

***Methamphetamine Crisis:
Addiction and Mental Health
Opportunity?***

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Tragedies

People with co-occurring MH and Addictive Disorders often seen in emergency rooms, jails, homeless shelters, on the streets, and in the obituaries.

What is necessary is to have reasonable expectations!

- ❖ **A patient who has continuous low grade hallucinations will not continue to come to group sessions that he can't understand.**
- ❖ **A client with memory and cognitive disabilities won't remember to keep her appointments.**
- ❖ **Often meth is more accessible than services that are compatible with the person's needs.**

Methamphetamine causes severe mental illness (DSM-IV)

- ❖ **Amphetamine-Induced Psychotic Disorder, with Delusions**
- ❖ **Amphetamine-Induced Mood Disorder**
- ❖ **Amphetamine-Induced Anxiety Disorder**
- ❖ **Amphetamine-Induced Sleep Disorder**
- ❖ **Amphetamine-Induced Psychotic Disorder, with Hallucinations**

Methamphetamine causes psychiatric symptoms

- ❖ **Amphetamine intoxication with perceptual disturbances**
- ❖ **Amphetamine withdrawal**

How can we deal with this epidemic?

- ❖ **Our CD recovery programs were not designed to treat addiction to methamphetamine, heroin, and prescription drugs.**
- ❖ **Our mental health programs are overwhelmed and often limited to crisis intervention only.**

The background features a soft, muted illustration of a mountain range in the distance and a willow tree with drooping branches on the right side. The overall color palette is light and naturalistic, with shades of beige, cream, and pale green.

*Now that everything is
changing, is it not up to us to
change ourselves?*

Rilke

Co-occurring MH and Addictions

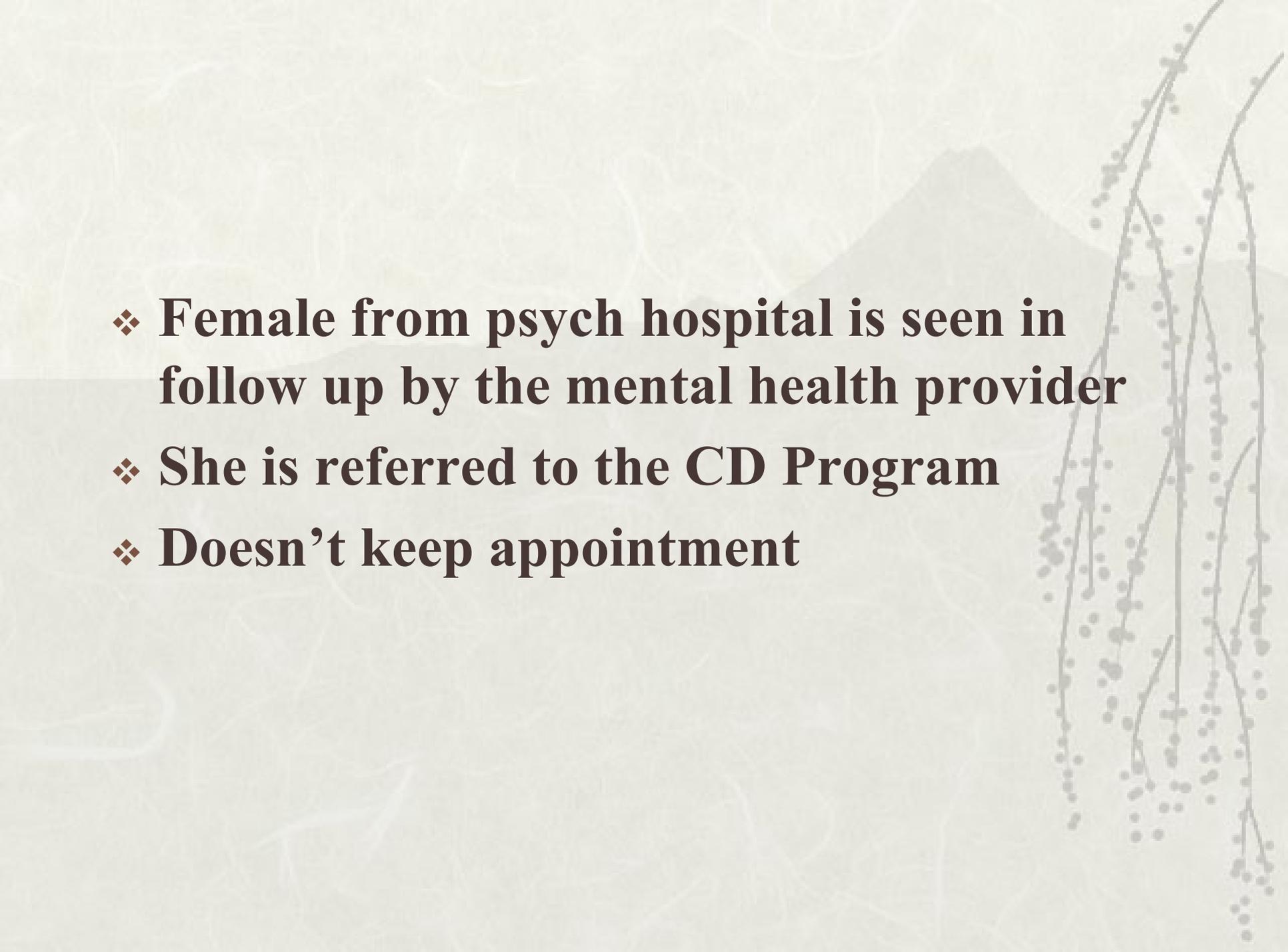
- ❖ **27 yo male in ER**
- ❖ **Brought by police**
- ❖ **Combative, hallucinating**
- ❖ **Intact reality testing**
- ❖ **Treated with Haldol and Ativan**
- ❖ **Calms down**
- ❖ **Drug screen + meth and morphine**

Co-Occurring Mental Health and Addictive Disorders

- ❖ **42 yo female**
- ❖ **Discharged from acute psych hospital**
- ❖ **3 days after suicide attempt**
- ❖ **Drug screen was positive for
methamphetamine**

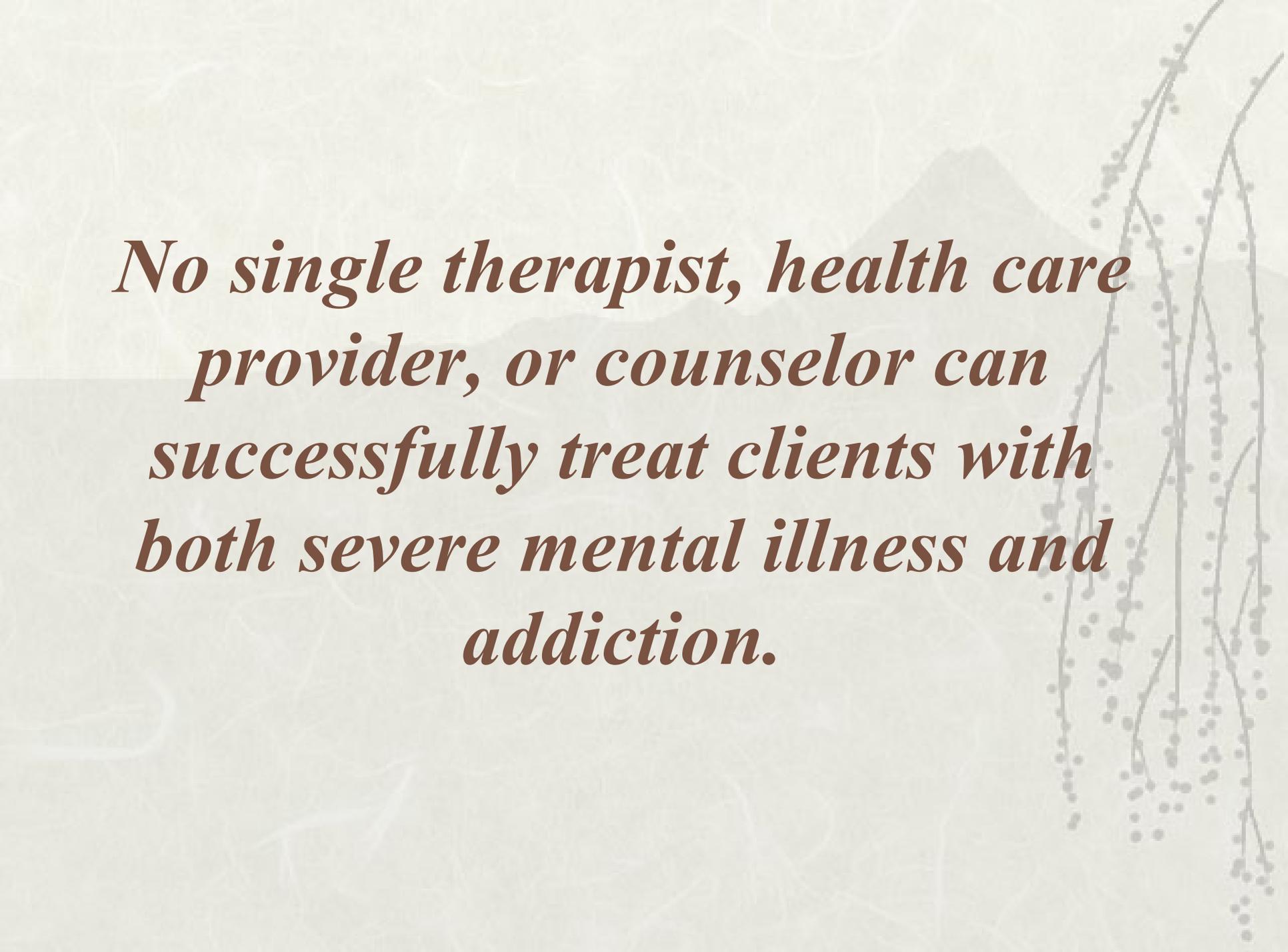
Sound Familiar?

- ❖ **Male from the ER is referred to the CD/Addiction counselor**
- ❖ **Doesn't keep appointment**

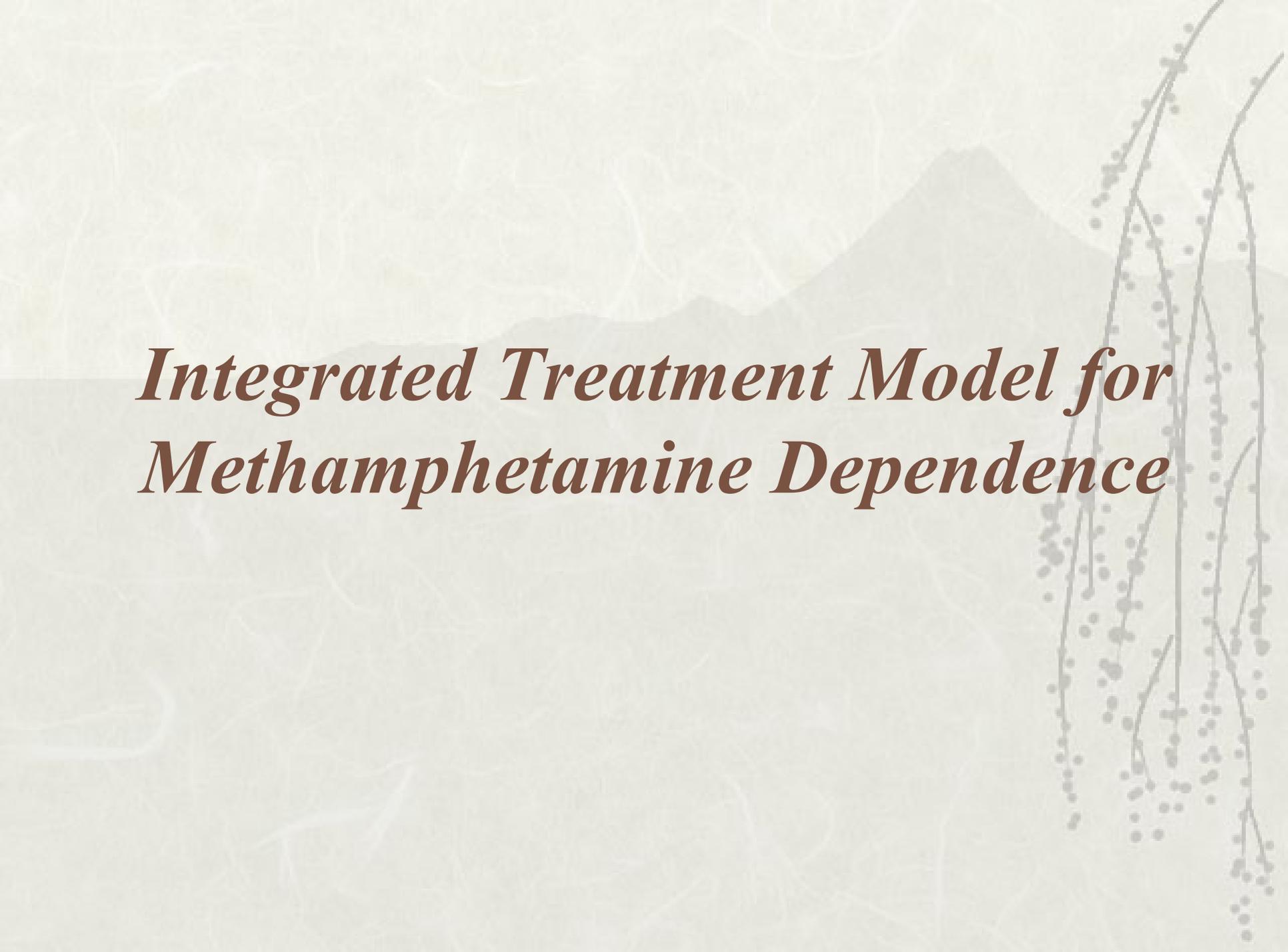
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- The background of the slide features a soft, light-colored landscape. In the center, there is a silhouette of a mountain range. On the right side, several thin, dark branches of a willow tree hang down, adorned with small, dark, round buds. The overall aesthetic is calm and natural.
- ❖ **Female from psych hospital is seen in follow up by the mental health provider**
 - ❖ **She is referred to the CD Program**
 - ❖ **Doesn't keep appointment**

Characteristics of Co-Occurring

- ❖ **Clients don't keep appointments**
- ❖ **They have many treatment and living situation needs**
- ❖ **Their treatment providers fail to communicate**
- ❖ **It's easy for them to fall through the cracks**
- ❖ **They don't have a lot of success**
- ❖ **They tend to get blamed for not doing well**

The background features a soft-focus landscape with a mountain range in the distance and a willow tree branch with small, dark buds on the right side. The overall color palette is muted and naturalistic.

No single therapist, health care provider, or counselor can successfully treat clients with both severe mental illness and addiction.

The background features a soft, muted landscape with rolling hills or mountains in shades of light green and beige. On the right side, there are several thin, dark branches of a willow tree, each adorned with small, dark, round buds or leaves. The overall aesthetic is calm and natural.

*Integrated Treatment Model for
Methamphetamine Dependence*

Stages of Treatment compared to Stages of Change

Patient's stage of change:

- ❖ Precontemplation
- ❖ Contemplation,
Preparation
- ❖ Action
- ❖ Maintenance

Our role:

Engagement
Motivation

Active Treatment
Relapse Prevention

Engagement: Strategies

- ❖ **26 yo male with paraplegia, depression, and methamphetamine dependence**
- ❖ **Stage: Not engaged in treatment**
- ❖ **Goal: Establish working alliance with client**
- ❖ **Interventions: Outreach, practical assistance, crisis intervention**

adapted from Mueser, 1999

Engaging the meth user in treatment

- ❖ **Ambivalence is expected**
- ❖ **Make treatment accessible**
- ❖ **Provide support for being in treatment (food vouchers, transportation, onsite child care)**
- ❖ **Respond quickly and positively when user makes contact with program**
- ❖ **Convey empathic concern**

CSAT, 1999

Motivation

- ❖ **14 yo female came in for pregnancy test, has needle marks. Mother is in clinic waiting room.**
- ❖ **Stage: Not aware that substance abuse is a problem for her. She is interested in the question of pregnancy, tho.**
- ❖ **Goal: Assess, motivate towards change**
- ❖ **Intervention: Urine drug test, (and pregnancy test,) interview mother.**
- ❖ **Referral made to BH/CD. Worker meets pt and mother**
- ❖ **Arrange for follow up with primary care doc/NP!**
- ❖ **Motivational intervention.**

Active Treatment Stage

- ❖ **46 yo male with Hepatitis C, one month off meth, depressed**
- ❖ **Stage: Motivated to reduce substance use**
- ❖ **Goals: Help client develop plan for abstinence. Instill hope.**
- ❖ **Interventions: Working relationship between MH, CD program is evident to client. Therapists and counselors are confident in ability to assist him.**

Stages in Methamphetamine Treatment

- ❖ **1. Get started**
- ❖ **2. Get clean**
- ❖ **3. Stay clean**
- ❖ **4. Stay Healthy (Long-term abstinence support plan)**

adapted from CSAT, 1999

Getting Started: what client/family need to know

- ❖ **Feel “yucky”:**
- ❖ **depression, fatigue, poor memory, trouble concentrating, irritability, craving for drug, sometimes paranoia**
- ❖ **Lasts 10 days-2 weeks**

Getting Started: what we need to do:

- ❖ **Frequent, brief, supportive visits**
- ❖ **Urine drug testing: mandatory, vigilant, frequent, and record of results protected by 42CFR regulations**
- ❖ **Client is not kicked out of treatment for positive drug test**
- ❖ **Instead, they are rewarded for clean urines (vouchers, etc.)**
- ❖ **Assess co-occurring mental health disorders**
- ❖ **Initiate treatment of MH disorders, including meds if needed**

*Get Started:
Look for co-occurring disorders*

- ❖ **Multidimensional assessment needed**
- ❖ **Look for safety/lethality issues**
- ❖ **Environmental/Medical/Cognitive**
- ❖ **If present, patient needs to go to
Stabilization Placement immediately**

First Face to Face Assessment

- ❖ **Questions to answer: immediate stabilization placement, or F/U appt?**
- ❖ **Danger to self or others?**
- ❖ **Psychotic/paranoid?**
- ❖ **Home is dangerous ?**
- ❖ **Unstable medical condition?**

Assess Barriers to Outpatient Treatment

- ❖ **Malnourishment**
- ❖ **Dental Deterioration**
- ❖ **Pregnancy**
- ❖ **Acute cognitive problems**
- ❖ **Psychosis**
- ❖ **Stage of readiness**
- ❖ **Withdrawal symptoms (fatigue, depression)**

ASAM 2001

Motivational Intervention to remove barriers to treatment

- ❖ **Address barriers to engagement in outpatient treatment**
- ❖ **Provide Motivational, low-intensity services**
- ❖ **Inpatient or outpatient**
- ❖ **High structure/high frequency services**
- ❖ **Family engagement**
- ❖ **Medical**
- ❖ **Dental**
- ❖ **Psychiatric care**

ASAM 2001

Behavioral Health and Primary Care

- ❖ **Depression/fatigue is a powerful motivation to resume use**
- ❖ **Joining with the client to address these issues is treatment— not “enabling!”**
- ❖ **BH treatment plan can include referral to Primary Care for evaluation and treatment of depression—meet and discuss your needs/expectations beforehand**
- ❖ **CD and Clinic need to ask client for consent to discuss their case (sign release forms)**

Getting Clean

- ❖ **45 yo male with Hep C**
- ❖ **One month off meth, has fewer cravings, mental status is clearing**
- ❖ **Is depressed**
- ❖ **Referred to MH from CD**
- ❖ **Integrated treatment plan**
- ❖ **Patient and family education on what to expect in recovery process**
- ❖ **Recovery community can be immense help.**

Getting Clean: Evidence-based Interventions

- ❖ **Case-Management**
- ❖ **Contingency Management**
- ❖ **Matrix Model**
- ❖ **Drug Court**
- ❖ **Exercise, Nutrition**
- ❖ **Couples Counseling**
- ❖ **18 months of services**

“Stay Clean”

What patient/family need

- ❖ **Support, encouragement, support!**
- ❖ **Dealing with relationships**
- ❖ **Individualized services**
- ❖ **Assessment of cognitive recovery**
- ❖ **Assistance with life issues:**
 - Legal, child custody**

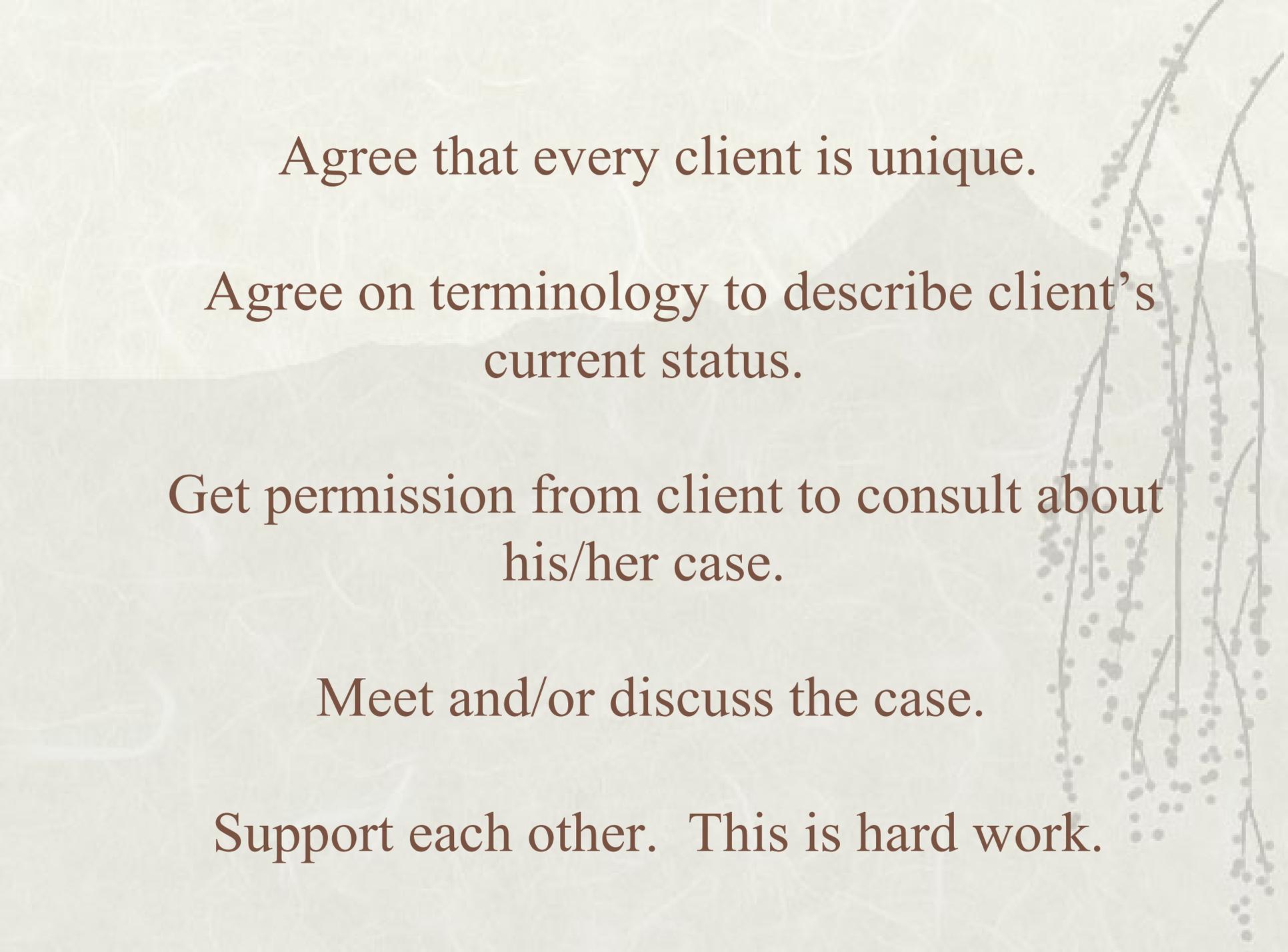
“Stay Healthy”

Relapse Prevention Stage

- ❖ **35 yo female with diagnosis of amphetamine-induced psychosis with delusions**
- ❖ **Stable on meds at home**
- ❖ **Last use of meth was six months ago**
- ❖ **Stage: Relapse prevention**
- ❖ **Goal: Extend recovery to other areas of life. Maintain awareness that relapse can happen. Stay on meds.**
- ❖ **Interventions: Cultural/traditional resources, case management, stress management**

MH and CD programs: engage each other

- ❖ **Outreach—visit each other's programs**
- ❖ **In-services—offer to teach each other**
- ❖ **Support—Ask clients for consent to consult with the other program whenever they are going to both programs**
- ❖ **Speak the same language—bring trainers in, go to the same training.**
- ❖ **Doesn't matter exactly what language you speak, as long as you understand each other!**

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Agree that every client is unique.

Agree on terminology to describe client's current status.

Get permission from client to consult about his/her case.

Meet and/or discuss the case.

Support each other. This is hard work.

*You are the experts:
Your community's treatment
model is in your hands.*



Summary

- ❖ **Our systems weren't designed for today's drug problems.**
- ❖ **Our clients are sicker and have more psychiatric problems than ever before.**
- ❖ **Evidence shows that integrated treatment is necessary for co-occurring MH and Addictions**
- ❖ **We are starting with simple, (not easy) steps to integrate treatment for clients with co-occurring mental health and addictions.**

References:

- ❖ American Psychiatric Association, DSM IV, 1994
- ❖ American Society of Addiction Medicine (2001)
Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC 2R)
- ❖ Consensus Panel on Treatment of Stimulant Use Disorders, Center for Substance Abuse Treatment, SAMHSA, 1999
- ❖ Fox K. Noordsy D. Drake R Fox L(2003) Integrated Treatment for Dual Disorders, Dartmouth Psychiatric Research Center. New York: Guilford Press
- ❖ Rawson RA, Gonzales R, Brethen P (2002) Treatment of methamphetamine use disorders: an update. Journal of Substance Abuse Treatment 23(2): 145-150