

**Final Report to the
MA Treatment Study Committee
of the
Nebraska Community Corrections Council:**

**MOVING PAST THE ERA OF GOOD
INTENTIONS: METHAMPHETAMINE
TREATMENT STUDY**

***FACT OR MYTH: THE ACCURACY OF COMMON IDEAS
ABOUT METHAMPHETAMINE***

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Introduction

The purpose of the *Initial Report* of the Methamphetamine Treatment Study (December 2005) was to provide the Community Corrections Council sufficient information and recommendations that it could develop programming plans and funding requests which were likely to have an immediate and short-term effect on Nebraska's MA problem. The purpose of this *Final Report* is somewhat different. As the 99th Unicameral adjourned on April 3, 2006, policy debates about the very specific recommendations from the *Initial Report* have largely concluded, at least for now. The function of this report is to encapsulate the research findings of the MTS and serve as a detailed reference for understanding the many dimensions of MA's impact on the State's social service and justice systems.

A report covering a problem as complex as MA abuse inevitably runs afoul of many ideas people have come to accept as given information on the subject. Even as the MTS research team was forced to gradually abandon misperceptions it held at the beginning of the study, the public and press challenged, chided and criticized the *Initial Report* based on a collection of popular ideas about MA. Few of those ideas are completely wrong, but few are as conveniently straight-forward as they might initially appear.

The following section explores many of the most common ideas expressed to the MTS research team members during the study. Most of these are discussed in detail later in the report, but it was hoped that this brief aside might prove useful in helping everyone gain a more uniform perspective on MA.

Fact or Myth: The accuracy of common ideas about methamphetamine

“Anyone can make MA” or “Meth is easy to make”

Short Answer: Without precursor ingredients such as ephedrine or pseudoephedrine, MA is impossible to make. If the precursors are available, then little expertise is required to make methamphetamine, but purity levels will vary widely depending on the production method.

Unlike cocaine or heroin which is derived from plants, MA is a synthetic drug which requires a man-made ingredient such as ephedrine or pseudoephedrine. There are only nine production facilities in the world that make pseudoephedrine. It is a complicated process requiring technological capacity that is well beyond the means of the most sophisticated MA makers.

Given a supply of pseudoephedrine or its related cold-medicines, however, MA can be made produced using common household items such as battery acid, iodine, anhydrous ammonia, lye, lantern fuel, and anti-freeze. At one time, recipes for cooking MA could be found on the internet, but much of this is being gradually eliminated. When ingredients and instructions were easily obtainable, people throughout the county cobbled together kitchen and container labs and brewed up batches of MA. The production of

MA requires no particular expertise, just access to the precursor chemicals and the ability to follow instructions.

Over the past two years, state and local governments, enacted legislation regulating the sale of over-the-counter medications containing pseudoephedrine. As a result, law enforcement reports a dramatic decline in the number of clandestine MA labs being discovered or seized. These recent successes, and some historical instances in which the illegal supply of pseudoephedrine was greatly reduced, show that restricting access to these necessary precursor chemicals directly reduces MA production.

MA is easy to make only when one has access to necessary precursor chemicals. When a drug-maker's access to pseudoephedrine or substitute ingredients is disrupted, it becomes impossible to make MA. Recent federal legislation which adds restrictions to cold-medicine retail sales will be helpful in states' struggles with MA, but an outright ban of pseudoephedrine-based cold and allergy medicines would eliminate the world-wide problem of MA.

“Most MA used in Nebraska comes from small, clandestine labs.”

Short Answer: Most of the MA used and seized in Nebraska is produced in sophisticated, mega-labs in Mexico, the Southwestern US or central California.

Although the existence of small clandestine MA labs has received much publicity, research suggests that they account for an ever-decreasing percentage of the MA consumed within the state. Small clandestine labs adversely impact the communities in which they operate. In addition to producing a debilitating drug, these labs produce toxic waste and render structures uninhabitable until expensive clean-up procedures are completed. Clandestine labs pose health hazards for those individuals who come in contact with them, often putting children and first responders at risk. While none of these negative impacts can be overlooked, small, clandestine labs contribute only minimally to the actual production of the MA consumed in Nebraska.

State law enforcement officials report a decline in the number of clandestine labs in Nebraska. As discussed above, the regulation of the precursor chemicals necessary for operating the labs accounts for part of the decline. Unfortunately, as law enforcement and new regulations suppress locally produced MA, users simply turn to other sources.

Nebraska users have always acquired MA from drug networks distributing MA produced in mega-labs located in Mexico, central California and the Southwest United States by Mexican drug cartels. These mega-labs acquire large quantities of precursor chemicals and produce vast quantities of MA at an astonishing rate. The mega-labs are able to produce a much purer form of MA than could ordinarily be found in a small kitchen or container lab. Accordingly, as the street-seized purity of MA increases in Nebraska, officials can be more certain that imported MA is filling the supply void left by eliminating clandestine labs.

“MA creates environmental hazards.”

Short Answer: Cooking MA produces dangerous fumes and by-products; the resulting chemical waste is toxic and requires special disposal procedures.

The production of MA creates toxic bi-products that contaminate the sites where the drug is made. Buildings, their contents, and any containers used to produce MA are contaminated. The production process generates hazardous waste that is dumped around the lab sites and surrounding areas. These dump sites often include chemical containers, coolers, plastic jugs and other garbage. A clandestine lab and dump site not only poses environmental hazards, they can be instantly hazardous to the health of anyone who comes in contact with one.

Individuals who come in contact with a clandestine lab or dump site should not touch anything. If you enter a building that you suspect has been used as a MA lab, you should leave the building immediately. Report any clandestine labs or dump sites to local law enforcement officers who are trained how to safely deal with the situation. When cleaning up a lab or dump site, law enforcement officers wear protective clothing to prevent contact with the hazardous materials or ingestion of methamphetamine. A modest MA lab or dump-site costs thousands of dollars to close and clean up. State and county budgets are strained to pay for the necessary clean up associated with these sites. Professionals at the Western Nebraska roundtable discussion expressed concerns about the clean-up expenses associated with buildings that have been used as methamphetamine labs.

As the number of clandestine MA labs in Nebraska declines, the health and environmental hazards posed by labs and dumps sites similarly decreases. Nebraska has such a large, rural landscape, though, abandoned labs and dump sites may lay undiscovered for years. The public must remain vigilant to the danger of MA dumpsites and particularly mindful of the risks they pose to livestock and children that might come into contact with one.

“MA is instantly addictive”, “Everyone who tries MA becomes addicted”, or “Trying MA, even once, produces an insatiable craving for the drug for the rest of your life”

Short Answer: MA triggers an extreme reaction within the brain. Whether one becomes addicted by one, two or a dozen exposures to MA depends on individual vulnerabilities to addiction, the potency of the MA, and future use patterns.

Except for possibly crack cocaine or heroine, people become addicted to MA more easily than any other drug. Research indicates this rapid addiction relates to the extreme chemical reaction MA produces and the euphoria associated with it. However, research also shows that very few people use MA as their first drug. The vast majority of MA users come to the drug after already developing heavy drinking habits and using marijuana or other illegal drugs. Research shows that MA users often transition from occasional use to a binge period. Once a user has gone through one of these binge periods, the desire to use MA gradually overpowers all other personal needs, responsibilities and relationships.

Taken together, these findings suggest that some people become addicted to MA faster than others. While the neuro-chemical reaction to MA is extreme, researchers cannot say that a single use causes irreversible, life-long damage to the brain. Like any other extreme metabolic event, different people possess different capacities for recovery. In terms of physiological dependency, it is unlikely that most people are damned to a life-

long need for MA after only one use. On the other hand, the extraordinary euphoria associated with MA use presents an extraordinary temptation that few users appear capable of resisting. There is no research available which says how many people become addicted to MA after only one use. The only users science knows anything about are those users who developed serious or fatal addictions to the drug.

The bottom line is that MA in general, and the potent MA imported to Nebraska in particular, is a terribly dangerous drug with which to flirt. Prevention advocates have good reason to warn against trying MA even one time.

That said, it must also be made clear to anyone who has ever experimented with MA that the hellish descent into MA addiction is not inevitable. The quicker someone seeks help with their drug and alcohol problems, the easier it will be to fight back an addiction to MA or any other drug. For someone who has used MA a few times, it may take awhile to forget the lure of the MA high, but the brain and organ damage associated with prolonged use and binging may be avoided altogether. More importantly, the personal degradation and loss of family, friends, and careers can be prevented. Experimenting with MA may not fit the clinical definition for “addiction”, but it reflects such a profound disregard for risk and personal well-being that anyone who has tried MA even once would be well-advised to seek counseling help. Securing early help may be all that stands between a long, normal life and one beset by one of the most vicious addictions that exist.

“There is no effective recovery strategy for MA addiction.”

Short Answer: With proper treatment and recovery plans, MA addicts have achieved higher abstinence rates than alcoholics and marijuana users. As with any other chemical dependency, recovery from MA use depends, in part, on society’s commitment to maintaining recovery support on which addicts can rely for the rest of their lives.

MA addiction responds well to treatment strategies that identify the individual’s particular treatment needs and establishes long-term recovery support. Part of that planning demands that providers recognize MA addiction requires different therapeutic strategies than most other drugs, but especially alcohol. Treatment providers and justice professionals throughout the state report alcohol treatment therapies are largely ineffective against MA addiction and that putting MA addicts and alcoholics in the same treatment group can produce a volatile mix.

The National Institute on Drug Abuse has found cognitive behavioral interventions effectively treat MA addiction and SAMHSA recommends the Matrix Model, in particular (Rawson R A 2004). A comprehensive study funded by SAMHSA and CSAT, found that MA-dependent individuals responded positively to the Matrix Model’s treatment protocols (Rawson R A 2004) (2005). Research has also shown that MA must include integrated treatment for co-occurring conditions, including mental health concerns and dependence on other substances such as alcohol or marijuana (Zweben J 2004) (Maxwell 2005).

MA users require an array of support services to successfully complete treatment. Research has found that structure is vital to a MA addict’s recovery. Recovery from MA requires long-term support services. A MA addict cannot be discharged from his

treatment program and left to fend for himself. The addict must have access to a network of support services specifically designed to support him in his continued recovery.

Although MA addicts may not receive effective treatment in existing programs designed for alcohol or other substances, MA users can recover from their addiction through the implementation of MA specific treatment and support services.

“Children exposed to MA will become drug addicts, alcoholics, and/or delinquents.”

Short Answer: The factors which contribute to a youth’s eventual substance use habits and delinquent behavior vary widely. Genetic predisposition, ingesting addictive drugs at an early age, life experiences within a dysfunctional family, trauma from victimization and neglect, and exposure to drug and criminal behaviors place any child at risk of undesired behaviors as they grow older. Concerted interventions which mitigate these influences greatly aid a child’s ability to avoid the trap of addiction and offending.

Children whose parents use MA are exposed to it in different ways. MA use causes medical complications on developing fetuses (Maxwell 2005). Newborns whose mothers have used MA are born with the drug in their systems. When law enforcement officers enter homes of MA users, they often find MA, other drugs and alcohol put within reach of children. Children watch their parents take drugs. Parents leave their children unsupervised while high on MA or sleeping off its effects. Neglected children can ingest MA and alcohol that is lying around the home. Older children who are experimenting with drugs have easier access to MA and other substances when their parents use it in the home.

The research is unclear whether anything less than the ingestion of MA leads children to become addicts. What research does show, however, is that parental substance abuse increases the chances of their children abusing drugs. While this research is not specific to MA, children tend to emulate parents’ habits regarding all types of substance abuse including drinking, smoking, or illegal drug use (Chassin et al. 1993; Conger et al. 1994b; Conger and Rueter 1995; Hawkins et al. 1992; Melby et al. 1993). Research also shows that not just substance abuse, but other anti-social behaviors exhibited by MA addicted parents, such as neglect and violence, place children at risk for becoming substance abusers. “In Iowa, a look at suspected child abuse cases in 16 counties showed that one in three was due to parental association with MA.” (Kraman, Pilar. March 2004; Drug Abuse in America – Rural Meth. The Council of State Governments. Lexington, KY.)

While it is over-reaching to say that all children of MA addicts will become addicts themselves, exposure to MA, a childhood of neglect and abuse, and trying to grow up in an uninterrupted stream of chaos all increase a child’s propensity to engage in such behaviors. The degree to which one factor or the other is more or less responsible hardly warrants the attention that could be better spent trying to help such a child overcome the difficult circumstances in which they have been embroiled.

“MA causes medical and dental problems.”

Short Answer: Prolonged MA use inevitably leads to a wide range of medical and dental problems.

MA users display a wide array of medical problems. Even small amounts of MA damage the central nervous system, causing increased wakefulness, irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. (NIDA InfoFacts. May 2005. National Institutes of Health – U.S. Department of Health and Human Services.) Other common medical conditions among MA users include increased heart rate, high blood pressure, respiratory problems, and an irregular heartbeat. (NIDA InfoFacts. May 2005. National Institutes of Health – U.S. Department of Health and Human Services.) MA can cause long term damage to internal organs, including the heart. In extreme cases, death can result from death from hyperthermia, convulsions and cardio collapse. (NIDA InfoFacts. May 2005. National Institutes of Health – U.S. Department of Health and Human Services.)

Poor circulation, poor diets, and obsessive scratching cause sores to develop on the skin of MA users. Treatment providers throughout the state reported difficulty in treating substance abuse problems until medical concerns were addressed. They reported that severe back pain and eating disorders were common among MA users and had to be dealt with in addition to providing treatment.

Dental complications arising from MA abuse also hinder treatment. As one treatment provider explained, it is hard to address treatment needs when a user’s “teeth are rotting out of their head.” Many MA users develop what is commonly known as “meth mouth.” Constriction of blood vessels that feed the teeth, lack of saliva production and horrible nutrition contribute to the severe tooth decay. Additionally, bruxism, or grinding of the teeth often results from MA use. (Maxwell 2005) (See S 2003).

“More women use MA.”

Short Answer: Women account for a disproportionate number of MA users.

Last year DCS admitted 418 men and 109 women who were confirmed methamphetamine users. When one looks at arrestees and the results from drug use surveys, women represent as much as half of all MA users. This ratio differs considerably from other drugs and alcohol where women may represent a third or less of all users.

The high rate of women users indicates a compelling need for some degree of gender-specific MA treatment. While some treatment providers report that both men and women appear to benefit from coed treatment groups, women frequently experience high rates of sexually related diseases, risk estrangement from their children, and self-medicate to escape unresolved issues related to earlier life trauma.

“MA is a white person’s drug.”

Short Answer: MA does not discriminate. Drug preferences may vary between different races and ethnicities, but once a person begins to regularly use MA, their craving for MA gradually dominates their drug seeking/using behaviors.

People rarely start out with MA as their primary drug. This is due to a number of factors including, easier access to other substances such as alcohol, marijuana or cocaine, local drug use patterns which have established distribution networks that do not include MA, and pre-existing addictions which pre-occupy a user from searching out or being exposed to MA. As MA gradually works its way into a community, its effectiveness as an intoxicant strengthens its competitive penetration in the drug distribution network. The drug trade is like any other market and grows according the laws of supply and demand. Once a threshold demand for MA exists, it becomes a more profitable risk for traffickers who increase the available supply and actively promote the expansion of the MA market.

The MA epidemic has spread eastward from the West Coast. The states through which it has passed are predominantly white with large numbers of Latinos and comparatively lower numbers of Blacks than are found along the East Coast and in the South. The national data on MA usage appears to reflect these disparities:

- During FY 2001, 3,404 federal drug offenders were convicted of committing an offense involving MA. Of those convicted of a Federal drug offense for MA, 59% were white, 35.2% were Hispanic, 4.2% were of another race, and 1.6% was black. (Lloyd, Jennifer. Nov. 2003. Methamphetamine - Factsheet. ONDCP Drug Policy Information Clearinghouse. Rockville, MD.)

Over the course of this study, the following findings for Nebraska have been made:

- In some communities near Lexington, Western Nebraska officials have estimated that 75-80% of probation contacts related to MA are non-English speaking.
- Eastern Nebraska Treatment Providers report a high need to fund interpreters for Spanish and Sudanese MA users.
- Western Nebraska Justice Professionals report that many Native Americans have a MA problem but cannot afford treatment. The system is also overloaded, making it impossible to send an estimated 400 Native American MA users for treatment.
- Eastern Nebraska Justice Professionals report recent increases in African American MA users and offenders.

These findings point to Nebraska's critical need to develop more minority substance abuse treatment providers and technicians. As with the gender-specific issues noted above for MA users who are women, the State cannot realistically expect to curtail substance abuse among racial, ethnic and language minority groups until sufficient resources have been placed to provide culturally competent recovery support.

“Coerced treatment does not work” or “Forcing addicts to go through treatment in the justice system is a waste of time and money”

Short Answer: MA may be the tip of an addict's substance abuse problem, but it is particularly vulnerable to forced treatment. Until an addict has been liberated from the lingering cognitive and psychological effects of MA use, it may be impossible to develop the individualized treatment strategies necessary to promote long-term recovery. Few addicts muster the motivation to quit MA until forced to do so.

Effective treatment, even if initially forced upon an addict, can reduce future drug use and criminal behavior.

Research from the *Principles of Drug Addiction Treatment (1999)* demonstrates that individuals entering treatment under pressure achieve outcomes as positive as those who enter treatment without pressure. In a study by Brecht et al. (Brecht M 2005), 350 Los Angeles County MA users were evaluated, comparing background and treatment characteristics and selected treatment outcomes across groups defined by existence of coerced treatment for MA. The pressured and non-pressured MA users saw no statically significant difference in outcome successes.

Farabee et al. (Farabee 1998) observed that just because clients enter treatment under pressure, the treatment may not be involuntary. In fact, several studies suggest that criminal justice coercion may increase patients' internal motivation to produce more successful treatment outcomes (De Leon 1994) (Joe 1999) (Simpson 1993). Coerced treatment research points to positive results for criminal offenders in general, with specific studies exhibiting success with heroin abusers (McGlothlin WH 1977; Brecht M 1993; Prendergast M 1995; Anglin MD 1998; Hiller M 1998; Miller N 2000). A study of inmates enrolled in a therapeutic treatment program in the Delaware State Prison that continued to receive treatment in a work-release program after prison were shown to be 70% less likely than non-participants to experience a drug relapse and incur rearrest. (1999)

In addition to strong recovery results, research also shows that coerced treatment can have a positive effect on criminal recidivism. The *Iowa Adult Methamphetamine Treatment Project – Final Report, 2003* indicated that 90.4% of MA clients had not been arrested 6 months after treatment and 95.7% of MA clients interviewed one year after treatment had not been arrested during the previous 6 months (Roth 2003). The Year Six Report of the *Iowa Project Outcomes Monitoring System 2004* recidivism numbers indicated no arrests in the six months after treatment for 86% of MA users; 90.7% of alcohol users; 79.2% of cocaine users; and 86.8% of marijuana users. These rates are compared to 30.9% of clients who had not been arrested in the 12 months prior to treatment. (Johnson A 2004)

“MA use increases sexual activity.”

Short Answer: MA use is strongly associated with sexual acting out.

One of the ways in which MA recovery can be distinguished from other drug and alcohol addictions is the out-of-control sexual activity which appears to be a key element of MA use. MA users report a loss of control over their sexual expression, describing sex as ‘compulsive’ and ‘obsessive’ (Maxwell 2005) (Reback C 2004). *TIP #33* (Rawson 1999) lists compulsive sexual behaviors for MA abusers as promiscuous sex, AIDS-risky behaviors, compulsive masturbation, compulsive pornographic viewing, and homosexual behavior for otherwise heterosexual individuals.

The medical treatment consequences of MA use include a full range of disease and disorders resulting from risk sexual activity. The disinhibitory affects of MA (and Ice in particular) have been strongly associated with sexual behaviors that put men at

high risk of sexually transmitted and blood-borne disease, including HIV infection (Maxwell 2005) (Kurtz S 2003). Studies have confirmed some of the medical complications arising from MA abuse. In HIV-infected patients complications include hypertension, hyperthermia, rhabdomyolysis, stroke, and some researchers believe that dopaminergic systems are vulnerable to the combined neurotoxicity of HIV infection and methamphetamine (Maxwell 2005) (Urbina 2004).

During this study, Eastern Nebraska Treatment Providers expressed concern over the sexual addiction associated with MA use and the spread of HIV. Treatment Providers from around the State would like to require a nursing assessment to test for STD's at the time of referral. Eastern Nebraska Treatment Providers also report that many MA users are infected with Hepatitis C.

Hardly a romantic aphrodisiac, MA saddles its users with sexually-related health complications which will require years of medical treatment and much state-funded care to address.

“MA affects your mental health” or “MA makes users psychotic”

Short Answer: As with individual susceptibilities to the physical consequences of MA, people vary in their psychological response to MA. However, prolonged use of MA consistently manifests psychological and emotional symptoms which were not apparent prior to use. Treatment providers may not be able to accurately assess an addict's “true” mental state until the user has abstained from MA for at least 45 to 60 days.

Psychiatric disorders arising from MA abuse were confirmed in a study of 405 methamphetamine users in Taipei. MA users with pre-morbid schizoid/schizotypal personality were found to be predisposed to developing psychoses (Maxwell 2005) (C. Chen 2003). A study among MA psychotic patients in a multi-country study involving Australia, Japan, the Philippines and Thailand indicated that persecutory delusion was the most common lifetime psychotic symptom, followed by auditory hallucinations, strange or unusual beliefs, and fear of thought reading (Maxwell 2005) (M. Srisurapanont 2003).

The key psychological side-effects of MA use as it relates to treatment, however, are those connected with detoxification. One of the ways in which MA differs from many other drugs is that users often manifest significant psychological and/or emotional symptoms up to 60 days or more after their last ingestion of MA. A psychologist from the Norfolk Regional Center reports observing a number of MA addicts committed as mental health patients who eventually recovered from their psychoses once they abstained from MA for a few months. Conversely, the research literature also reports MA patients who initially presented few mental health problems suddenly developed paranoia and uncontrollable rage as they hit “The Wall” 45 to 60 days after they quit using MA.

The consistency with which this phenomenon has been observed across MA users shows that individualized recovery strategies may be difficult, if not impossible to nail down during the first couple of months that an addict abstains from MA. For these reasons, general treatment approaches which emphasize structure, abstinence, and non-confrontational accountability seem to offer the best course for addressing the early stage of a MA's recovery program. Once providers can be reasonably assured that sufficient

time has elapsed for the MA addict's psychological condition to stabilize, they can proceed with more individualized assessments and recovery planning.

“MA eventually leads to Alzheimer’s Disease in recovered addicts.”

Short Answer: Much research remains to be done before the long-term effect of MA on recovered addicts can be stated.

MA appears to damage brain cells that contain the neurotransmitters dopamine and serotonin. Without sufficient dopamine, the brain develops symptoms like those of Parkinson's disease. (NIDA InfoFacts. May 2005; National Institutes of Health – U.S. Department of Health and Human Services.) Other research shows that people who use MA risk long-term damage to their brain cells similar to that caused by strokes or Alzheimer's disease. In an article published in the March 28, 2000, issue of *Neurology*, scientists at the Harbor-UCLA Medical Center in Torrance, California, used magnetic resonance spectroscopy to take measurements of three parts of the brains of 26 participants who had used methamphetamine and then compared them with measurements of the same regions in the brains of 24 people who had no history of drug abuse. In their study, Dr. Linda Chang and Dr. Thomas Ernst measured levels of brain chemicals that indicate whether brain cells are healthy or are diseased or damaged. "While the meth users in this study hadn't used the drug for some time--anywhere from two weeks to 21 months, this research strongly suggests that methamphetamine abuse causes harmful physical changes in the brain that can last for many months and perhaps longer after drug use has stopped," said Dr. Alan I. Leshner, Director, National Institute on Drug Abuse (NIDA).

“MA is Nebraska’s biggest substance abuse problem”

Short Answer: *Substance abuse* is Nebraska’s biggest substance abuse problem. Methamphetamine use is merely the most prominent indicator of the State’s need to respond more effectively to all forms of chemical dependency.

Data from the Arrestee Drug Abuse Monitoring Program (“ADAM”) shows that Omaha arrestees’ positive tests for all types of drugs increased from 2000 to 2003. In 2003 75% of all arrestees tested positive for some type of drug at the time of their arrest: marijuana-51%, multiple drugs-31%, MA and Cocaine tied at-21%, and Opiates-5%.

Except for alcohol, however, MA reigns supreme for the profound effect it has exerted on so many communities across Nebraska. When its pervasiveness is combined with the devastating speed by which it destroys families, careers, and lives, MA has certainly reached crisis proportions in Nebraska.

If one accepts that nearly all MA users are also addicted to alcohol and use other drugs, it can be seen that Nebraska’s response to this crisis demands that all substance abuse services be strengthened. Anything less leaves the door open for other drugs to quickly fill MA’s place.

“MA is mainly a problem for people older than 18.”

Short Answer: Substance abuse does not wait for adulthood. A foundation of alcohol consumption and experimentation with other drugs is typically laid between the ages of 12 to 18 years of age. Failing to provide effective substance abuse treatment to juveniles greatly increases the risk that they will eventually graduate to MA or some other addiction as an adult.

A school administrator from southeastern Nebraska recently said, “they get boys going on beer and marijuana first, then give them MA. Girls—they just give them MA”. Western Nebraska justice professionals report that juveniles start using MA between 12-15 years of age with many learning from their siblings. Eastern Nebraska treatment providers noted that MA use among 16-19 year olds is diminishing juveniles’ cognitive abilities and placing a burden on school districts.

The average age of first use among new methamphetamine users was 18.9 years in 2002, 20.4 years in 2003, and 22.1 years of age in 2004. (This Short Report, The NSDUH Report: Methamphetamine Use, Abuse, and Dependence: 2002, 2003, and 2004, is based on SAMHSA’s National Survey on Drug Use and Health (NSDUH), formerly called the National Household Survey on Drug Abuse conducted by SAMHSA’s Office of Applied Studies (OAS) in the Substance Abuse and Mental Health Services Administration (SAMHSA). According to the 2003 National Survey on Drug Use and Health (SAMHSA, 2005), 12.3 million Americans age 12 and older had tried methamphetamine at least once in their lifetimes (5.2 percent of the population), with the majority of past-year users between 18 and 34 years of age.

“The State of Nebraska can effectively treat the methamphetamine problem by focusing on felony drug offenders.”

Short Answer: Felony drug offenders are at the peak of the substance abusing pyramid in Nebraska. Many offenders whose crimes are related to substance abuse are convicted of less serious crimes. To reduce the number of crimes either directly or indirectly tied to substance abuse, the justice system must broaden its focus to include testing and evaluations of as many offenders as possible, without regard for the formal charges which bring them within the influence of the courts, probation, and corrections.

Nebraska does not have unlimited resources to address its substance abuse problems. One can certainly understand that focusing on felony drug offenders is a reasonable way to prioritize funding and treatment capacity. At the same time, only about 500 MA using offenders were sentenced to prison in 2005. Given the number of arrestees who tested positive for MA in 2003, it is estimated that approximately 19,000 offenders would have probably tested positive for MA if every arrestee had been subjected to a drug test. *This means that 97% of all of Nebraska’s offenders who use MA were not sent to prison in 2005.*

For Nebraska to appreciably reduce the number of crimes related to MA use, it must commit to long-term strategies aimed at addressing the substance abuse treatment needs of all offenders no matter how their crime is classified. A solid step in the right direction can be seen in the Unicameral’s recent appropriation of 4.3 million dollars to

fund testing, treatment and increased justice capacity for all offenders (LB1060). Through these funds, the Community Corrections Council has resources with which it can pro-actively encourage all offenders to discard their substance abuse problems. While sobriety offers no guarantee that a person will cease offending, an addicts' recovery increases his or her chances of maintaining a job, family and the normal responsibilities and benefits which insulate all of us from committing crimes.

“The State of Nebraska can quantify the need for methamphetamine treatment within the state.”

Short Answer: Due to the lack of standardized data, Nebraska cannot accurately quantify the need for MA treatment.

State agencies throughout the state keep internal records indicating the number of MA related cases that they receive and justice professionals screen arrestees and probationers for drug use. But, there is no standardized method for assessing drug use within the state. Attempts at quantifying the scope of the MA problem are dependent on piecing together data that is gathered from various sources throughout the state. Identifying gaps and overlap in data is challenging. A standardized data collection process and a centralized database are essential to accurately determining the number of MA users in Nebraska. Until Nebraska can accurately quantify the need for MA treatment, it cannot efficiently allocate funding and develop treatment resources.

“Children face a decrease risk of harm now that clan labs have been shut down across the state.”

Short Answer: The reduction in clan labs lessens, but does not eliminate the harm children face as a result of MA.

To support their MA habits, parents cook MA in their homes. The presence of toxic chemicals and possibility of explosions inherent in this activity creates an obvious danger for children in those homes. As regulation of precursor medications forces a decrease in clandestine labs, it would be easy to assume that the harm to children as a result of MA has subsided.

In-home MA labs are not the only danger facing children in MA affected homes. Parents seeking the next high do not care for their children's basic needs. Obtaining and using MA becomes the parents' sole preoccupation. House care and meal preparation fall by the way side. Homes are filthy and children go without regular meals. Schedules are forgotten and children are responsible for getting themselves to school. Parents' moods and behaviors hinge on where they are at in their cycle of drug use. Parents can exhibit psychotic paranoia or sleep for days at a time.

This type of neglect can become abuse. Violence and weapons are commonplace in MA affected homes. Children of MA addicted parents are exposed to overt sexual behavior and are at a high risk for sexual abuse. These dangers exist even when parents are not producing MA in their homes.

Eliminating clandestine MA labs reduces only one of the dangers children face as a result of MA. Over the past two years, there has been a crackdown on MA labs in

southwest Iowa. In spite of this effort by law enforcement, the percentage of child neglect cases involving MA using parents has remained at approximately 49%. Children in MA affected homes continue to suffer from abuse and neglect as a result of their parents drug use.

“A parent that has used MA will never regain custody of their child.”

Short Answer: With treatment and recovery services, parent can regain custody of their children.

Family-oriented, community-based treatment prevents parents from having to choose between treatment and their children. As a parent emerges from the clouded thinking caused by MA use, their love for a child and the desire to make up for time lost to MA can become powerful motivations for maintaining sobriety. When treated parents resume their place in a family, far from being treated soft-heartedly, they are being held accountable for their acts in the most appropriate way society can design: they are being forced to daily assume responsibility for repairing the damage left in the wake of their substance abuse and offending. With sufficient recovery support and relapse prevention services in place, MA addicted parents can resume their role as a contributing member of society and the web of social involvement which keeps them from succumbing to old habits becomes even stronger.

Sadly, MA using parents who escape coerced recovery through cracks in the criminal justice and social service systems, or those parents who lack the social support network required to maintain a stable recovery, must be recognized for the ongoing danger they present to a child’s well-being and development. The termination of parental rights may be one of the most severe consequences an addict faces. Cutting a child’s connection to even the most dysfunctional parent generates a powerful grief no child should endure. For these reasons, the social service system needs to develop strong treatment and recovery plans which provide MA using parents every opportunity to avoid termination. *Such treatment plans must include access to vouchers for evaluation and therapy, medical care, counseling, job-training, housing assistance, relapse response services, and peer-support groups.*

Case workers must understand their central role in compelling parents to succeed in treatment. At certain stages of the recovery process, case workers will need to monitor MA using parents’ progress on a daily basis. When case-workers become active partners in a parent’s recovery, the likelihood of reunification substantially increases. However, in those cases where a parent cannot meet fair treatment expectations, comply with regular drug and alcohol testing, or demonstrate compelling evidence of concern for their children outside a juvenile court hearing, the State must move swiftly to end the limbo in which children hang while waiting for their parents to abandon drugs.

If the child welfare system delivers prompt treatment planning and the comprehensive array of services on which MA recovery depends, parents who continue to choose addiction have discarded their children as clearly as they have rejected recovery. At that point, the State can only be faulted for the delay in which it acts to restore a child’s sense of permanency.

Recovery may be a life-long process for addicted parents, but childhood, adolescence, and the transition into young adulthood are not. The developmental needs

of children cannot be subordinated to the pace of a parent's recovery. Failure to prioritize the child's long-term well-being over a parent's addiction risks surrendering two victims to MA: the parent and the child.

“Funding support for substance abuse treatment diminishes community-based mental health capacity.”

Short Answer: Substance abuse and mental health must work together to provide comprehensive, community-based treatment.

The Criminal Justice/Mental Health Consensus Project released in 2002 by the Council of State Governments detailed the extent to which U.S. prisons have become a repository for the mentally ill. As states move from institutionalized care to community-based mental health services, prisons across the country report an increase in the number of mentally ill inmates in their custody.

About 16% of the prison/jail population has serious mental illness in contrast to 5% of the general U.S. population. Men with mental illness are 5 times as likely to be incarcerated as the general population. As institutions close, mentally ill patients are unable to secure housing or access mental health services. Instead of shifting to community-based services, the mentally ill are shuffled into the prison system. Prison populations rise and the incarcerated mentally ill are unlikely to access the intensive mental health care that they need. Increased reliance on incarceration is contradictory to the Community Correction Council's aim to reduce incarceration and calls into question the development of necessary community-based mental health services.

Approximately 75% of inmates with serious mental illness have a co-occurring substance abuse disorder. Neither substance abuse nor mental health treatment will be successful without addressing the co-occurring condition. This underscores the need for mental health and substance professionals to work together in creating sufficient community-based services for both conditions. Funding substance abuse treatment does not usurp mental health support. In an environment of limited funding, it is critical that mental health and substance abuse professionals work in tandem to ensure community-based services reduce the State's reliance on prisons as receptacles for the addicted and mentally ill.

“Methamphetamine detoxification requires residential treatment in a drug rehab center.”

Short Answer: Effective MA detoxification can be accomplished without residential treatment. Out-patient detoxification requires intense supervision, frequent drug screens and accountability to be successful.

The detoxification process for MA lasts longer than for other drugs. The effects of MA may persist for 45-60 days. Treatment providers have observed dramatic changes in personality once detoxification is complete. Often, users are mentally unable to focus on treatment until MA is completely gone from their systems.

The key to MA detoxification is ensuring that an addict does not use during the 45-60 day detoxification period. In most cases, research consistently shows that

residential treatment is not required to prevent use. For example, day reporting centers can be designed to deliver the supervision and structure that MA users need to maintain sobriety. These resources include daily, personal contact with case-workers, frequent drug screens and individual and group therapy.

Occasional episodes of relapse are to be expected, especially during the early stages of recovery from MA addictions. However, in those cases where an addict repeatedly proves incapable of avoiding MA use for 45 to 60 days, or when a user suffers from psychotic symptoms that put her, or the community, at risk, residential *placement* may be needed. The confines of a controlled environment should finally deprive a user of MA long enough for detoxification to be completed. Removing a MA addict from their home-based community setting should be considered a last resort. Successful long-term recovery heavily depends on the addict developing strategies and life-skills which enable them to avoid the environmental triggers and relationships associated with their past use. The improper application of expensive residential placement in the name of “treatment”, wastes precious funding and is more likely to delay recovery than obtain it.

“Recovery from MA demands a complete abstinence from MA and all other drugs and alcohol.”

Short Answer: The treatment community generally views the use of alternative drugs and alcohol as incomplete recovery, even if an addict discontinues MA use. During the early stages of MA treatment, breaking the cycle of MA use may represent a critical step forward in addressing a user’s overall addiction problem.

The research surrounding MA treatment does not provide answers to this statement which prove universally satisfying to treatment professionals.

Many therapists trained in traditional drug abuse treatment models, especially those derived from alcohol treatment, strenuously disagree with the notion that recovery from MA use is fundamentally different from any other addiction. “Clean and sober” means a complete abstinence from everything.

Except nicotine. And, except caffeine.

The obvious point is that even the strictest treatment models frequently make allowances for substances known to be addictive and even harmful, provided the tolerated dependencies relate to substances with less destructive potential than the primary addiction.

Some MA treatment specialists have come to see the recovery process as a prioritized spectrum. One provider said that once an addict stops using MA, she focuses on alcohol, marijuana, and finally other drugs; the order dictated by the risk of personal and community harm she perceives to be associated with each class of drugs. For such treatment providers, sustained abstinence from MA is the critical goal. Once an addict’s recovery from MA addiction has stabilized, discharge from treatment, *MA treatment*, is appropriate. Even though the addict may persist in the use of alcohol or marijuana, the dependency on MA has been broken. These providers are not denying the risks associated with continued alcohol and marijuana use, they simply believe that the first success in the recovery process has been reached. Freed from the mental and emotional

distortions of MA, the groundwork has been laid for real work to begin on the remainder of the addiction problem.

From a practical standpoint, any MA addict who uses alcohol or, especially marijuana, remains dangerously poised to relapse for MA. Not only do these substances interfere with the clear-eyed thinking on which long-term recovery relies, but access to marijuana supplies is likely to eventually present an addict with potential access to MA. A single re-exposure to MA may be all that is required to drop the addict right back into the patterns of use from which they have worked so hard to escape.

Based on the research and treatment providers' comments reviewed for this report, prioritizing MA abstinence above all other addictions appears to be a reasonable way for MA treatment strategies to be compartmentalized. Given that most addicts possessed alcohol and other drug dependencies before becoming MA users, however, these residual addictions seriously jeopardize long-term resistance to MA use. Whether changing focus from MA to other drugs and alcohol constitutes a "discharge" is not a trivial question of semantics. Genuine, substantive issues related to payment and assessing treatment success revolve around the partial versus complete resolution of a patient's overall addiction.

The justice and social service systems will have to grapple with the best way to resolve this conflict as they refine their measurements of recovery progress within treatment planning. Is the all or nothing approach the best way to guarantee long-term recovery? Are programs which gradually dismantle a composite addiction, brick by brick, more likely to retain patients in the long-run? Until research data comparing the relative outcomes of both approaches have been collected and analyzed, we lack the evidence required to declare one philosophy therapeutically superior to the other.