VIII. Fact Sheet: Myths

The current methamphetamine situation has spawned several myths and inaccuracies:

Myth: Methamphetamine is the number one substance abuse problem today.

The accuracy of such a claim depends on who is making it and what measures and "lens" they are using. In many places, drug units of law enforcement agencies, drug court treatment programs, child protective services and foster care placement agencies, substance abuse treatment programs, and hospital emergency departments are seeing increasing meth-related problems, sometimes more than any other drug problem. For them, methamphetamine *is* the biggest substance abuse problem they are addressing.

But these accounts do not offer a consistent national picture showing where methamphetamine fits in the Nation's overall substance abuse patterns. Given the uneven regional distribution of methamphetamine use, manufacture, and distribution, an overall picture is somewhat elusive. Even so, publicly funded treatment admissions are one helpful measure—methamphetamine ranked sixth in 2003, accounting for only 7.7 percent of such admissions. (Alcohol alone led with 23.2 percent, followed by alcohol plus another drug at 18.7 percent, marijuana at 15.4 percent, heroin at 14.4 percent, and smoked cocaine [crack] at 9.9 percent).[1]

According to the 2004 Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH), almost 600,000 Americans aged 12 years and older reported methamphetamine use in the past month. They were among about 1.5 million who said they had used methamphetamine at least once in the past year, and a total of 12 million who reported having used it at least once in their lifetime.[2]

[1] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. 2003 Treatment Episode Data Set. As referenced by NIDA. March 2005. InfoFacts: Treatment Trends. www.nida.nih.gov/Infofacts/treatmenttrends.html

[2] 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

Myth: Methamphetamine is popular among teens.

Thus far, this does not appear to be true, although methamphetamine use among certain teen subgroups in some communities may be increasing (e.g., among lesbian, gay, bisexual, and transgender [LGBT] youth in some cities; among rural youth in some parts of the country). Nationally, methamphetamine use among 12- to 17-year-olds has declined as the average age of first use has risen (to 22.1 years of age in 2004).[3] SAMHSA data for 2002, 2003, and 2004 show prevalence of past-year methamphetamine use among 12- to 17-year-olds at 0.7 percent.[4] The 2005 Monitoring the Future survey also reported that methamphetamine use has declined among high school students in recent years, although the survey's principal author took note that these findings are at odds with recent press reports of increasing use among young people and said, "…it is possible that use is increasing among high school dropouts, who are not captured in the survey, and among young adults."[5]

Myth: Even occasional use of methamphetamine leads to addiction.

Methamphetamine is often referred to as a "highly addictive" drug. One indication of the drug's addictive nature comes from a highlight from the 2004 NSDUH: "…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."[6]

SAMHSA's Center for Substance Abuse Treatment (CSAT) estimates that the lag time from first use of methamphetamine to addiction is from 2 to 5 years, but also cites reports that addiction may be established in less than 1 year after first use.[7] However, addiction to methamphetamine, as to any addictive substance, is usually the result of chronic use, leading to increased tolerance, higher and more frequent dosages, and changes in ingestion methods.[8] Although any meth use is risky, some people use methamphetamine

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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

[3] 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

[4] Ibid.

[5] 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. http://monitoringthefuture.org/pressreleases/05drugpr.pdf

[6] 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

[7] 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

[8] 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

once or twice, or infrequently, without becoming addicted. Nevertheless, the euphoria and intense well-being methamphetamine users experience leaves many users who did not plan to continue using meth eager to repeat the experience, thus luring them on to increased and frequent use.

Myth: Babies born to meth-using women are likely to have serious, long-term damage.

Some evidence indicates that methamphetamine use during pregnancy *may* result in certain birth abnormalities or learning disabilities.[9] However, information about the effects of prenatal exposure to methamphetamine is still limited. For now, inflammatory terms like "meth babies" and "ice babies" should not be used.[10] Obviously, women who are pregnant or planning for motherhood should avoid methamphetamine along with all forms of substance abuse.

Myth: More children are endangered by methamphetamine-using caregivers than by adults using any other drug.

Children in the care of adults who use or sell methamphetamine are certainly at increased risk for being neglected or abused. If these adults also are engaged in the manufacture of methamphetamine, they and anyone else in their household is at great risk of serious harm from exposure to chemicals used in this process. But not all methamphetamine-using adults neglect or abuse children in their care, and most methamphetamine users do not attempt to make the drug themselves.

According to Federal estimates, there are far more children living with families who have alcoholism than there are children in the care of adults who use methamphetamine or are involved in its manufacture and distribution. In 2003, for example, an estimated 1,300 meth lab incidents involved a child being exposed to toxic chemicals, and 724 children were removed from such sites.[11] Based on 2001 data, SAMHSA estimated that "more than 6 million children lived with at least 1 parent who abused or was dependent on alcohol or an illicit drug" that year.[12]

It is important to increase awareness about risks to children posed by meth use and production. Information on what others can do to prevent or limit such risks for children

[9] Volkow, Nora, M.D., Director, NIDA. April 21, 2005. Testimony Before the Subcommittee on Labor, Health, and Human Services; Education; and Related Agencies. Committee on Appropriations, U.S. Senate. www.hhs.gov/asl/testify/t050425b.html
[10] Lewis, D., M.D., Brown University. July 25, 2005. Meth Science, Not Stigma: Open Letter to the Media. Join Together Online. www.jointogether.org/sa/news/features/reader/0,1854,577769,00.html
[11] 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
[12] The Substance Abuse and Mental Health Services Administration/Office of Applied Studies. June 2, 2003. The NSDUH Report: Children Living With Substance-Abusing or Substance-Dependent Parents. http://oas.samhsa.gov/2k3/children/children.htm

should be communicated, along with steps children in substance abuse situations can take to protect themselves. But messages should avoid demonizing users, who need to be encouraged to step forward and seek treatment.

Myth: Methamphetamine abusers/addicts do not respond to treatment.

Anecdotally, a number of substance abuse and mental health treatment providers have expressed disappointment and frustration in treating clients whose only or primary drug problem is methamphetamine. However, programs specifically tailored to respond to the unique treatment needs of methamphetamine addicts are reporting successes, sometimes at exceptional rates. In its May 2005 "Fact Sheet: Methamphetamine," for example, the National Association of State Alcohol and Drug Abuse Directors provides these examples:[13]

- Colorado—80 percent of meth users were abstinent at discharge.
- Tennessee—65 percent of meth users were abstinent 6 months after treatment.
- Texas—88 percent of meth users were abstinent 60 days after discharge.
- Utah—60.8 percent of meth users were abstinent at discharge.

A review of treatment outcomes of Iowa's publicly funded substance abuse programs found that 65.5 percent of methamphetamine clients were still abstinent 6 months after discharge, the highest rate of any drug category in the State.[14] As in other examples of treatment success in working with meth clients, Iowa's programs found that these addicts often needed more time in treatment than others.

Similarly, the Matrix Model, based on an earlier cocaine treatment model of the Matrix Institute, was adapted with support from the National Institute on Drug Abuse to treat methamphetamine addicts and has demonstrated high rates of abstinence 6 months after completion of the 16-week program. With additional testing of the Matrix Model in additional communities funded by SAMHSA's CSAT, this model has now been adopted by several programs throughout the United States, and the curriculum is now marketed by the Hazelden Foundation, a well-known distributor of substance abuse education materials.[15]

Even programs serving populations deemed particularly difficult to reach have had success in treating clients with meth problems. Since gay men were among the earliest groups reported to be increasing their use of methamphetamine more than a decade ago, LGBT-identified programs were among the first to cope with the results and among the

[13] National Association of State Alcohol and Drug Abuse Directors. May 2005. Fact Sheet: Methamphetamine. www.nasadad.org/resource.php?base_id=328
[14] The Iowa Consortium for Substance Abuse Research and Evaluation. September 2004. Outcome Monitoring System: Iowa Project: Year Six Report. www.idph.state.ia.us/bhpl/common/pdf/substance_abuse/sa_oms_report.pdf
[15] Hazelden Foundation. The Matrix Model Family of Products. www.hazelden.org/servlet/hazelden/cms/ptt/hazl_7030_shade.html?sh=t&sf=t&page_id=29787

first to create effective treatment approaches. The Stepping Stone, a residential program for gay persons in San Diego, instituted a Sexual Behavior Relapse Prevention pilot program to increase client retention, decrease client recidivism, and reduce HIV-infection from drug- or sex-linked relapse. At 6-month and 1-year followups, significant improvement on all three measures was reported for clients on the pilot-study track, compared with clients on the traditional program.[16]

But by the time many people with a serious meth problem reach treatment, the degree of impairment they present may be more severe than with many other substance abuse clients; they may have a number of physical and mental health issues that existing treatment programs are not equipped to handle. Methamphetamine withdrawal can last from 2 days to 2 weeks, with various degrees of brain dysfunction continuing for months after a user becomes abstinent. Problems that may need to be addressed in treating meth addicts include depression, fatigue, anxiety, anergia (passivity and lack of energy), drug craving, severe cognitive impairment, continuing paranoia, hypersexuality, irritability, drug craving in response to conditioned cues, and even violence.[17]

In some places where methamphetamine has recently emerged as a significant treatment issue, substance abuse treatment resources may be limited at best, and it is unlikely that programs in such communities have adequate mental health and medical staff, or even adequate meth-specific training for substance abuse services staff. As yet, only a few treatment programs exist nationwide that have successfully adapted models to address the unique treatment needs of methamphetamine addicts.[18]

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[16] Braun-Harvey, D.; Zians, J. December 2004. Using Sexual Behavior Relapse Prevention To Reduce Chemical Dependency Treatment Failures. Conference PowerPoint presentation at the 26th annual Southeast Conference on Alcohol Dependence (SECAD), Atlanta, GA.
[17] Methamphetamine Interagency Task Force. 2000. *Final Report: Federal Advisory Committee. Part III: Treatment*. www.ojp.usdoj.gov/nij/methintf/3.html
[18] Ibid.