V. About Methamphetamine: Overview/Discussion

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V. About Methamphetamine: Overview/Discussion

"The alarming growth of methamphetamine use over the last 10 years and, in part, its popularity can be explained by the drug's wide availability, ease of production, low cost, and highly addictive nature."

Charles Curie, M.A., A.C.S.W.
Administrator, SAMHSA
April 2005[1]

What is methamphetamine?

Methamphetamine is a powerful stimulant drug, classified as a psychostimulant. Other drugs in the psychostimulant category include cocaine and amphetamine. Methamphetamine is similar in its structure to amphetamine and to the neurotransmitter dopamine.

Methamphetamine is quite different in structure from cocaine, but both drugs cause accumulation of high levels of dopamine in the brain, and this concentration of dopamine produces the stimulation and euphoria users experience. However, cocaine and amphetamine metabolize quickly, and the effects wear off within a few minutes. In contrast, methamphetamine remains unchanged in the body for several hours, resulting in prolonged effects.[2]

The Drug Enforcement Administration (DEA) cautions that "amphetamine, dextroamphetamine, methamphetamine, and their various salts often are collectively referred to as amphetamines..." and their chemical properties and actions are so similar

[1] Curie, Charles, M.A., A.C.S.W., Administrator, SAMHSA. April 21, 2005. Testimony on the Prevention and Treatment of Methamphetamine Abuse Before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate. www.hhs.gov/asl/testify/t050425.html.
[2] National Institute on Drug Abuse. April 1998, Reprinted January 2002. Research Report Series: Methamphetamine Abuse and Addiction. www.nida.nih.gov/ResearchReports/methamph/methamph.html

that even experienced users can't be sure which drug they have taken. DEA also points out that methamphetamine is the most commonly abused of the group.[3]

Methamphetamine is also called "speed," "meth," and "chalk." In its smoked form, it is often referred to as "ice," "crystal," "crank," and "glass." A combination of methamphetamine and caffeine, produced in tablet form in Southeast and east Asia, is known as "Yabba" ("Ya Ba" in some references) and is sometimes called "crazy medicine" or "Nazi speed."[4]

All of these drugs (including cocaine) are listed in Schedule II under the Federal Controlled Substances Act, passed in 1970 and amended several times since then.[5] Schedule II drugs have a high potential for abuse; have legal and medical applications in the United States; and, if used regularly, may lead to physical and psychological dependence. Other Schedule II drugs include morphine, phencyclidine (PCP), and methadone.[6]

Medically, methamphetamine may be prescribed in the treatment of narcolepsy, attention deficit disorder, and obesity, although current medical use is limited. Except for such medically prescribed uses, it is against the law to use, possess, manufacture, or distribute Schedule II drugs.

Since methamphetamine has gained popularity among some youth and young adults at dance venues, "raves," "circuit parties," and in similar settings, it is often referred to as a "club drug." But, in general, use of the other club drugs[7]—ecstasy (MDMA), liquid ecstasy (GHB), "roofies" (rohypnol), "Special K" (ketamine), and "acid" (LSD)—is most likely to take place at clubs or in party environments in conjunction with youthful socializing. Chronic methamphetamine use and problems occur often among adults who have no connection to what most people would recognize as the dance club or party scene.

Where does methamphetamine come from?

Methamphetamine is a synthetic drug and can be made easily using ingredients that are legally available and usually not hard to find, such as cold medicines, fertilizer, cat litter, and drain-cleaning compounds. Historically, in 1887 a German chemist first synthesized amphetamine, from which methamphetamine is derived and to which it is closely related. Thirty-two years later, a Japanese chemist synthesized methamphetamine. During World War II, methamphetamine was distributed to U.S., German, and Japanese troops as a

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[3] U.S. Drug Enforcement Administration. Methamphetamine Fact Sheet. www.usdoj.gov/dea/concern/meth_factsheet.html

[4] National Drug Intelligence Center, U.S. Department of Justice. June 2003. Yaba Fast Facts: Questions and Answers. www.usdoj.gov/ndic/pubs5/5048/index.htm

[5] U.S. Drug Enforcement Administration. Drug Scheduling. www.usdoj.gov/dea/pubs/scheduling.html

[6] U.S. Drug Enforcement Administration. The Controlled Substances Act, Chapter 1. www.dea.gov/pubs/abuse/1-csa.htm#Schedule%20II

[7] Leshner, A., Ph.D. Updated June 14, 2005. Club drugs aren't fun. National Institute on Drug Abuse. www.drugabuse.gov/Published_Articles/fundrugs.html

stimulant to counter combat fatigue. After the war, amphetamine/methamphetamine products such as Benzedrine and Dexadrine were commonly available in the United States to treat a variety of ailments, including alcoholism, depression, fatigue, and weight problems.[8] In 1967, prescriptions for methamphetamine reached a peak of 31 million.[9]

Coincidentally, 1967 was also the year when San Francisco became the site of a massive celebration of "hippies," "flower power," and psychedelic culture popularly known as the Summer of Love. Along with alcohol, marijuana, and hallucinogenic drugs, thousands of young people caught up in this anti-establishment movement used methamphetamine with devastating and sometimes deadly consequences.[10] By then, "Speed Kills," previously applied to traffic safety measures, had become a familiar anti-drug slogan.

The 1970 Controlled Substances Act (CSA) imposed strict controls on the importing, manufacture, and retail availability of amphetamine-related drugs. Over-the-counter amphetamine/methamphetamine products such as diet pills all but disappeared. The Chemical Control and Trafficking Act (1988) mandated additional control of pseudoephedrine and other methamphetamine precursor[11] substances and imposed mandatory sentences for methamphetamine possession.[12]

By the 1990s, illegal methamphetamine labs in Mexico and the United States were providing an increasing supply of the drug, and "super labs" in the American Southwest and across the Mexican border controlled the trade. In 1996, passage of the Comprehensive Methamphetamine Control Act increased penalties for making and selling the drug and created a task force to combat its spread. The 2000 Methamphetamine Anti-Proliferation Act imposed further limits on the sale of precursor ingredients used in other products.[13]

Smaller "mom and pop" methamphetamine labs, however, can and do spring up quickly and can move easily to avoid detection. Many of those engaged in these operations are addicted to drugs themselves, and their ability to handle the dangerous and volatile chemicals required to manufacture methamphetamine safely may be severely impaired.

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[8] Wikipedia. November 16, 2005. Methamphetamine: History. http://en.wikipedia.org/wiki/Methamphetamine#History

[9] Anglin, M.D.; Burke, C.; Perrochet, B.; Stamper, E.; Dawud-Noursi, S. April–June 2000. History of the Methamphetamine Problem. UCLA Drug Abuse Research Center/UCLA Department of Psychiatry; UCLA/Matrix Coordinating Center for the CSAT Methamphetamine Treatment Project, Los Angeles, CA. *J Psychoactive Drugs.* 32(2):137-41. http://amphetamines.com/methamphetamine/index.html

[10] Bonné, J. 2005. Hooked in the Haight: Life, Death, or Prison. MSNBC. http://msnbc.msn.com/id/3071769/

[11] A precursor is a substance that is combined with another substance to produce a new substance.

[12] *The CQ Researcher*. July 15, 2005. Methamphetamine: Are Tougher Anti-Meth Laws Needed? Volume 15, Number 25. CQ Press. www.chpa-info.org/Web/advocacy/federal_advocacy/CQ_Press_Meth.pdf#search='Methamphetamine%3A%20Are%20Tougher%20AntiMeth%20Laws%20Needed%20cq%20researcher'

[13] Ibid.

Their activities also pose serious threats to the physical environment and to the safety of those in their vicinity, particularly children.[14]

Pseudoephedrine is an ingredient in a number of over-the-counter cold remedies anyone can purchase in retail stores or via the Internet, and it can easily be extracted from these products to produce methamphetamine. A number of recent policy initiatives have set out to reduce bulk sale of these products and to restrict purchase of even single units. Some stores and retail chains, such as many Target, Wal-Mart, and Rite-Aid locations, have voluntarily taken such products out of their aisles and placed them where their purchase can be carefully monitored and restricted.[15, 16]

Many States have enacted legislation that make such practices mandatory for retailers. Oklahoma, Oregon, Georgia, Kentucky, Kansas, Iowa, Tennessee, Illinois, Arkansas, Wyoming, West Virginia, Mississippi, and South Dakota were among the first to do so, and more States have followed or soon will.[17] Early reports suggest that these policies are reducing the number of "mom and pop" meth labs and motivating more methamphetamine addicts to seek treatment.

However, not everyone is convinced of the benefits of such laws. Frontiers of Freedom, a nonprofit group chaired by former Wyoming Republican Senator Malcolm Wallop, insists that meth manufacturers obtain ingredients in bulk from illegal sources inside and outside the United States and that the new restrictions on access to cold remedies impose needless hardships on law-abiding cold sufferers.[18] Several national authorities also express doubts that cutting access to popular cold remedies will have much impact on the supply of methamphetamine in the long run.[19] Early reports from some States with such policies show sharp declines in the number of meth lab seizures, but not necessarily in the use of the drug, strongly suggesting that out-of-State and across-the-border sources have stepped in to maintain or even increase availability. Meanwhile, at the end of 2005, Federal measures appeared likely to limit consumer access to ephedrine and pseudoephedrine medicines to a greater extent.[20]

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[14] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Prevention. 2002. Meth: What's Cooking in Your Neighborhood? http://media.shs.net/prevline/pdfs/vhs143g.pdf

[15] *Washington Post*. May 14, 2005. Retailers restrict some cold medicines: Ingredients can be used to make meth. www.washingtonpost.com/wp-dyn/content/article/2005/05/13/AR2005051301449.html

[16] *USA TODAY*. April 25, 2005. States limiting sale of cold remedies. www.usatoday.com/news/health/2005-04-25-methamphetamine_x.htm

[17] Ibid.

[18] NPNWeb.com. June 16, 2005. Web Exclusives: Groups question merits of anti-meth legislation; research details effect on retailers. www.npnweb.com/uploads/featurearticles/2005/WebExclusives/061605_we.asp

[19] *The CQ Researcher*. July 15, 2005. Methamphetamine: Are Tougher Anti-Meth Laws Needed? Volume 15, Number 25. CQ Press. www.chpa-info.org/Web/advocacy/federal_advocacy/CQ_Press_Meth.pdf#search='Methamphetamine%3A%20Are%20Tougher%20AntiMeth%20Laws%20Needed%20cq%20researcher'

[20] *New York Times*. December 15, 2005. Restrictions on meth ingredients are sought. www.nytimes.com/2005/12/15/health/15meth.html?ex=1292302800&en=410ca0e70ab6f3b5&ei=5088&partner=rssnyt&emc=rss

One recipe for making meth—sometimes known as the "Nazi method"—calls for anhydrous ammonia, a colorless gas normally used as a fertilizer or as an industrial refrigerant. Anhydrous ammonia can be explosive and lethal; in the environment, it can produce acute injuries to those engaged in meth manufacture, emergency responders, and others. Widespread theft of anhydrous ammonia by operators of meth labs has prompted health and law enforcement officials to recommend a number of security measures for unattended tanks, such as fencing and valve locks, and for use of personal protective equipment for those responding to the release of anhydrous ammonia.[21]

What does methamphetamine do? How and why do people use it?

Initially, methamphetamine decreases fatigue and appetite, heightens attention, and increases activity and respiration, creating feelings of high energy.[22] Women (primarily) use meth to lose weight. Men and women both use it to remain alert and productive for long hours while engaged in work that is physically demanding or tedious.[23] Long-distance truck drivers use it this way, as do students writing term papers and professional athletes faced with physically exhausting competition schedules. Others, such as people who have HIV/AIDS, use methamphetamine to *regain* feelings of energy and capability that they no longer experience in their normal lives.[24]

Some people use methamphetamine simply for the brief but intense "rush" they experience immediately after smoking or injecting the drug, as well as for the feeling of euphoria, or well-being, that can last from 20 minutes to 12 hours.[25] For those who want to take something that will produce a high and make it possible for them to stay awake and be physically (and perhaps sexually) active for long periods of time, methamphetamine is an inexpensive, readily available, and long-lasting choice. For them, methamphetamine compares favorably with other drugs capable of inducing some of the same effects, including cocaine, heroin, and some so-called "club drugs."[26, 27, 28]

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[21] Centers for Disease Control and Prevention. April 15, 2005. Anhydrous Ammonia Thefts and Releases Associated With Illicit Methamphetamine Production—16 States, January 2000–June 2004. *MMWR Weekly*. 54(14); 359-361. www.cdc.gov/mmwr/preview/mmwrhtml/mm5414a4.htm
[22] National Institute on Drug Abuse. April 1998, Reprinted January 2002. Research Report Series: Methamphetamine Abuse and Addiction. www.nida.nih.gov/ResearchReports/methamph/methamph.html
[23] Rawson, R.A., Ph.D.; Anglin, M.D., Ph.D.; Ling, W., M.D. 2002. Will the Methamphetamine Problem Go Away? UCLA Integrated Substance Abuse Programs, UCLA Department of Psychiatry. *Journal of Addictive Diseases*. Vol. 21(1). www.asam.org/jol/Articles/Rawson%20et%20al%20article.pdf
[24] UCSF Center for AIDS Prevention Studies. July 2004. How Do Club Drugs Impact HIV Prevention? UCSF-CAPS Fact Sheet #55E. www.caps.ucsf.edu/publications/clubdrugs.html
[25] Office of National Drug Control Policy. Updated October 13, 2005. Drug Facts: Methamphetamine. www.whitehousedrugpolicy.gov/drugfact/methamphetamine/index.html
[26] National Institute on Drug Abuse. April 1998, Reprinted January 2002. Research Report Series: Methamphetamine Abuse and Addiction. www.nida.nih.gov/ResearchReports/methamph/methamph.html
[27] Institute for Intergovernmental Research. The Methamphetamine Problem: A Question and Answer Guide. www.iir.com/centf/guide.htm
[28] Gahlinger, Paul M., M.D., Ph.D., M.P.H. June 1, 2004. Club Drugs: MDMA, Gamma-Hydroxybutyrate (GHB), Rohypnol, and Ketamine. *American Family Physician*. Vol. 69/No. 11. www.aafp.org/afp/20040601/2619.html

When they stop using methamphetamine, users may experience a variety of withdrawal symptoms, including fatigue, depression, anxiety, paranoia, aggression, and an intense craving for more of the drug. In some cases, psychotic symptoms may persist for months or years following use.[29]

How addictive is methamphetamine?

Many published references caution that methamphetamine is a highly addictive drug. One indication of the addictive nature of the drug is provided by a Substance Abuse and Mental Health Services Administration (SAMHSA) finding, following the release of the 2004 National Survey on Drug Use and Health (NSDUH):

> "Although the number of past-year and past-month methamphetamine users did not change significantly between 2002 and 2004, the number of past-month methamphetamine users who met criteria for abuse or dependence on one or more illicit drugs in the past year increased from 164,000 (27.5 percent of past-month methamphetamine users) in 2002 to 346,000 (59.3 percent) in 2004."[30]

According to SAMHSA's Center for Substance Abuse Treatment (CSAT), the lag time between first use of methamphetamine and addiction is from 2 to 5 years. But CSAT also notes that a good deal of clinical experience and anecdotal information strongly indicate that for those who inject or smoke the drug—as many regular users do—addiction may be established in *less than 1 year*.[31]

How does methamphetamine use affect other aspects of health?

Chronic use of methamphetamine can lead to serious health problems, although users are more likely to show up in hospital emergency rooms because they have been injured in fights or accidents than because of deteriorating health.[32]

In general, effects of chronic meth abuse include:[33]

- Organ toxicity
- Compromised health (e.g., malnourishment, poor hygiene)

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[29] Office of National Drug Control Policy. November 2003. Fact Sheet: Methamphetamine. www.whitehousedrugpolicy.gov/publications/factsht/methamph/

[30] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004: Highlights. http://oas.samhsa.gov/2k5/meth/meth.cfm

[31] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Chapter 2. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57619

[32] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Chapter 5. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57794

[33] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Chapter 2. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57619

- Dental problems
- Dermatitis

Chronic psychological effects include various psychiatric disorders, such as:[34]

- Psychosis
- Paranoia
- Suicidal tendencies

Among bingers, who repeat cycles of use and experience both the initial “rush” and subsequent dysphoria of withdrawal, sometimes referred to as “tweaking,” effects include:[35]

- Not eating
- Depression
- Increased paranoia
- Belligerence
- Aggression

The dental effects of chronic methamphetamine use are the subject of numerous recent media accounts. The American Dental Association (ADA) advises that “the oral effects of methamphetamine can be devastating.” ADA describes “meth mouth” as including rampant caries (cavities), a result of meth’s acidic nature, its xerostomic (dry mouth) effect, and the tooth grinding and teeth clenching often observed in meth addicts. Added to these effects, methamphetamine use often makes its users crave high-calorie (i.e, sugar-laden) soft drinks.[36]

SAMHSA’s CSAT lists physiological problems likely to be reported by chronic methamphetamine users:[37]

- Extreme fatigue—with physical and mental exhaustion and disrupted sleep patterns
- Nutritional disorders—extreme weight loss, anemia, anorexia, cachexia (body wasting)
- Poor hygiene and self-care
- Skin disorders and secondary skin infections—itching, lesions, hives, urticaria
- Hair loss

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[34] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Chapter 2. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57619

[35] Ibid.

[36] American Dental Association. Updated August 9, 2005. Dental Topics A to Z: Methamphetamine Use. www.ada.org/prof/resources/topics/methmouth.asp

[37] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Figure 5-6: Common Symptoms of Chronic Stimulant Abuse/Dependence. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.59145

- Muscle pain/tenderness—may indicate rhabdomyolysis (breakdown and release of muscle fibers into the circulatory system, often leading to kidney damage)
- Cardiovascular damage—from toxicity and contaminants in meth production, with concurrent renal and hepatic problems
- Hypertensive crises with renal damage from sustained hypertension
- Difficulty breathing—may reflect pulmonary edema, pneumonitis, obstructive airway disease, barotrauma (pressure-related ear pain), and other complications
- Myocarditis, infarcts (tissue death due to lack of oxygen)
- Headaches, strokes, seizures, vision loss
- Choreoathetoid (involuntary movement) disorders
- Impaired sexual performance and reproductive functioning
- Cerebrovascular changes, including evidence of cerebral hemorrhages and atrophy with associated cognitive deficits
- Ischemic bowel (death of part of the intestine when its blood supply is cut off), gastrointestinal complaints

On the psychiatric and behavioral side, CSAT's list includes:

- Paranoia with misinterpretation of environmental cues; psychosis with delusions and hallucinations
- Apprehension—with hopelessness and a fear of impending doom that resembles panic disorder
- Depression—with suicidal thinking and behavior
- Acute anxiety
- Eating disorders

Also on the list of harmful consequences related to meth use, abuse of such stimulants can "lead to uncharacteristically aberrant or deviant sexual behaviors, the use of prostitutes, and HIV high-risk behaviors."[38] High-risk behaviors for HIV, of course, create similar risks for other STDs.

Who is most likely to use methamphetamine or develop problems?

If there is any good news about methamphetamine, it's that meth has not yet gained widespread popularity among teens. Use has occurred traditionally among people ages 19 to 40. In fact, use of methamphetamine among those ages 12 to 17 has declined somewhat in recent years. For example, according to the National Institute on Drug Abuse's (NIDA's) Monitoring the Future survey, use dropped about one-third between 2001 and 2004, when 8th- , 10th- , and 12th-grade numbers are combined.[39] Further good

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[38] The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. 1999. Treatment Improvement Protocols: TIP 33: Treatment for Stimulant Use Disorders, Chapter 2. www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57619

[39] Office of National Drug Control Policy. December 19, 2005. National Survey Finds Overall Youth Drug Use Down Again: Declines Seen in Meth, Marijuana, Steroids, Ecstasy, and Alcohol. Media Campaign Flash.

news is that the average age of first use has been increasing, from 18.9 years in 2002 to 20.4 years in 2003 and to 22.1 years in 2004.[40]

Overall, use is somewhat higher among males (0.7 percent) than females (0.5 percent).[41] But in "large clinical populations," the ratio of men to women has been found to be one to one.[42] As with other methamphetamine-related data, there also may be regional differences regarding relative rates of use by gender. NIDA's Community Epidemiology Workgroup (CEWG) found male use higher in several cities, the same in others, but lower than female use in still others.[43]

In terms of ethnic/racial prevalence, SAMHSA found that Native Hawaiians and other Pacific Islanders (2.2 percent) reported the highest rates of past-year methamphetamine use, followed by American Indians or Alaska Natives (1.7 percent) and persons reporting two or more races (1.9 percent). Past-year methamphetamine use among whites (0.7 percent) and Hispanics (0.5 percent) was higher than among Asians (0.2 percent) or blacks (0.1 percent).[44]

Men who have sex with men (MSM), a research category that includes self-identified gay and bisexual men as well as men who do not identify themselves as such but sometimes have sex with other men, are a population in which methamphetamine use has had particularly deadly consequences. Because MSM frequently use methamphetamine specifically for its aphrodisiac effects, enabling them to engage in extended periods of sexual activity, their use of the drug has greatly increased their risks for HIV/AIDS and other STDs. In spite of numerous press accounts of widespread methamphetamine use at gay dance clubs and among young gay men, specific information is scarce. However, studies have found as many as 25 percent of gay men who reported past-month use of methamphetamine to be HIV positive.[45] As one of the earliest groups hit by the current resurgence of the drug's popularity in the United States, gay communities have also been among the first to mount aggressive methamphetamine prevention efforts. Although results are difficult to measure, in 2005 both San Francisco and New York City reported signs that gay men in their communities may be reducing their use of this drug.

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[40] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. September 16, 2005. The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004, In Brief. http://oas.samhsa.gov/2k5/meth/meth.htm
[41] Ibid.
[42] Rawson, R.A., Ph.D. June 2005. Methamphetamine Addiction: Cause for Concern—Hope for the Future. Department of Psychiatry and Behavioral Sciences, UCLA. www2.apa.org/ppo/rawson62805.ppt#257,1
[43] Office of National Drug Control Policy. November 2002. Pulse Check: Trends in Drug Abuse: January–June 2002 Reporting Period. www.whitehousedrugpolicy.gov/publications/drugfact/pulsechk/nov02/pulse_nov02.pdf
[44] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004: Highlights. http://oas.samhsa.gov/2k5/meth/meth.cfm
[45] Specter, Michael. May 23, 2005. Higher risk: Crystal meth, the Internet, and dangerous choices about AIDS. *The New Yorker.* www.newyorker.com/fact/content/articles/050523fa_fact

How big is America's methamphetamine problem?

In its executive summary, the *Methamphetamine Interagency Task Force—Final Report: Federal Advisory Committee* summarized findings and recommendations of the November 1999 Task Force meeting and National Town Hall Meeting on Methamphetamine. This report contained two important points about the scope of the current methamphetamine problem in the United States:[46]

- "There is a lack of data about the prevalence of methamphetamine use and abuse." (Editor's note: Subsequent surveys have improved understanding of meth problems in the United States, although much more research is needed.)
- "A number of indicators…show that methamphetamine use is spreading…. Since the early 1990s, methamphetamine gradually has been moving into the Midwest and South. The drug is manufactured and distributed by Mexican sources using established drug trafficking routes; domestic clandestine laboratories are another significant source. Now, methamphetamine is used throughout most major metropolitan areas, less in the Northeast."

Meth does not appear to be the "biggest" national drug problem, even for treatment programs. An October 2005 article in *Youth Today* refers to SAMHSA data and points out that "Meth is not even close…. Meth was the drug of choice for only 7 percent of people who sought treatment in 2003."[47] (This 7 percent—which actually includes all stimulant use under the major category of "amphetamine/methamphetamine"[48]—compares with 14 percent for cocaine, 16 percent for marijuana, 18 percent for opiates, and 42 percent for alcohol.)

In many cases, the severe effects of repeated meth use may account for much of the increasing demands on treatment services and law enforcement. As early as 1996, DEA noted that today's ephedrine-based methamphetamine is "several times more potent than its other forms."[49]

How many people use methamphetamine?

According to SAMHSA's 2004 NSDUH, nearly 12 million Americans aged 12 or older reported that they had used methamphetamine at least once in their lifetime. Not quite 1.5 million of them said they had used meth at least once in the past year. More than one-third of that group—583,000—reported past-month use of methamphetamine.[50]

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[46] Methamphetamine Interagency Task Force. 2000. *Methamphetamine Interagency Task Force: Final Report: Federal Advisory Committee*. www.ojp.usdoj.gov/nij/methintf/index.html.
[47] Shirk, M. October 2005. The meth epidemic: Hype vs. reality: The facts about how the drug affects child welfare and how agencies have coped. *Youth Today.* www.youthtoday.org/youthtoday/oct05/story2_10_05.html
[48] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. Drug Abuse Warning Network, 2003: Interim National Estimates of Drug-Related Emergency Department Visits. http://dawninfo.samhsa.gov/files/DAWN_ED_Interim2003.pdf
[49] U.S. Drug Enforcement Administration. March 1996. Methamphetamine Situation in the United States. www.fas.org/irp/agency/doj/dea/product/meth/toc.htm
[50] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. Updated October 2, 2005. NSDUH 2004. Appendix H, Selected Prevalence Tables, Table H.1—Types of Illicit

Among youth between ages 12 and 17, lifetime use of methamphetamine in the SAMHSA data was 1.2 percent for 2004, down from 1.5 percent in 2002. Past-year use was 0.6 percent, compared with 0.9 percent for 2002. Past-month use was 0.2 percent among 12- to 17-year-olds in 2004 vs. 0.3 percent in 2002.[51] (Alcohol is by far the substance most likely to be abused by underage youth; their past-month use of marijuana, cocaine, psychotherapeutics, and pain relievers is at substantially higher levels than their past-month use of methamphetamine.)

These findings are consistent with those of NIDA's 2004 Monitoring the Future survey. Monitoring the Future also concluded that past-year prevalence for methamphetamine use among 8th- , 10th- , and 12th-grade students was "down considerably" from 1999.[52] For 2005, Monitoring the Future found statistically significant declines in student use of methamphetamine in one or more grades.[53] The Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System has reported similar declines.[54]

But these numbers only tell a part of the story about America's current methamphetamine "epidemic"—and by no means the most compelling part, according to many who speak out on the issue. As the director of the Office of National Drug Control Policy's (ONDCP's) National Youth Anti-Drug Media Campaign said at a recent press conference, "As good as the news is from national statistics on the decline in teen drug use, national surveys tend to mask local and regional drug trends."[55] In releasing the 2005 Monitoring the Future survey, the survey's principal investigator acknowledged "that the pattern of declining meth use among adolescents seems to be inconsistent with recent press reports of a growing meth epidemic" and speculated that use might be increasing among school dropouts not included in the survey.

How many meth users are in the treatment, hospital, and criminal justice systems?

Another look at NSDUH reveals sharp increases (164,000 for 2002 vs. 346,000 in 2004) in the numbers of past-month meth users who met criteria for abuse of or dependence on

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Drug Use in Lifetime, Past Year, and Past Month Among Persons Aged 12 to 17: Numbers in Thousands, 2002–2004. http://oas.samhsa.gov/NSDUH/2k4NSDUH/2k4results/appH.htm

[51] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. Updated October 2, 2005. NSDUH 2004. Appendix H, Selected Prevalence Tables, Table H.3—Types of Illicit Drug Use in Lifetime, Past Year, and Past Month Among Persons Aged 12 to 17: Percentages, 2002–2004. http://oas.samhsa.gov/NSDUH/2k4NSDUH/2k4results/appH.htm#tabh.3

[52] National Institute on Drug Abuse. April 2005. Monitoring the Future: National Results on Adolescent Drug Use: Overview of Key Findings 2004. www.monitoringthefuture.org/pubs/monographs/overview2004.pdf

[53] Johnston, L.D.; O'Malley, P.M.; Bachman, J.G.; Schulenberg, J.E. December 19, 2005. Teen drug use down, but progress halts among youngest teens. University of Michigan News and Information Services: Ann Arbor, MI. www.monitoringthefuture.org/pressreleases/05drugpr.pdf

[54] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System (YRBSS). Youth Online: Comprehensive Results: Percentage of Students Who Used Methamphetamine One or More Times During Their Life. http://apps.nccd.cdc.gov/yrbss/SelectLocyear.asp?cat=3&Quest=Q53

[55] Denniston, R., Director, National Youth Anti-Drug Media Campaign. December 15, 2005. Personal communication. Office of National Drug Control Policy.

one or more illicit drugs. Similarly, SAMHSA also found big increases in the number of past-month meth users who met criteria for stimulant abuse or dependence.[56]

Other reports from numerous public and private sources describe dramatic, alarming, and sometimes overwhelming increases in meth-related hospital and substance abuse treatment admissions, meth crimes and court cases, meth-related damage to the environment, and cases of child endangerment due to meth use. It's not unusual for these sources to describe methamphetamine use as "a growing problem" or even to claim that it's "the biggest drug problem." For example, in a 2005 report by the National Association of Counties (NACo), 58 percent of law enforcement officials in 500 U.S. counties said that methamphetamine was the biggest drug problem in their counties.[57]

Methamphetamine users and manufacturers enter the criminal justice system in a number of ways, and it is here that reports of big increases in methamphetamine-related problems are found. Of about 35,000 DEA arrests in 2001, for example, nearly a third (32.0 percent) fell under the category of "other drugs," which included "stimulants (e.g., methamphetamine), depressants (e.g., barbiturates), and hallucinogens (e.g., LSD and PCP)." Rapid increases in the numbers of reported annual drug lab seizures, with meth labs representing the majority, add thousands of annual arrestees to the justice system.[58] Although published studies of a link between identity theft and meth use have yet to appear, law enforcement personnel in several communities have reported that methamphetamine is involved in the majority of such crimes in their areas.[59]

In many communities, drug courts have provided the "central response" to methamphetamine problems. In western States, some of these drug courts have reported huge increases in the numbers of meth-related cases in their jurisdictions.[60] Nationally, 4,453 offenders who were in the Federal court system during 2003 received treatment for methamphetamine abuse.[61] A 2005 report on the progress of California's widely discussed Proposition 36 program for court referral of non-violent offenders to treatment noted that more than half (52.7 percent) of the 51,033 offenders who entered drug treatment during the program's third year, which ended on June 30, 2004, reported

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[56] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. September 16, 2005. The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004, In Brief. http://oas.samhsa.gov/2k5/meth/meth.htm

[57] National Association of Counties. July 5, 2005. The Meth Epidemic in America: Two Surveys of U.S. Counties: The Criminal Effect of Meth on Communities/The Impact of Meth on Children. www.nationaldec.org/research%20and%20articles/research/NACO%20Report.pdf

[58] Office of National Drug Control Policy. March 2003. Drug Data Summary: March 2003. www.whitehousedrugpolicy.gov/publications/factsht/drugdata/

[59] County of Los Angeles Department of Health Services, Public Health, Alcohol, and Drug Program Administration. January 2006. Review of Methamphetamine Use and Costs in Los Angeles County.

[60] Huddleston, C.W., III. May 2005. Drug Courts: An Effective Strategy for Communities Facing Methamphetamine. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. www.ncjrs.gov/pdffiles1/bja/209549.pdf

[61] Administrative Office of the U.S. Courts Office of Public Affairs. July 2004. Addicted and a Danger to the Community: Supervising Meth Addicts. *The Third Branch*. Volume 36, Number 7. www.uscourts.gov/ttb/july04ttb/addicts/index.html

methamphetamine as their primary drug problem.[62] (It is worth noting, in light of questions about the effectiveness of methamphetamine treatment, that about one-third of those sent to treatment under Proposition 36 during this period completed treatment, with meth users as likely to complete treatment as others.)

The National Drug Intelligence Center (NDIC), a service of the U.S. Department of Justice, flatly states, "The threat posed to the United States by the trafficking and abuse of methamphetamine is high and increasing" in a February 2005 document, "National Drug Threat Assessment 2005."[63] NDIC cites a number of reports of increased methamphetamine production, related arrests, treatment admissions, and apparent sharp increases in the smuggling of methamphetamine from Mexico since 2001.

What about methamphetamine-endangered children?

The plight of children who live with methamphetamine-using adults or are at or near meth labs is cause for real public concern. Demands on services needed to get these children out of harm's way and provide for their needs have increased in some jurisdictions, even though national numbers do not yet reflect a widespread need for such services. Of more than 14,000 meth lab incidents in 2003 reported to DEA, just under 1,300 incidents involved a child being exposed to toxic chemicals, and 724 children at these sites were taken into protective custody. (Additional data relating to drug-endangered children and methamphetamine are included in the Fact Sheet: Children in this resource kit.)

NACo published other alarming reports in 2005 on methamphetamine's impact on communities and on children, such as increases in out-of-home placements of children across the United States because of methamphetamine. The NACo reports also spawned a number of national media stories, such as one called "Meth's Youngest Victims," aired on *NBC Nightly News* in August 2005.[64]

The *NBC Nightly News* story cited double-digit increases in out-of-home placements of children in California, Colorado, and Minnesota due to meth lab incidents. NBC called these children "meth orphans" and said that "3,000 children were pulled from homes during meth lab seizures last year." This figure appears to have come from the DEA's El Paso Intelligence Center report that in 2003 "over 3,000 children were present during the seizure of clandestine laboratories nationwide."[65] But this analysis may overstate the real

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[62] Douglas Longshore, Ph.D.; Darren Urada, Ph.D.; Elizabeth Evans; Yih-Ing Hser, Ph.D.; Michael Prendergast, Ph.D.; and Angela Hawken. July 22, 2005. Evaluation of the Substance Abuse and Crime Prevention Act: 2004 Report. UCLA Integrated Substance Abuse Programs. www.uclaisap.org/Prop36/documents/sacpa080405.pdf

[63] National Drug Intelligence Center, U.S. Department of Justice. National Drug Threat Assessment: 2005. www.usdoj.gov/ndic/pubs11/12620/index.htm

[64] MSNBC. August 9, 2005. Meth's youngest victims: Children of meth lab homes are placed into foster care. *NBC Nightly News* with Brian Williams. www.msnbc.msn.com/id/8888124/

[65] U.S. Drug Enforcement Administration. November 18, 2004. Law Enforcement and the Fight Against Methamphetamine: Statement of Joseph T. Rannazzisi, Deputy Chief, Office of Enforcement Operations, Before the House Government Reform Committee, Subcommittee on Criminal Justice, Drug Policy, and Human Resources. www.usdoj.gov/dea/pubs/cngrtest/ct111804.html

number. ONDCP, in citing the 3,000 figure, elaborates: "The labs affected more than 3,000 children. This includes children who were residing at the labs but may not have been present at the time of the seizure as well as children who were visiting the site." In fact, the actual number of children taken into protective custody during meth lab-related incidents in 2003 was 724, according to the original DEA/El Paso Intelligence Center data.[66]

The October 2005 *Youth Today* feature on the subject of methamphetamine's impact on children found some national experts skeptical of the NACo report. For example, the executive director of the National Coalition for Child Protection Reform expressed his belief that fears of losing foster care entitlements were behind some of the county statistics summarized in the reports. Others whom *Youth Today* asked about this pointed to significant *declines* in big-city foster care admissions in recent years, in contrast to some of the NACo findings.[67]

Do regional differences explain discrepancies in reported numbers? Are some users under-reported?

Sharp regional differences in the popularity of methamphetamine may explain some seeming discrepancies. Places with the greatest numbers of users and associated problems also may be generating the most frequent and attention-getting reports. A look at the June 2005 Advance Report of NIDA's Community Epidemiology Work Group (CEWG) provides a good illustration. The CEWG meeting noted that there were exceedingly high percentages of meth-related treatment admissions in Hawaii (57.3 percent), San Diego (45.2 percent), Arizona (37.5 percent), and Los Angeles (26.7 percent); there also were relatively high proportions of primary methamphetamine admissions for Minneapolis/St. Paul (19.6 percent), Denver (17.6 percent), Seattle (15.2 percent), San Francisco (14.5 percent), Atlanta (11.3 percent), and St. Louis (6.5 percent). However, methamphetamine reports, relative to numbers of emergency room reports for other drugs (alcohol was excluded), were *low* in other areas where CEWG captures such information, such as Baltimore, Boston, Chicago, Detroit, New York, and Newark.[68]

Some of the groups whose methamphetamine use actually is increasing at alarming rates are under-represented in national data, resulting in additional discrepancies in reported numbers. For example, small-town and rural youth may not be as well-represented in national surveys as those who live in larger cities, but DEA estimates that 12- to 14-year-olds in smaller communities are 104 percent more likely to use meth than their peers in larger cities (bear in mind that only 0.7 percent of those between ages 12 and 17 report past-month use, according to NSDUH, so the numbers of meth users in this age group

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[66] Office of National Drug Control Policy. February 6, 2004. Fighting Methamphetamine in the Heartland: How Can the Federal Government Assist State and Local Efforts? www.whitehousedrugpolicy.gov/news/testimony04/020604/meth.html

[67] Shirk, M. October 2005. The meth epidemic: Hype vs. reality: The facts about how the drug affects child welfare and how agencies have coped. *Youth Today.* www.youthtoday.org/youthtoday/oct05/story2_10_05.html

[68] National Institute on Drug Abuse's Community Epidemiology Workgroup. June 2005. Epidemiological Trends in Drug Abuse: Advance Report. www.drugabuse.gov/PDF/CEWG/AdvReport605.pdf

will be relatively low everywhere).[69] Similarly, although MSM are widely believed to be using methamphetamine at much higher rates than others, they may be significantly under-represented in national surveys. In San Francisco, where the gay meth-and-AIDS connection has been reported by many sources, a 2005 street interview survey of MSM found 10 percent reporting crystal meth use during the prior 6 months, compared with 18 percent in a comparable 2003 survey. Experts believe this may signal a decline in meth's popularity in this population.[70]

What does all this mean?

The finding of the Methamphetamine Interagency Task Force at the end of 1999—that access to and use of methamphetamine is spreading eastward and into rural America[71]—continues to be echoed in subsequent State and local data. At the same time, declining use of the drug in some populations may contribute to stable and decreasing prevalence nationally, while the swift devastation methamphetamine visits on those who use it repeatedly propels increasing numbers of users into treatment, jails, and drug court programs.

Prevention

In its final report, the Methamphetamine Interagency Task Force included a section on prevention and education that stressed comprehensive, targeted, community-based prevention.[72] This section offered a set of guiding principals, summarized here:

- Effective drug prevention requires the involvement of many segments of the community.
- Methamphetamine prevention should use established prevention principles and be part of broader drug abuse prevention efforts.
- Methamphetamine prevention must clearly identify target populations, motivations, risk factors, and demographics and tailor strategies to address the specific needs of communities. Prevention efforts also must recognize the multigenerational characteristics of meth manufacturing.
- Prevention must be guided by research and evaluation.
- Prevention programs must be evaluated to determine their effectiveness.
- Parents/adults should be included in prevention programs for youth.
- Community prevention should target adult users with both long and short histories of meth use.

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[69] Drug Enforcement Administration. Fact Sheet: Fast Facts About Meth. www.dea.gov/pubs/pressrel/methfact03.html

[70] Buchanan, Wyatt. November 4, 2005. San Francisco interviews indicate drop in meth use by gay men: Experts say results should be backed by other research. *San Francisco Chronicle*. www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2005/11/04/BAG7KFJ1GL1.DTL

[71] Methamphetamine Interagency Task Force. 2000. *Methamphetamine Interagency Task Force: Final Report: Federal Advisory Committee*. www.ojp.usdoj.gov/nij/methintf/index.html.

[72] Methamphetamine Interagency Task Force. 2000. *Final Report: Part II—Prevention and Education. Federal Advisory Committee.* www.ojp.usdoj.gov/nij/publications/methintf/2.html

Based on these principals, the Methamphetamine Interagency Task Force made a series of specific prevention recommendations that are likely to be familiar to those already engaged in evidence-based substance abuse prevention:

- Address methamphetamine issues through broad-based drug prevention and education efforts that target all forms of drug use and that are based on research and established prevention principles.
- Develop science-based prevention program planning and intervention guidelines in communities where methamphetamine is already a problem.
- Involve the entire community in prevention efforts, including educators, youth, parents, vendors of materials used in meth manufacture, law enforcement officials, business leaders, members of the faith community, social services providers, and representatives of government agencies and organizations.
- Identify the changing population characteristics of users, their motivations, risk factors, and demographics.
- Involve parents and other adults in prevention and education programs for youth, particularly in the areas of monitoring for "latchkey" children, enhancing parent-child communication skills, and providing consistent family/home rules for youth behavior and leisure time activities.
- Ensure that media campaigns proceed with caution, focusing on raising awareness of methamphetamine using messages designed to minimize unintended effects, such as arousing curiosity about meth.
- Develop or augment programs aimed at educating those communities in which methamphetamine is an emerging or chronic problem.

NIDA makes the following broad recommendation for preventing methamphetamine abuse:[73]

> "Effective prevention of drug use begins with assessing the specific nature of the drug problem within the local community and adapting prevention programs accordingly. Prevention programs should start early, be comprehensive, and stress key points repeatedly. Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children and adolescents only."

In recent years, SAMHSA has awarded several CSAP Targeted Capacity Expansion (TCE) grants for methamphetamine and inhalant prevention, intervention, and infrastructure development. In announcing some of these awards, SAMHSA has noted that methamphetamine abuse has spread eastward, even as Western and Mountain States are experiencing increasing rates of methamphetamine addiction. At the same time, SAMHSA has published public education materials and collaborated with ONDCP on other publications to raise awareness about the threat of methamphetamine and to teach effective prevention strategies.

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[73] National Institute on Drug Abuse. March 1999. NIDA Notes: Methamphetamine Abuse Alert. Volume 13, Number 6. www.drugabuse.gov/NIDA_Notes/NNVol13N6/tearoff.html

SAMHSA also has emphasized application of its Matrix and Strategic Prevention Framework to efforts aimed at preventing methamphetamine abuse. (See sections III and IV of this resource kit to review the SAMHSA Matrix and to read more about SAMHSA's Strategic Prevention Framework.)