purchase of materials used in meth production in order to make it more difficult to manufacture. Provider education programs have been stepped up. Practitioners are more aware of the signs of use and communicate more about what they are seeing in their practices. Officer Dilley presents classes for first-responders through the University of Pittsburgh. Beyond provider education, he believes dedicated rehab units or even separate facilities are needed to effectively deal with the unique and intense meth recovery process.

Both men agree: Public education is critical particularly for students and other niches of the population who see the short-term advantages over the long-term effects - including heart attacks and strokes. Officer Dilley cautions against the false security that meth is not a problem in your area. “It’s everywhere,” he says.

Labs Seized (where the PSP Clandestine Lab Response Team was activated):

	2001	2002	2003	2004
Crawford County	2	3	7	41
Erie County	0	2	8	10
Venango County	0	4	11	11
Warren County	1	1	0	3
Forest County	1	1	3	4
Regional Totals	4	11	29	69
State Total	19	34	64	127

Source: Titusville Police Department, Titusville, PA. The Titusville Police Department has five officers that serve on the Pennsylvania Attorney General’s Bureau of Narcotics Investigation Drug Task Force that covers the following counties in Northwest PA: Erie, Crawford, Warren, Venango, and Forest. www.titusvillecityhall.com/stats.htm

Pennsylvania Department of Health Bureau of Drug & Alcohol Programs: Emerging Issues! – Methamphetamine

<http://www.dsf.health.state.pa.us/health/cwp/view.asp?A=173&Q=242343>

FEATURED PRODUCTS:

METHAMPHETAMINE 101: ETIOLOGY AND PHYSIOLOGY OF AN EPIDEMIC (2004)

This video module is designed to provide an overview of the medical, psychological and societal effects of methamphetamine abuse and dependence and is intended to be used in conjunction with the second module addressing methamphetamine treatment.

PRESENTERS:

Tom Freese, Ph.D., UCLA; Rick Rawson, Ph.D., UCLA; Michael S. Shafer, Ph.D., University of Arizona, Tucson, Arizona

1.70 hours training time

VHS + course materials: \$75

DVD + course materials: \$50

METHAMPHETAMINE 102: INTRODUCTION TO EVIDENCE-BASED TREATMENTS (2004)

This module addresses foundations for a clinical approach to methamphetamine treatment with emphasis on the Matrix Model, an evidence-based treatment protocol that has withstood the rigors of clinical trial research.

The module also presents additional behavioral therapies that have been shown to be successful in treating methamphetamine abuse.

PRESENTERS:

Tom Freese, Ph.D., UCLA; Jeanne Obert, MFT, MSM, Executive Director, Matrix Institute; Rick Rawson, Ph.D., UCLA; Mickey McCann, Ph.D., Associate Director, Matrix Institute; Michael S. Shafer, Ph.D., University of Arizona

2.00 hours training time

VHS + course materials: \$75

DVD + course materials: \$50

SPECIAL!

METHAMPHETAMINE 101 & 102 COMPLETE SET

3.70 hours training time

VHS + course materials: \$130

DVD + course materials: \$85

**These products can be ordered from the
Pacific Southwest Addiction Technology Transfer Center**

<http://www.psattc.org>

Phone: 310-445-0874

Toll Free: 866-892-3724

Fax: 310-312-0538

Look for future newsletters and learn more about the Northeast Addiction Technology Transfer Center at www.neattc.org.

Contact info@neattc.org to join our e-mail list and receive articles and notices on-line.

PLEASE COPY AND POST THIS NEWSLETTER



EDITOR:

Michael T. Flaherty, PhD

CO-EDITORS:

Eileen Henry, EdD
Janice Pringle, PhD

ASSISTANTS:

Holly Hagle
Tamara Heming
Lisa Howard
Diane Wuycheck

CONTRIBUTORS:

Congressman John E. Peterson
Thomas Freese, PhD
Rachel Gonzales, MPH
Richard Rawson, PhD

POINT-OF-VIEW INTERVIEWS:

Neil Capretto, MD - Pennsylvania
Officer William Dilly - Pennsylvania
John Kriger - New Jersey
Christopher Murray, LMSW - New York

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

Phone: 412-258-8565
Fax: 412-391-2528

www.neattc.org
www.ireta.org

© 2006
Published by the Institute
for Research, Education and
Training in Addictions
(IRETA)

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

NONPROFIT ORG
U.S. POSTAGE
PAID
PITTSBURGH PA
PERMIT #215

ireta

Institute for Research, Education
and Training in Addictions



The NeATTc is a federally funded program administered by IRETA.

2 Continuing Education Hours for \$20

You are eligible to receive (2) Continuing Education (C.E.) credits by completing a post-test based on this issue of the *Resource Links*. Return the completed post-test and a \$20 check for processing fee to the Institute for Research, Education and Training in Addictions (IRETA). Please make check payable to IRETA. A passing grade for the post-test is 80%. Applicants that receive an 80% or above will receive a certificate by return mail stating that he/she has been awarded 2 CEs. Credits are issued by the National Association for Addiction Professionals (NAADAC).

— REGISTRATION FORM —

Methamphetamine: Debunking the Myth

NAME AND DEGREE AS YOU WISH THEM TO APPEAR ON YOUR CERTIFICATE (PLEASE PRINT):

NAME: _____ DEGREE: _____

ADDRESS: _____

PHONE: _____ FAX: _____

E-MAIL ADDRESS: _____ LICENSE #: _____

I confirm that I personally have completed the above test, and I am submitting it for evaluation and certification.

SIGNATURE: _____ DATE COMPLETED: _____

Evaluation: Overall, this issue of *Resource Links* (circle appropriate response)

PROVIDED INFORMATIVE UPDATES	5	4	3	2	1	WAS NOT INFORMATIVE
EXPANDED MY KNOWLEDGE	5	4	3	2	1	DID NOT EXPAND MY KNOWLEDGE
PROVIDED USEFUL RESOURCES	5	4	3	2	1	DID NOT PROVIDE USEFUL RESOURCES
WAS APPROPRIATE FOR MY TRAINING LEVEL	5	4	3	2	1	WAS NOT APPROPRIATE



The NeATTC is a federally funded program administered by IRETA.

IRETA | Regional Enterprise Tower | 425 Sixth Avenue | Suite 1710 | Pittsburgh, PA 15219

Methamphetamine: Debunking the Myth

POST-TEST

You are eligible to receive two (2) Continuing Education (CE) credits by completing this quiz based on this issue of *Resource Links*. INSTRUCTIONS: Indicate the best answer to each of the following questions and return the completed test and application form (on back) with a check for \$20 to The Institute for Research, Education and Training in Addictions.

1. Methamphetamine (MA), is known on the street by:
 - a. meth
 - b. speed
 - c. crystal
 - d. crank
 - e. ice
 - f. Tina
 - g. all of the above
2. Which body system does MA stimulate?
 - a. the endocrine system
 - b. the cardiovascular system
 - c. the central nervous system
 - d. the immune system
 - e. none of the above
3. What is the worldwide estimated rate of MA use?
 - a. 62 million
 - b. 52 million
 - c. 42 million
 - d. 32 million
4. Which neurotransmitter is the euphoria or "high" produced by MA use directly linked too?
 - a. the release of dopamine
 - b. the release of serotonin
 - c. the release of medication
 - d. the release of norepinephrine
5. Research has demonstrated the impact of MA on certain kinds of:
 - a. information processing
 - b. memory
 - c. motor tasks
 - d. all of the above
6. Research examining the treatment responses of MA and _____ users suggests that both have very similar outcomes when exposed to the same treatments.
 - a. inhalents
 - b. marijuana
 - c. alcohol
 - d. cocaine
7. The article endorsed the use of which type of model?
 - a. Matrix Model
 - b. Outcomes Model
 - c. Context Model
 - d. Experience Model
8. The article states that Contingency Management (CM) is positive reinforcement and is a powerful tool in increasing desired behaviors.
 True
 False
9. Women use MA at rates:
 - a. 4:1 ratio to men
 - b. 3:1 ratio to men
 - c. 2:1 ratio to men
 - d. 1:1 ratio to men
 - e. less than men
10. Issues around sexual readjustment during sobriety are very important and can play a very big role in relapse, if not properly addressed.
 True
 False

THE ALCOHOL USE DISORDER IDENTIFICATION TEST **AUDIT**

The **Alcohol Use Disorder Identification Test – AUDIT** is a questionnaire developed by the World Health Organization (WHO) to identify persons whose alcohol consumption has become hazardous or harmful to their health. It is a ten-item questionnaire. It takes about two minutes to complete. Answers for each question range from 0 to 4. Maximum score of 40. There is no set cut-off point indicating harmful use. A score of 2 or more indicates some level of harmful use.

THE COMBINED NUMBER FOR EACH RESPONSE IS THE NUMBER OF POINTS.

Questions 1-3 are about ALCOHOL CONSUMPTION.

High scores on the first 3 items, in the absence of elevated scores on the remaining items suggest hazardous alcohol use.

Questions 4-6 are about ALCOHOL DEPENDENCE.

Elevated scores on these questions imply the presence or emergence of alcohol dependence.

Questions 7-10 are about PROBLEMS CAUSED BY ALCOHOL.

High scores on these questions suggest harmful alcohol use.

SOURCES:

The Alcohol Use Disorder Identification Test AUDIT retrieved January 27, 2006 from http://www.projectcork.org/clinical_tools/index.html
World Health Organization (WHO) AUDIT for Primary Health Care Workers. Scoring of the Alcohol Use Disorders Identification Test - AUDIT retrieved January 27, 2006 from <http://www.prodigy.nhs.uk/ClinicalGuidance/ReleasedGuidance/webBrowser/pils/plaudit.htm>



The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Institute for Research, Education
and Training in Addictions

The Alcohol Use Disorder Identification Test - AUDIT

CLIENT _____ DATE _____ SCORE _____

1. How often do you have a drink containing alcohol

Never	(0)	_____
Monthly or less	(1)	_____
Two to four times a month	(2)	_____
Two to three times a week	(3)	_____
Four or more times a week	(4)	_____

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	(0)	_____
3 or 4	(1)	_____
5 or 6	(2)	_____
7 to 9	(3)	_____
10 or more	(4)	_____

3. How often do you have six or more drinks on one occasion?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

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?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	(0)	_____
Less than monthly	(1)	_____
Monthly	(2)	_____
Weekly	(3)	_____
Daily or almost daily	(4)	_____

9. Have you or someone else been injured as a result of your drinking?

No	(0)	_____
Yes, but not in the last year	(2)	_____
Yes, during the last year	(4)	_____

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking, or suggested you cut down?

No	(0)	_____
Yes, but not in the last year	(2)	_____
Yes, during the last year	(4)	_____

TOTAL: _____