



RESEARCH AND ADVOCACY FOR REFORM

THE NEXT BIG THING? METHAMPHETAMINE IN THE UNITED STATES

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THE NEXT BIG THING? METHAMPHETAMINE IN THE UNITED STATES

“Methamphetamines have become the drug of choice across the nation and the ‘one hit and you’re hooked’ drug is one of the hardest for health officials to treat and users to kick.” – Levi Hill, *Silver City Sun-News*¹

“Political judgment and values have been paramount in the establishment of national drug policies . . . considerable political acumen is required to modify prevailing fear and anger into constructive programs.” – David F. Musto, *The American Disease*.²

Methamphetamine is a dangerous drug that represents a substantial challenge to policymakers, health care professionals, social service providers, and the law enforcement community. Over time, methamphetamine abuse can result in the deterioration of physical and mental capacities, the dissolving of family ties, diminished employment prospects, and a lifetime spent cycling through the criminal justice system. The consequences of irresponsible drug abuse harm not only the individual, but his or her family and the larger community. Thus, it is important that our public resources be effectively directed to both *prevent* the development of such a habit as well as *treat* those individuals before the proverbial die has been cast.

Unfortunately, the American strategy of drug control since the early 20th Century has emphasized an approach of *prevention* based on instilling fear about a substance through dramatized descriptions and images of the consequences of use coupled with a notion of *treating* people with harsh punishments out-of-step with the harm caused by the drug. Historically, the domestic response to drug use has been to demonize the drug and the people who use it while exaggerating the impact of its use (“You’ll be hooked the first time you try it”). This strategy has been complemented in the past two decades with mandatory minimums, sentencing enhancements, and a ban on access to services such as public housing, income assistance, and federal educational aid as the result of a drug conviction.

¹ Levi Hill (2006, March 6). “Addicts, Community Battle Meth,” *Silver City Sun-News* (NM).

² Musto, D.F., M.D. (1999). *The American Disease: Origins of Narcotic Control*. New York: Oxford University Press. Pp. 298-299.

Historian David Musto suggests that the incongruity between what people were told about drugs and personal experiences had a critical impact on public perceptions about drug policy beginning in the 1960s. As more people tried drugs and realized that many of the horrific consequences did not result, a mistrust of government statements about drug use began to emerge. There is evidence suggesting that this approach of “prevention through scare tactics” not only fails to diminish drug use, but may undermine public education efforts.

Over the last hundred years, opium, cocaine, heroin, marijuana, and crack cocaine have all been the “new” focus of drug enforcement efforts at different points in time. Since 2000, the latest drug occupying media headlines and receiving the disproportionate attention of law enforcement and policymakers is methamphetamine. This report examines the development of methamphetamine as the “next big thing” in drug threats by analyzing drug use rates through a series of different measures, investigating the role of the media in perpetuating the “epidemic” language, and assessing the state-of-the-art in methamphetamine treatment options.

Key findings include:

- **Methamphetamine is among the least commonly used drugs**
 - Only 0.2% of Americans are regular users of methamphetamine.
 - Four times as many Americans use cocaine on a regular basis and 30 times as many use marijuana.
- **Rates of methamphetamine use have remained stable since 1999**
 - The proportion of Americans who use methamphetamine on a monthly basis has hovered in the range of 0.2-0.3% between 1999 and 2004.
- **Rates of methamphetamine use by high school students have declined since 1999**
 - The proportion of high school students who had ever used methamphetamine (lifetime prevalence rates) declined by 45% between 1999 and 2005, from 8.2% to 4.5%.

Mischaracterizing the impact of methamphetamine by exaggerating its prevalence and consequences while downplaying its receptivity to treatment succeeds neither as a tool of prevention nor a vehicle of education.

- **Methamphetamine use remains a rare occurrence in most of the United States, but exhibits higher rates of use in selected areas**
 - Only 5% of adult male arrestees tested positive for methamphetamine, compared with 30% for cocaine and 44% for marijuana.
 - In some west coast cities – Los Angeles, Portland (OR), San Diego, and San Jose – positive responses for methamphetamine use among arrestees registered between 25-37%.
 - In those cities, the *overall* rate of drug use did not rise between 1998 and 2003, suggesting that the increased use of methamphetamine *replaced* other drugs, particularly cocaine.
- **Drug treatment has been demonstrated to be effective in combating methamphetamine addiction**
 - Studies in 15 states have demonstrated significant effects of treatment in the areas of abstinence, reduced arrests, employment, and other measures.
 - Methamphetamine abuse has generally been shown to be as receptive to treatment as other addictive drugs.
- **Misleading media reports of a methamphetamine “epidemic” have hindered the development of a rational policy response to the problem**
 - Media accounts are often anecdotal, unsupported by facts, and at odds with existing data.
 - Exaggerated accounts of the prevalence, addictiveness, and consequences of methamphetamine abuse risk not only misinforming the public, but may result in a “boomerang effect” in which use and perception are negatively affected.

The findings of this report refute the image of methamphetamine use in the United States as popularly conveyed by both the media as well as many government officials. Mischaracterizing the impact of methamphetamine by exaggerating its prevalence and consequences while downplaying its receptivity to treatment succeeds neither as a tool of prevention nor a vehicle of education. To the contrary, this combination of rhetoric and misinformation about the state of methamphetamine abuse is costly and threatening to the national drug abuse response because it results in a misallocation of resources. We urge vigilance in tempering our national response to methamphetamine, keeping the focus local and providing federal funding to augment evidence-based treatment protocols that have been demonstrated successful in a number of jurisdictions.

Methamphetamine in America: The Extent of the Problem

Both national use rates as well as criminal justice data belie the emergence of a methamphetamine epidemic. Regular and lifetime use figures, rather than suggesting widespread addiction, demonstrate that the vast majority of people who use methamphetamine do so infrequently. Only a fraction goes on to become regular users, and for those individuals there are a number of promising treatment options.

Our assessment of these trends covers four measures: national use rates, high school student use rates, treatment and emergency room admissions, and arrestees use rates.

National Use Rates

Methamphetamine remains a drug used by a very small proportion of Americans. In 2004, 0.2% (583,000) of Americans over the age of 12 were regular users of methamphetamine.

Nationally, use of methamphetamine, as collected by the *National Survey on Drug Use and Health* (NSDUH), has been steady over the past five years.³

Methamphetamine remains a drug used by a very small proportion of Americans. In 2004, 0.2% (583,000) of Americans over the age of 12 were regular users of methamphetamine.⁴ As seen in Figure 1, the frequency of methamphetamine use is similar to crack cocaine, near the lowest levels of regular drug abuse.⁵ The percentage of monthly methamphetamine users, the best proxy for individuals who are likely to have a substance abuse problem, is 1/4th that of cocaine users and 1/30th of marijuana users. Meanwhile, the number who report binge drinking in the last month is more than 90 times the number who report methamphetamine use in the last month.⁶

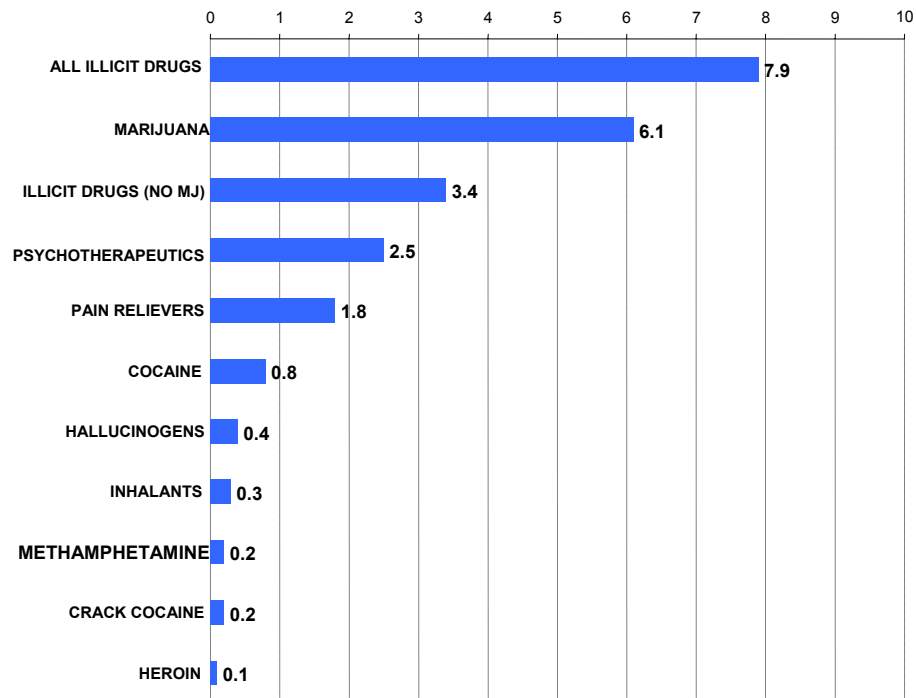
³ The Substance Abuse and Mental Health Association, which conducts the NSDUH, only began to systemically present comparable monthly methamphetamine use figures in 1999.

⁴ Office of Applied Studies. (2005). Results from the *2004 National Survey on Drug Use and Health: National Findings* (DHHS Publication No. SMA 05-4062, NSDUH Series H-28). Rockville, MD: Substance Abuse and Mental Health Services Administration. Table 1.1A, 1.1B.

⁵ A regular user is defined as someone who has used methamphetamine during the month previous to the survey.

⁶ *Supra*, note 4, Table 2.1A.

**FIGURE 1 – DRUG USE RATES BY PERSONS 12 AND OVER,
PAST MONTH, 2004 (%)⁷**



Lifetime use rates, which are frequently used when ascribing descriptors such as “epidemic” and “plague” to methamphetamine use, provide an imprecise reflection of how many people are *currently* using the drug. In 1999, 9.4 million Americans reported having used methamphetamine in their lifetime, a doubling of the number from a 1994 study.⁸ By 2004, the lifetime number had increased to nearly 12 million. By any account, this rapid growth in lifetime users could, and has, raised alarms among the public. However, between 1999 and 2004, the proportion of all methamphetamine users who were regular (monthly) users increased only slightly, from 4.6% to 5%. The distinction is that even one-time users are still considered lifetime users, although they clearly do not suffer from current substance abuse.

⁷ Adapted from Office of Applied Studies, 2005, Table 1.1B.

⁸ Data from 1994 published in Office of Applied Studies, *National Household Survey on Drug Abuse Advance Report #18*, 1995. Data for 1999 published in Office of Applied Studies, *National Household Survey on Drug Abuse, 1999 and 2000*. Rockville, MD. Table 1.1A.

Historic trends in methamphetamine use do not suggest the development of a looming problem. In 2004, 1.44 million Americans over the age of 12 had used methamphetamine in the past year, and 583,000 were regular users.⁹ The Substance Abuse and Mental Health Services Administration (SAMHSA) only recently began to collect regular, systematized figures on methamphetamine use in 1999, but as seen in Table 1, it is apparent in those six years of data collection that monthly use rates have remained steady.

**TABLE 1 – MONTHLY METHAMPHETAMINE USE RATES
BY PERSONS 12 AND OVER, 1999-2004¹⁰**

Year	% Use
1999	.2
2000	.2
2001	.3
2002	.3
2003	.3
2004	.2

Since 2002, the annual number of “new initiates”¹¹ has remained stable at around 300,000.¹² This is not the first time that this country has experienced rates of new methamphetamine users at annual levels about 300,000. In 1975, there were 400,000 new methamphetamine initiates, the highest level on record.¹³ Trends in new methamphetamine users during the 1990s more than doubled (164,000 to

⁹ *Supra*, note 4.

¹⁰ Adapted from National Survey on Drug Use and Health Detailed Table reports. Available: <http://oas.samhsa.gov/WebOnly.htm>; accessed February 27, 2006. Table 1.1B.

¹¹ People who used methamphetamine for the first time in their lives during the preceding 12 months before the survey.

¹² Substance Abuse and Mental Health Services Administration. (2005). *Overview of Findings from the 2004 National Survey on Drug Use and Health* (Office of Applied Studies, NSDUH Series H-27, DHHS Publication No. SMA 05-4061). Rockville, MD.

¹³ Substance Abuse and Mental Health Services Administration. (2002). *Results from the 2001 National Household Survey on Drug Abuse: Volume 1. Summary of National Findings* (Office of Applied Studies, NHDSA Series H-17, DHHS Publication No. SMA 02-3758). Rockville, MD. P. 48.

344,000), but these levels still do not match the annual growth seen in the 1970s and early 1980s.¹⁴ Moreover, since the recent spike of new users in 2000 (344,000), the number of initiates has steadily declined to about 318,000 in 2004.

High School Student Use Rates

Concern has been expressed that the impact of methamphetamine abuse may be particularly acute for young people, who are considered most vulnerable to the negative consequences of drug abuse. The University of Michigan's *Monitoring the Future* (MTF) study surveys 8th, 10th, and 12th graders about tobacco, alcohol and illicit drug abuse. As with the NSDUH study, MTF did not begin to administer systematic measurement of methamphetamine use until 1999. Trends over the last six years of data collection indicate that, as with the total adult and juvenile population annual and monthly methamphetamine use among high school students has also been steady since 1999.¹⁵

Since 1999, the lifetime prevalence of high school seniors reporting methamphetamine use dropped by 45% from 8.2% to 4.5% in 2005.

Usage patterns of high-school seniors are good indicators of cautionary developments that might affect adult drug abuse patterns. Since 1999, the lifetime prevalence of high school seniors reporting methamphetamine use dropped by 45% from 8.2% to 4.5% in 2005.¹⁶ During that same period, the annual prevalence figures declined from 4.7% to 2.5%, while daily figures remained steady between .1% and .2%. Thus, since the advent of measurement of methamphetamine use by high-school seniors, lifetime, yearly, and daily trends have shown an aggregate decline.

The authors of the report note the incongruity between the results of the analysis and the common perception of use patterns, and suggest that perhaps the school-based survey instrument is missing individuals who have dropped out from school

¹⁴ Ibid.

¹⁵ Johnston, L.D., O'Malley, P.M., Bachman, J.G., & Schulenberg, J.E. (2005). *Monitoring the Future National Survey Results on Drug Use, 1975-2004: Volume 1, Secondary School Students* (NIH Publication No. 05-5727). Bethesda, MD: National Institute on Drug Abuse. Tables 5-5b, 5-5c.

¹⁶ 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. [On-line]. Available: www.monitoringthefuture.org; accessed January 25, 2006.

and may have higher rates of use.¹⁷ If that were the case, the national survey data of persons 18 to 25 years of age would be a good place to observe any spikes in use. As seen in Table 2, data from the NSDUH show generally steady monthly use rates for 18 to 25-year-olds during the period of 1999-2004. The slightly higher rates than the general population are to be expected because this is a younger age cohort; however, the trend is virtually identical to general use rates.

**TABLE 2 – MONTHLY METHAMPHETAMINE USE RATES
BY PERSONS 18 TO 25, 1999-2004¹⁸**

Year	% Use
1999	.5
2000	.3
2001	.7
2002	.5
2003	.6
2004	.6

Treatment and Emergency Room Admissions

Both the NSDUH and MTF survey combine to paint a picture of methamphetamine use that is at worst, steady, and may even be on the decline. Another national drug use measure that has been referred to in support of the growth of methamphetamine abuse is the Treatment Episode Data Set (TEDS). TEDS data indicates that between 1993 and 2003, treatment admissions for methamphetamine increased more than five-fold.¹⁹ However, relative to other drugs, methamphetamine remains a small fraction of total annual admissions. In 2003, despite the decade-long increase, methamphetamine represented 6.3% of total

¹⁷ Press Release. December 19, 2005. "Teen Drug Use Down But Progress Halts Among Youngest Teens," Ann Arbor: University of Michigan News Service.

¹⁸ *Supra*, note 10, Table 1.3B.

¹⁹ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1993-2003. National Admission to Substance Abuse Treatment Services*, DASIS Series: S-29, DHHS Publication No. (SMA) 05-4118, Rockville, MD, 2005.

treatment admissions; far lower than alcohol (41.7%), marijuana (15.5%), heroin (14.8%), and cocaine (13.6%).²⁰

“treatment admissions to publicly funded treatment facilities for methamphetamine [have] increased since the 1990s, most likely because of increased access to drug treatment and increases in treatment referrals from drug courts.”

Additionally, treatment admissions are not an accurate indicator of the prevalence of drug use in a society; rather, they are frequently a reflection of court dynamics. The expansion of drug courts and alternative sentencing programs in the last decade has had a significant impact on the number of persons being admitted to drug treatment. In response to TEDS, the National Drug Intelligence Center of the United States Department of Justice, in its 2006 *National Drug Threat Assessment* concluded that “treatment admissions to publicly funded treatment facilities for methamphetamine [have] increased since the 1990s, most likely because of increased access to drug treatment and increases in treatment referrals from drug courts.”²¹ Thus, it is important to temper any tendency to read too much into treatment admission data, as the factors that affect these figures are more complex than the frequency of use of the substance in question.

Emergency room data is another imprecise indicator of drug use, albeit one commonly used when discussing drug abuse trends. The Drug Abuse Warning Network (DAWN) collects the frequency of “mentions” of specific drug types from patients when admitted to a hospital emergency room. An analysis of methamphetamine “mentions” between 1995 and 2002 found, despite yearly fluctuations (specifically, a brief spike in 1997), no statistically significant change.²² When controlling for the overall number of drug mentions, the proportion of methamphetamine mentions actually *declines* from 1.8% to 1.5%.²³ It is critical to note that these figures are likely to overestimate the impact that methamphetamine exhibits upon the health care system. DAWN collects “mentions” of a drug, which may or may not be the primary cause for the hospital admission. Thus, a mention could span the spectrum from someone suffering life-threatening consequences of using methamphetamine to a patient entering the hospital for a totally unrelated

²⁰ Ibid., Table 2.1b

²¹ National Drug Intelligence Center, Department of Justice. *National Drug Threat Assessment 2006*. Product No. 2006-Q0317-001, 2006.

²² Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Emergency Department Trends From the Drug Abuse Warning Network, Final Estimates 1995-2002*, DAWN Series: D-24, DHHS Publication No. (SMA) 03-3780, Rockville, MD, 2003. Table 2.2.0

²³ Ibid.

condition, but responding in the affirmative to a question on the intake instrument about past drug use. This measure does not distinguish in regards to underlying behavior leading to the “mention,” and as such, its meaning is uncertain and provides only limited insight into drug trends. To the contrary, this imperfect reflection of drug use habits is problematic because, taken out of context, it is likely to needlessly alarm the public and policymakers.

Methamphetamine Use Among Arrestees

None of the traditional measures of methamphetamine use support the emergence of a widespread epidemic. However, there is common criticism that national use survey instruments provide an imprecise reflection of the prevalence of drug abuse, and in particular, miss the contours of more entrenched drug abuse due to underreporting in certain drug using populations.²⁴ In order to reach a different component of the population, we consult the *Arrestees Drug Abuse Monitoring* (ADAM) dataset. Although also fraught with threats to its validity, ADAM provides some insight into methamphetamine use among persons arrested in a number of cities. In the same way that the NSDUH and MTF studies may miss a certain component of the chronic drug using population, ADAM is likely to *overreport* by only focusing on persons who are arrested, many of whom may have been arrested on more than one occasion. However, examining these different sources of data on methamphetamine use enhances our understanding of drug use patterns.

In a 1998 report examining methamphetamine trends during the 1990s, ADAM researchers found the percentage of arrestees testing positive for the drug varied widely.²⁵ Some cities, such as San Diego (33.2%) and Portland, Oregon (18.1%) registered a significant proportion of arrestees testing positive for methamphetamine in 1998. In contrast, seven cities had no positive tests, and 18 of the 35 cities had less than 2% of arrestees test positive. As seen in Table 3, of the 19 cities for which data was available for 1990, 1998, and 2003, there were a variety of experiences

²⁴ See Kleiman, M. “The Reality Based Community: Meth Gets a Coat of Tierney Whitewash.” Available: http://www.samefacts.com/archives/drug_policy/2005/08/meth_gets_a_coat_of_tierney_whitewash.php; accessed March 1, 2006.

²⁵ Arrestee Drug Abuse Monitoring. (1999). *1998 Annual Report on Methamphetamine Use Among Arrestees*. Washington, DC: National Institute of Justice.

across the country. Of these 19 sampled cities, the median percentage of adult male arrestees testing positive for methamphetamine use increased from 0.6% in 1990 to 2.6% in 2003. The average percent of positive tests increased from 3.5% to 11.3%; however, due to the substantial variance among cities, the median is a more stable and accurate indicator. It is evident from this data that methamphetamine use is a highly localized issue. The overall increase is driven by six cities (Los Angeles, Omaha, Phoenix, Portland, San Diego, and San Jose), while for the remaining 13 cities, the increase has been negligible (average increase of 1.5% points).

TABLE 3 – ARRESTEES TESTING POSITIVE FOR METHAMPHETAMINE, 1990, 1998, 2003 (%)²⁶

City	1990	1998	2003
Atlanta	0.0	0.0	2.0
Birmingham	0.0	0.0	.3
Chicago	0.0	0.2	1.4
Cleveland	0.0	0.0	0.3
Dallas	1.9	3.3	5.8
Denver	0.7	5.2	4.7
Houston	0.6	0.2	2.1
Indianapolis	0.0	0.8	1.9
Los Angeles	5.7	8.0	28.7
New Orleans	0.2	0.2	2.6
New York City	0.0	0.0	0.0
Omaha	0.6	10.2	21.4
Philadelphia	0.9	0.6	0.6
Phoenix	6.7	16.4	38.3
Portland (OR)	10.9	18.1	25.4
San Antonio	2.1	2.0	3.5
San Diego	27.3	33.2	36.2
San Jose	8.9	19.7	36.9
Washington, DC	0.1	0.0	0.7
MEDIAN	0.6	0.8	2.6
AVERAGE	3.5	6.2	11.3

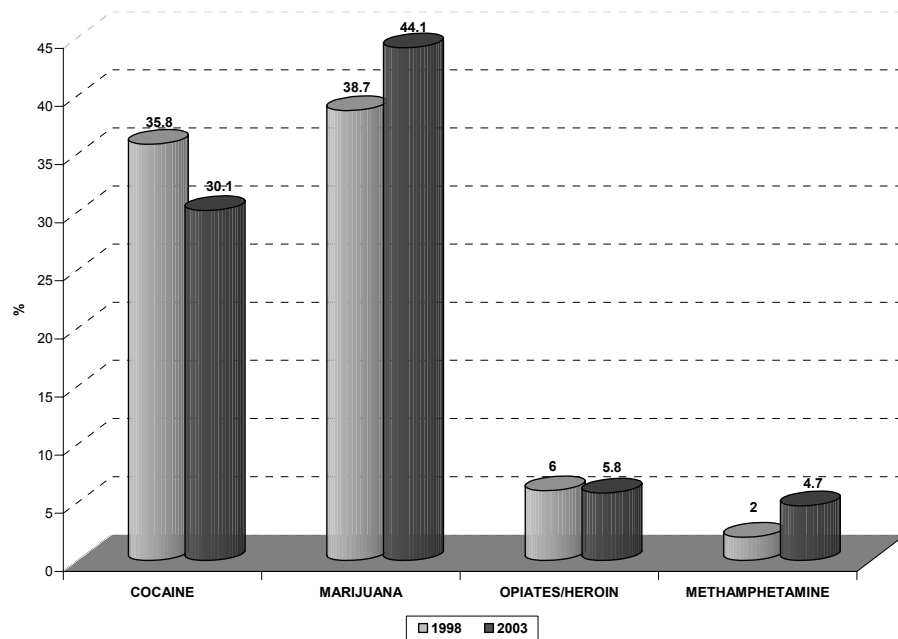
It is important to put these positive test rates in perspective. In 2003, of five primary drugs²⁷ measured by ADAM for adult male arrestees, methamphetamine

²⁶ Adapted from 1998 Annual Report on Methamphetamine Use Among Arrestees, Table 1 and Zhang, Z. (2004). Drug and Alcohol Use and Related Matters Among Arrestees, 2003. Chicago, IL: National Opinion Research Center.

²⁷ Crack cocaine, powder cocaine, marijuana, methamphetamine, and heroin.

registered the lowest national median. As seen in Figure 2, across all sites (not just those in the sample above), 30% of adult male arrestees tested positive for crack or powder cocaine, 44% for marijuana, 6% for heroin/opiates, and 5% for methamphetamine.²⁸ The figures in 1998 were not dramatically different: 36% tested positive for cocaine (powder and crack),²⁹ 39% for marijuana,³⁰ 6% for opiates/heroin,³¹ and 2% for methamphetamine.³²

FIGURE 2 – POSITIVE DRUG USE AMONG ADULT MALE ARRESTEES (%)



This is not meant to suggest that in certain jurisdictions methamphetamine does not represent a much higher proportion of positive responses. In some of those cities the number of positive methamphetamine tests was comparable to marijuana and exceeded cocaine. However, as seen in Figure 3, the overall positive rates in those cities for all drugs were comparable to the national median in both 1998 and

²⁸ Zhang, Tables 4-8.

²⁹ National Institute of Justice. (1999). *ADAM: 1998 Annual Report on Cocaine Use Among Arrestees*, Washington, DC: National Institute of Justice.

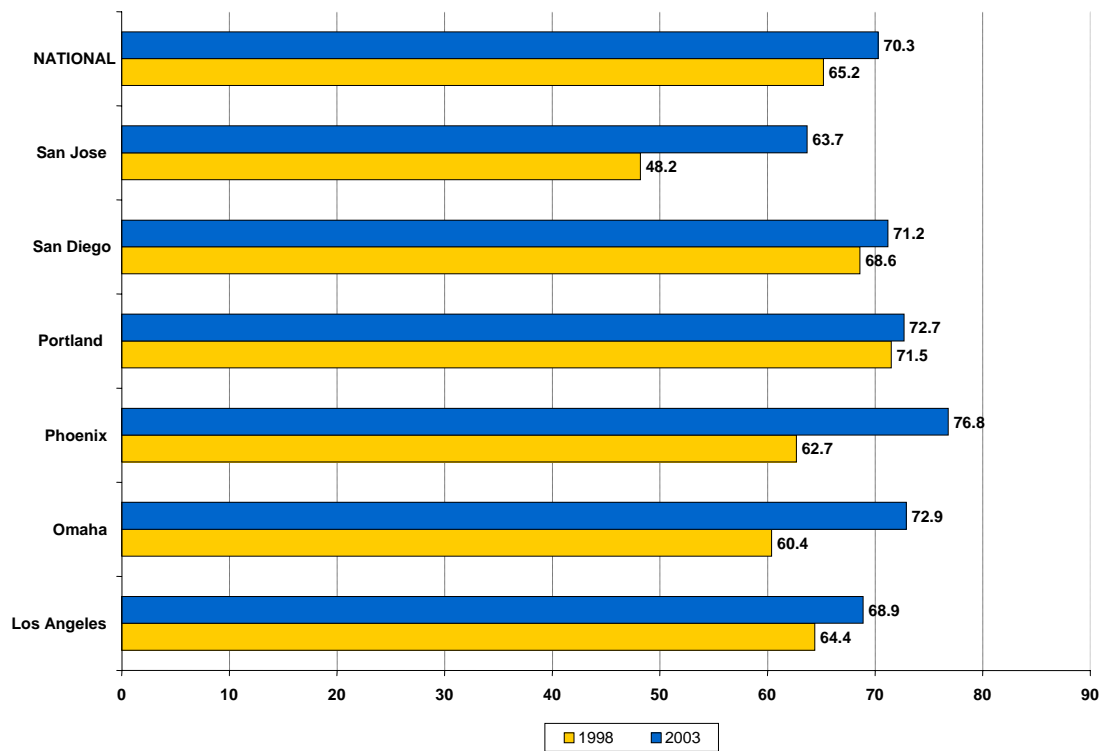
³⁰ National Institute of Justice. (1999). *ADAM: 1998 Annual Report on Marijuana Use Among Arrestees*, Washington, DC: National Institute of Justice.

³¹ National Institute of Justice. (1999). *ADAM: 1998 Annual Report on Opiate Use*, Washington, DC: National Institute of Justice.

³² Median calculated using figures available in *ADAM: 1998 Annual Report on Methamphetamine Use Among Arrestees*.

2003.³³ Thus, methamphetamine use has not resulted in a higher *overall* rate of drug use among arrestees, but rather a *shift* in drug preference. The higher rates of methamphetamine positives in these cities indicate unique and local contours of drug markets. In a city like San Jose, which experienced a very low rate of positive responses in 1998, much of the growth in overall positive responses by 2003 appears to be the result of methamphetamine use. The same is likely true in Phoenix and Omaha.

FIGURE 3 – POSITIVE DRUG SCREENS AMONG ADULT MALE ARRESTEES IN SELECT CITIES (%)



In addition to the drug market dynamics in cities like San Jose, Phoenix, and Omaha, some jurisdictions appear to be experiencing a replacement effect of methamphetamine for other drugs. For example, in San Diego the number of positive cocaine responses declined by 46% between 1998 and 2003, in Los Angeles the decline was 44%, while Phoenix experienced a 25% drop. Interestingly, of the sample cities, all of those jurisdictions that experienced high rates of

³³ *Supra*, note 26.

methamphetamine positive responses had cocaine positives below the sample median. Meanwhile, all but two of the remaining 13 jurisdictions had cocaine positives above the sample median. This indicates that methamphetamine may be replacing cocaine in some drug markets, perhaps as the result of financial pressures as methamphetamine is far more affordable than cocaine.

methamphetamine may be replacing cocaine in some drug markets, perhaps as the result of financial pressures as methamphetamine is far more affordable than cocaine.

The arrest data leads to an obvious conclusion: drug markets are inherently provincial and policymakers must pay attention to local dynamics rather than developing policy based on the trends of other jurisdictions. Some of the high rate cities in this sample may be witnessing an outright increase in use, while in others the data suggest that methamphetamine is replacing other substances as the drug of choice. Each of these scenarios raises difficult and unique policy and enforcement questions for communities. The decisions that need to be made in San Diego or Phoenix, both in regards to methamphetamine as well as all illicit drugs, are very different than the concerns for New York City or Cleveland. The needs of a population using methamphetamine call for different enforcement and treatment strategies than one where cocaine or heroin dominates the market.

The Incentives of Federal Funding

There is serious risk when a jurisdiction shifts resources in response to political pressure, misperceived dangers, or external developments that have not been demonstrated locally. This temptation is frequently exacerbated when millions of federal dollars are offered to local entities engaged in the detection and enforcement of certain crime types. For example, the Drug Enforcement Administration's National Clandestine Laboratory Seizure Database, which monitors production facility enforcement outcomes for all illicit drugs, found that between 1998 and 2004, the number of methamphetamine labs seized nationally increased 422% from 3,441 to 17,956.³⁴ This increase coincided with the passage and implementation of the Meth Initiative, or "Meth/Drug Hot Spots" Program, which offered \$385.6 million in federal dollars to state and local agencies for the detection and eradication

³⁴ United States Department of Justice. (2006). *The Office of Community Oriented Policing Services Methamphetamine Initiative*, Washington, DC: United States Department of Justice, Office of the Inspector General, Audit Division.

of methamphetamine laboratories. This rapid growth in laboratory seizures is not corroborated by any of the drug use data described above and no evidence is available suggesting that the more than four-fold increase was in response to a sudden exponential expansion of methamphetamine lab production. In all likelihood, this increase in lab seizures was the product of expanded law enforcement efforts targeting methamphetamine production facilities in response to financial incentives.³⁵

Much of this money is distributed with congressional earmarks for certain locales, which means that these projects do not need “to be vetted for duplication, necessity, [or] fiscal accountability.”³⁶ Thus, the money is distributed based on neither need nor the demonstration of any evidence-based techniques. The lack of sufficient oversight in many of these jurisdictions, identified in the report issued by the Audit Office of the Department of Justice, opens up the opportunity for securing funds whether a locality needs, or even intends, to pursue methamphetamine violations.

The federal grant system creates an incentive for law enforcement agencies to increase their efforts targeting methamphetamine, which manufactures the artifice of a problem. The increased arrests or seizures, the result of aggressive enforcement rather than substantiated use patterns, reinforce the perception of widespread methamphetamine use. Meanwhile, personnel and fiduciary resources are diverted from other substance abuse concerns that may pose far greater harms in that locality. Focusing too narrowly on one element obscures more imminent problems and results in policy that is not properly calibrated to address the greatest needs of a particular locality.

³⁵ For a discussion of the intersection of law enforcement practice, federal funding, and policy, see Rasmussen, D.W. & Benson, B.L. (1994). *The Economic Anatomy of a Drug War: Criminal Justice in the Commons*. Lanham, MD: Rowman and Littlefield. Pp. 132-139.

³⁶ *Supra*, note 34, p. 11.

Perpetuating the “Myth of the Methamphetamine Epidemic”: The Role of the Media

Media coverage of methamphetamine – both of its prevalence and the consequences of its abuse – has increased substantially in the last five years. The common thread that runs through this coverage is that methamphetamine is unique in terms of addictiveness and consequences of use relative to other drugs. An official from the Office of National Drug Control Policy referred to methamphetamine as “the most destructive, dangerous, terrible drug that’s come along in a long time.”³⁷ The governor of Montana described the situation in his state with the following warning: “It’s destroying families; it’s destroying our schools; it’s destroying our budgets for corrections, social services, health care. . . [w]e’re losing a generation of productive people. My God, at the rate we’re going, we’re going to have more people in jail than out of jail in 20 years.”³⁸

Recent coverage of methamphetamine in the press has followed a generally formulaic approach that may include: leading with anecdotal stories that distort national trends in methamphetamine use, mischaracterizing the consequences of use and receptivity to treatment, and warnings of an impending invasion of methamphetamine in jurisdictions in which current use is rare.

The media has picked up on this theme, routinely referring to a methamphetamine “epidemic.” Recent coverage of methamphetamine in the press has followed a generally formulaic approach that may include: leading with anecdotal stories that distort national trends in methamphetamine use, mischaracterizing the consequences of use and receptivity to treatment, and warnings of an impending invasion of methamphetamine in jurisdictions in which current use is rare. These stories are framed in such a way as to support a preconceived notion or theory about methamphetamine, and as such, dissenting viewpoints and critical assessment are seldom pursued. Common to many stories are the inclusion of predictions of dire consequences, often in the person of officials speaking about issues for which they lack expertise. For example, a law enforcement officer stating that methamphetamine addiction is impossible to treat. A general lack of critical analysis coupled with widespread reporting of opinions masquerading as facts have resulted in a national media that has been complicit in perpetuating a “myth of a methamphetamine epidemic.”

³⁷ Brad Knickerbocker (2005, July 15). “Meth’s Rising US Impact,” *The Christian Science Monitor*.

³⁸ Kate Zernike (2006, February 18). “With Scenes of Blood and Pain, Ads Battle Methamphetamine in Montana,” *The New York Times*.

The Construction of an Epidemic

Many news outlets have portrayed methamphetamine as America's most threatening "boogeyman," frequently making sweeping statements as to the drug's prevalence, addictive properties, and consequences while failing to provide documentation or foundation for these claims beyond a quote or two. Emblematic of this brand of coverage is the following: "Methamphetamines have become the drug of choice across the nation and the 'one hit and you're hooked' drug is one of the hardest for health officials to treat and users to kick."³⁹ That opening line of an article from a New Mexico newspaper has the distinction of offering three separate statements unsupported by fact (methamphetamine as the drug of choice, it only takes one "hit" to become addicted, and it is more difficult to treat than other drugs).

Many media outlets have been guilty of grossly distorting methamphetamine use trends, often using a single case to illustrate an emerging "pattern" posited in the article. In August of 2005, *Newsweek* featured a cover story calling methamphetamine "America's Most Dangerous Drug," in which it described methamphetamine use as an "epidemic" and a "plague," while observing that it has "quietly marched across the country and up the socioeconomic ladder."⁴⁰

Beginning with a story about an upper-middle class family, the article describes the downward spiral of a woman who lost everything due to her methamphetamine addiction and eventually was arrested for operating a meth lab. The obvious implication of this story is that if this can happen to a "good" family with two children, a six-figure income, a dog and a Volvo in the garage, then it can happen to anyone.

However, absent anecdotal stories and a handful of sensationalist quotes, the article fails to substantiate the claim posited in the title. This scenario, of methamphetamine use "march[ing] across the country," is not corroborated by any evidence. No statistics are provided to support the theme of a methamphetamine epidemic, no data indicates that methamphetamine is more dangerous than any other drug, and no regional statistics illustrate this purported cross-national "march" of

³⁹ *Supra*, note 1.

⁴⁰ David J. Jefferson (2005, August 8). "America's Most Dangerous Drug," *Newsweek*.

methamphetamine. In place of data, the article liberally employs quotations intended to convey the gravity of the situation. The ominous conclusion suggests grim prospects for the future, noting “like the addiction itself, this epidemic can only be arrested, not cured.” The source for this assertion is neither a law enforcement expert nor a treatment professional; rather, it is the opinion of a 46-year old former methamphetamine dealer.

Media coverage of methamphetamine has relied almost exclusively upon anecdotal stories and uncorroborated opinions from individuals as a means of illustrating the threat posed by the drug. In a 2004 article in *The New York Times* about the environmental hazards of methamphetamine production, Fox Butterfield includes a quote from a law enforcement officer about the harms of methamphetamine and the difficulty of overcoming addiction. “Meth makes crack look like child’s play, both in terms of what it does to the body and how hard it is to get off.”⁴¹ The perception is that methamphetamine is somehow unique among narcotics in terms of its impact on the body and is much less receptive to treatment. This comparison to the crack epidemic as a means of illustrating the unique nature of methamphetamine addiction is a common theme among law enforcement officials (“It makes the crack epidemic of the 80s look like kids eating candy”).⁴² No empirical evidence is provided to support these claims, just the opinion of a single individual.

In some cases, media stories about methamphetamine present contradictions within the same article. For example, a South Carolina newspaper ran a story about youthful methamphetamine users, stating that “[e]xperts say meth . . . is starting to show up in the littlest addicts.”⁴³ The theme of the article was that the risks of methamphetamine are now threatening the most vulnerable population: adolescents and pre-adolescents. The article predictably begins with the story of a 13-year-old who tried methamphetamine at the age of 12 and is now in a rehabilitation center and recovering from a suicide attempt. The article continues by suggesting that the region is experiencing a “disturbing [methamphetamine] trend,” evidenced by the

⁴¹ Fox Butterfield (2004, February 23). “Home Drug-Making Laboratories Expose Children to Toxic Fallout,” *The New York Times*.

⁴² David Williams (2006, February 23). “Meth Makes Its Way to Top of Drug Chart,” *Anderson Independent-Mail* (SC).

⁴³ Amanda Ridley (2006, February 22). “The Littlest Addict,” *The Spartanburg Herald Journal*.

recent arrest of five area teens for possession of methamphetamine with intent to distribute. Further investigation into this arrest indicates that two of the teens were 18 and the other three were 17.⁴⁴ This is not to downplay the offense, but rather to highlight that this collection of “teens” are at a very different level of maturity than the featured 13-year-old.

Regarding the “emerging problem” of youthful methamphetamine use, the story does note that national data indicate that methamphetamine use is leveling off. Actually, although not mentioned in the story, recent data suggest it is declining in the population featured in this article. That fact notwithstanding, two treatment experts are cited as suggesting, absent any supporting evidence, that there is a significant threat lurking regarding juvenile methamphetamine use. The article states that “counselors are afraid that *eventually* [emphasis added] even more teens will experiment with meth,” while a representative of Child Protective Services admits that her office has not removed any children from domestic situations in which methamphetamine was present, “but she knows that the drug is out there.” No rationale is given to support their fear of increasing teen use rates. These remarks, and the story as a whole, illustrate a general paranoia regarding methamphetamine that results in people ascribing validity to unsubstantiated fears while ignoring empirical data. This irrationality both fuels and is fueled by the media, which responds to sensationalist claims about trends and consequences by printing alarming stories of “epidemics” and “crises,” while in turn perpetuating a widespread misperception that these claims are fact. In a self-fulfilling feedback loop, this increases public susceptibility to believe the epidemic mythology.

Another example of an article reporting disquieting claims about methamphetamine, “Nightmarish Meth Spills into the State: Highly Addictive Drug Inflicts Heavy Brain Damage,” comes from the *Milwaukee Journal-Sentinel*.⁴⁵ In contrast to the compelling title, the article primarily focuses on the fact that Wisconsin law enforcement officials do not see it as a major problem, and U.S. Senator Herb Kohl is quoted as saying “[w]e saw (meth) coming down the road . . . and we’ve been

⁴⁴ Tara Jennings (2006, February 6). “Teens Charged in Meth Bust,” *The Gaffney Ledger*.

⁴⁵ Graeme Zielinski (2005, March 5). “Nightmarish Meth Spills Into State: Highly Addictive Drug Inflicts Heavy Brain Damage,” *Milwaukee Journal-Sentinel*.

relatively successful” in preparing for the problem. The article concedes that other drugs such as marijuana and cocaine pose far greater dangers in the region, but warns that, “in some communities, the battle with meth isn’t being joined. It already has been decided.” This fatalistic sentiment is supported by the obligatory law enforcement quote (“In 25 years of law enforcement, I have never seen a drug simply take over people like this.”) and suggestions of the hopelessness of treatment (“If you use it once, you’ll become an addict.”).

The article takes an approach of countering statewide data with a single example of a struggling jurisdiction. The reader’s natural inclination, cued by persistent media claims of a “meth epidemic,” is to discard the data and extrapolate the localized experience to the entire state. Even the title of this article is not supported by the research and treatment community. In fact, the claim that the drug “inflicts heavy brain damage” is only substantiated by a quote from a treatment professional who claims that “[m]any of them will never recover.” The fact that this opinion is countered by a wealth of empirical research on successful treatment is never addressed in the article. Instead, the opinion of one person stands as testament to the irreversible effects of methamphetamine use.

In some areas of the country, particularly in the eastern states, the approach has been to warn of an impending methamphetamine crisis. A recent story in *The Washington Post* aimed to capitalize upon many readers’ familiarity with the warnings about the crack cocaine “epidemic” of 20 years past.⁴⁶ The article leads with the story of Jimmy Garza and the impact that methamphetamine has had upon his life (arrested and lost his home and employment). The theme of the article is that methamphetamine “has infiltrated suburbs in Virginia and, to a lesser degree, Maryland” and poses a growing threat to the Washington, D.C. metropolitan area. The evidence in support of this conclusion is data on increasing lab seizures and quotes from local officials (“We really need to stop sitting around and just hoping that meth won’t become the next crack cocaine . . .”).

The problem with the premise of the article is that lab seizure data is a notoriously unreliable predictor of criminality because it is subject to law enforcement patterns

⁴⁶ Amit R. Paley (2006, March 19). “The Next Crack Cocaine?,” *The Washington Post*.

(themselves subject to financial incentives, as described above) and the meaning of a “seizure” is ambiguous. A lab seizure may range from a one-person operation to a large manufacturing plant. This issue notwithstanding, there has been only one seizure in the District of Columbia between 2000 and 2005, 11 in the state of Maryland, and 196 in the Commonwealth of Virginia. The article reports 75 seizures in 2004 and 2005 in Virginia. But, the DEA reports “most of the [manufacturing] activity [is] centered on the far southwestern corner of the state bordering West Virginia, North Carolina, and Kentucky.”⁴⁷ In Maryland, the 8 lab seizures occurring in 2005 were small operations, likely for personal use, including manufacturing paraphernalia found in a suitcase and one non-functioning lab.⁴⁸ These reports indicate neither a growth in distribution-level manufacturing, nor that the increase in lab seizures (the only supporting evidence provided) reported in the article represents any tangible threat to the metropolitan Washington area. Thus, the notion of methamphetamine infiltrating the suburbs of the capital remains the stuff of fiction.

In an effort to establish a local methamphetamine problem, media often rely on remarkably tenuous, and sometimes implausible, sources of evidence. One article from a local newspaper in Wisconsin led with the conclusion that “[m]ethamphetamine cases appear to be on the rise in La Crosse County,” and substantiated this claim by noting there had been 22 prosecutions for methamphetamine-related offenses in 2005.⁴⁹ How significant of an increase are these 22 prosecutions over years past? Impossible to tell, unfortunately, because the article notes that statistics regarding methamphetamine prosecutions for the preceding two years *are not available*. How, then, is a trend established with only one year of data? In this case, through the personal observations of a local assistant prosecutor who assured the reporter that “he’s definitely seen an increase in meth-related crimes in the past two years.” While it may be a mathematical rule that a trend cannot be established without at least two points of data, in journalism, the unsubstantiated remarks of a

⁴⁷ DEA Briefs and Background, Drugs and Drug Abuse, State Factsheets, Virginia.

Available: <http://www.dea.gov/pubs/states/virginia.html>; accessed May 5, 2006.

⁴⁸ Adapted by CESAR from Washington/Baltimore HIDTA, *Methamphetamine in Maryland, 2005*, 2006.

⁴⁹ Anne Jungen (2006, May 13). “La Crosse County Meth Case Numbers Higher,” *Holmen Courier*. This article was included in a section of the newspaper website dedicated to covering local methamphetamine stories, titled “Meth Menace.”

single individual apparently amount to sufficient grounds for a reporter to file a story concluding that methamphetamine is of growing local concern.

An article in a Connecticut newspaper noted the impending threat of methamphetamine by citing *two* recent lab busts in Connecticut and a rise in treatment admissions from 12 in 2000 to 109 in 2004.⁵⁰ Despite the fact that methamphetamine represented just .28% of all drug treatment admissions in Connecticut in 2004, legislators are scrambling to consider legislative responses. Moreover, growth in treatment admissions is frequently the result of court-ordered sentences and heightened attention paid to the drug, not any substantial increase in use.

Other newspapers in the Northeast are capitalizing on the fear that methamphetamine abuse is an impending tidal wave about to crest on their community. “It’s on its way . . . [a]nd it scares the hell out of me” is a quote from a District Attorney in Massachusetts about methamphetamine in an article titled “The Next Big Fear: Methamphetamines.”⁵¹ As is typical in most stories of this type, no data were provided to support this contention, just an unsubstantiated quote and an anecdotal story included to add gravitas to the situation.⁵²

The Distortion of Reality

The media have also been reticent to critically evaluate studies released by organizations that perpetuate the “mythology of the methamphetamine epidemic.” For example, a survey by the National Association of Counties (NACo) released in 2006 reported “there are more meth-related emergency room visits than for any other drug.”⁵³ The report surveyed 200 hospitals and found that half of responding hospitals reported methamphetamine to be the most frequently presented drug in the emergency room, and three-quarters reported an increase in methamphetamine

⁵⁰ Gregory Seay (2005, June 26). “State Urged to Fight Meth Head-On,” *Hartford Courant*.

⁵¹ Jill Harmacinski (2006, February 26). “The Next Big Fear: Methamphetamines,” *Eagle-Tribune* (MA).

⁵² See also Patricia Cronin (2006, February 23). “Officials: Meth is the Next Drug to Fight,” *Gloucester Daily Times* (MA). (“It [methamphetamine] really is coming, and we are not going to be exempt from this at all.” This remark from a public health official in Gloucester, MA).

⁵³ National Association of Counties, *The Meth Epidemic in America II: Two New Surveys of U.S. Counties*. Washington, DC: National Association of Counties.

presentations over the last five years.⁵⁴ This report garnered substantial press coverage, including stories in the *New York Times*,⁵⁵ *USA Today*,⁵⁶ and *NBC Nightly News*. All of these stories reported the alarming news that emergency room hospitals were being overrun with methamphetamine addicts, and were facing an impending crisis. However, none of the reports challenged the findings or sought to compare this single-survey to the more comprehensive, national DAWN survey. A cursory examination would have discovered that national estimates suggest a *decline* in methamphetamine “mentions” in hospitals and indicate that the drug represents only a fraction of all emergency room admissions. As Jack Shafer points out in a column critiquing the media coverage of the report, the NACo survey was very narrow and highly skewed to rural, unrepresentative facilities.⁵⁷ Thus, the report is not insightful as a tool for understanding national trends in methamphetamine abuse. However, that did not prevent the conclusion of the survey from being broadcast widely across print and news media, as well as being distributed across countless internet sites. In doing so, unchallenged findings become fact and the rhetoric supporting the methamphetamine epidemic continues to escalate.

This reluctance to critically assess information also translates to claims made by officials about the effectiveness of programs designed to prevent methamphetamine abuse. One high-profile example is the Montana Meth Project, a multi-millionaire dollar print, radio, and television advertising campaign that has saturated the state with gritty and disturbing portrayals of the impact of methamphetamine abuse.⁵⁸ The campaign’s mission is to “significantly reduce the prevalence of first-time methamphetamine use in Montana” and it has adopted the tagline of “Meth: Not Even Once.”⁵⁹ To that end, the approach of the advertisements has been to link first-time methamphetamine usage with physical deterioration (scabs, missing or rotting teeth), sexual violence, and criminal predatory behavior.

⁵⁴ Ibid.

⁵⁵ Kate Zernike. (2006, January 18). “Hospitals Say Meth Cases Are Rising, and Hurt Care,” *The New York Times*.

⁵⁶ Donna Leinwand. (2006, January 18). “Meth Cases Put Strain on ERs,” *USA Today*.

⁵⁷ Jack Shafer. (2006, January 19). “This Is Your County On Meth,” *Slate*.

Available: <http://www.slate.com/id/2134392/>; accessed March 18, 2006.

⁵⁸ See www.montanameth.org

⁵⁹ www.montanameth.org/about_mission.aspx

Despite the difficulty in measuring the success of such a campaign, early reports in the media were positive. The graphic nature of the images attracted both local and national attention and state Attorney General Mike McGrath proclaimed the campaign “very effective.”⁶⁰ A sponsor of the campaign noted, “[y]ou may not like the ads, but they’re effective.”⁶¹ The project executive director admitted initial skepticism, but after seeing the ads noted “the quality and the impact.” This message of success was echoed in another article, claiming that the campaign has “helped reduce meth use among teens by as much as 30 percent.”⁶² The positive media coverage has led to interest from other states that wish to replicate the advertised success.⁶³ However, notably absent in this coverage is any empirical evidence demonstrating the program’s effectiveness, or whether in fact the program has actually resulted in a 30 percent decline in teen methamphetamine use.

Instead, extensive media coverage has been conflated with success, when in reality media accounts of the program have simply repeated the same groundless conclusions. In fact, one article analyzing the Montana project observed that when the first data was released about the campaign – a survey of teenage perceptions of the dangers of trying methamphetamine – the results actually showed a *decline* in the percentage of respondents who thought that trying methamphetamine posed a dangerous risk since the campaign was launched.⁶⁴ If it is true that the Montana Meth campaign has had little demonstrable impact, that result should not come as a surprise considering that the longitudinal evaluation of the Office of National Drug Control Policy’s National Youth Anti-Drug Media Campaign has shown little impact on drug usage or perceptions of the consequences of drug use.⁶⁵ Another study of anti-marijuana advertisements discovered a “boomerang effect,” in which attitudes toward marijuana were actually *less negative* after viewing the

⁶⁰ Matt Gouras (2006, March 21). “Meth Project: More Money Needed to Keep Graphic Ads on the Air,” *Associated Press*. Printed in *The Missoulian*.

⁶¹ *Supra*, note 38.

⁶² Chip Scutari (2006, April 17). “State Seeks Anti-Meth Ads, Eyes Montana’s Tough Campaign,” *The Arizona Republic*.

⁶³ See Scutari article for discussion of Arizona’s interest. Also, interest reported by other states in Matt Gouras (2006, March 23). “Ad Campaign Paints Ugly Picture of Meth,” *Associated Press*.

⁶⁴ Montana Meth Project, Montana Meth Use & Attitudes Survey, April 2006. Available: http://www.montanameth.org/documents/MMP_Survey_April_2006.pdf; accessed June 5, 2006.

⁶⁵ National Institute of Drug Abuse, Evaluation of the National Youth Anti-Drug Media Campaign. Available: <http://www.nida.nih.gov/DESPR/Westat/>; accessed May 11, 2006.

commercials.⁶⁶ These studies support the premise that the approach of using fear as a deterrent can result in unintended consequences, such as actually piquing interest in experimenting with the substance.

From a policy perspective, there is an inherent danger when officials make claims of success by offering baseless figures of declines in use, and that risk is amplified when the media simply parrots these claims, thereby casting these falsehoods as truths and extending these myths to other jurisdictions as potential cures to misperceived ills.

The Need for a Changing Role in the Media

A call for a shift in the discourse surrounding methamphetamine abuse has been issued by a collection of researchers and treatment professionals.⁶⁷ In the summer of 2005, a letter signed by 92 prominent physicians, treatment specialists, and researchers called on the media to be responsible in its characterization of methamphetamine use. The authors wrote “to request that policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice.” The letter identifies a number of media stories that have passed along misinformation or discounted the rate of positive treatment outcomes. The letter seeks to curb the continuation of sensationalized coverage of methamphetamine use and prevalence in the general community, as well as encourage a reliance on facts and qualified experts to help shape future policy.

Some media outlets have been following this recommendation, turning the lens of analysis on the way that methamphetamine has been covered. The *Miami Herald* ran a piece critical of the media’s portrayal of the methamphetamine epidemic, noting its inconsistency with national use data.⁶⁸ Conventional wisdom about methamphetamine trends in the criminal justice system has frequently overstated the impact of the drug. In Montana, a state that is reported to be suffering significantly from problems associated with methamphetamine, a recent newspaper article

⁶⁶ Czyzewska, M. & Ginsburg. (2006). “Explicit and Implicit Effects of Anti-Marijuana and Anti-Tobacco TV Advertisements,” *Addictive Behaviors*, Forthcoming. 14 pages.

⁶⁷ David C. Lewis, M.D. (July 27, 2005). Open Letter to the Media.

⁶⁸ Glenn Garvin (2006, February 15). “Frontline – The Meth Epidemic – 10 to 11 Tonight,” *Miami Herald*.

suggests that these perceptions should be subjected to more rigorous screening.⁶⁹ The article noted that officials had maintained that the number of persons facing charges or being held in a local jail for a methamphetamine-related offense was close to 90 percent, although that figure had never been validated. A small study of court processing and jail population data by a local newspaper concluded that, at most, that figure was closer to 30 percent. These rates frequently become part of conventional wisdom regarding methamphetamine prevalence, eventually reaching lawmakers and influencing policy.

Making assumptions based on dubious research or statistics from which no foundation can be established was also exposed in a piece by the *Willamette Week* in Oregon.⁷⁰ In reference to “at least 261 stories” appearing in *The Oregonian* in the 18 months preceding the story, *Willamette Week* research indicated that *The Oregonian*’s series of stories trumping up the “meth epidemic” in the state “relied on bad statistics and a rhetoric of crisis, ultimately misleading its readers into believing they face a far greater scourge than the facts support.” *The Oregonian* series repeatedly referred to a “meth epidemic” in Oregon without providing any statistical support, mischaracterized the significance of the growth in methamphetamine treatment admissions, and suggested a link between Oregon property crime rates and methamphetamine use that has been generally refuted by empirical research.

Methamphetamine’s Coverage in Context

All of this should sound eerily familiar to students of the history of drug policy in the United States. David Musto, in *The American Disease: Origins of Narcotic Control*, writes that the common thread between different eras of prohibition (opium in the late 19th Century, cocaine in the early 20th Century, and marijuana in the mid-20th Century) was a carefully crafted campaign of fear used to convince people of the need for prohibition.⁷¹ Musto suggests that frequently economic, political or social issues were at the foundation of each of these prohibition

⁶⁹ Chery Sabol (2006, February 18). “Methamphetamine-Related Charges Around 30 Percent,” *Daily Inter Lake* (MT).

⁷⁰ Angela Valdez (2006, March 22). “Meth Madness: How *The Oregonian* Manufactured an Epidemic, Politicians Bought It and You’re Paying,” *Willamette Week*.

⁷¹ *Supra*, note 2.

movements; however, the consequences of the drug were frequently overstated in order to create an image of the drug as an impending menace to social order.

This pattern was repeated, more recently, with the dizzying escalation of media exposure about the consequences of crack cocaine. Crack cocaine, which is pharmacologically the same drug as powder cocaine but is delivered in smokable form, became a national issue seemingly overnight in the mid-1980s. Crack created significant concern due to its affordability, the fact that it can be produced in small batches by local distributors, and the physiological impact resulting from smoking cocaine, which delivers the drug into the bloodstream more rapidly than nasal inhalation. However, widespread speculation about the impact of crack cocaine began to take root rapidly, despite the lack of any empirical validation. It was fueled by the media's sensationalist, and largely erroneous, coverage of the prevalence of crack use and its impact on users. This, in turn, was responsible in no small part for galvanizing congressional action, which resulted in some of the harshest sentencing legislation on record – the 100-to-1 powder/crack cocaine sentencing disparity. Print, television, and radio media all increased their coverage of crack cocaine, and by the summer of 1986 it was regularly referred to as a “crisis,” “plague,” “epidemic,” and “eating away at the fabric of America.”⁷² Between 1986 and 1989, media coverage of crack cocaine was sensational, with grave warnings of the drug's relentless spread through all corners of the nation and prognostications of a catastrophic impact on future generations of “crack babies.”

History proved the “epidemic” prognostications of crack cocaine false, as has occurred with every other drug that garnered national attention for a period in time. There is some evidence that potentially explains why our national fascination with certain drugs tends to ebb and flow. Musto describes a learning effect in which a generation's perception of the harmfulness of drugs is shaped by the shared experiences of those who have preceded. Musto posits that many of the generation born in the 1920s were raised by parents who had experienced first-hand the consequences of drug abuse, namely opium, heroin, and cocaine.⁷³ These children

⁷² Reinerman, C. & Levine, H.G. (1997). “The Crack Attack: Politics and Media in the Crack Scare,” in *Crack in America: Demon Drugs and Social Justice*, Craig Reinerman & Harry G. Levine, (Eds.), pp.18-51.

⁷³ *Supra*, note 2.

developed a healthy mistrust of narcotics as a result of their parents' experiences, and data from that era indicate infrequent drug use. However, the next generation ("baby boomers") "carried no direct knowledge of narcotics but had heard exaggerations about them that were in fact minatory rather than informative."⁷⁴ Musto argues that first-hand experiences with the harms of drug abuse coupled with an honest treatment of these consequences is an effective deterrent to use. A study of the decline in crack cocaine use in New York City during the 1990s confirms Musto's hypothesis. "Many youth had intimate experience with the variety of problems that afflicted their elders as an outcome of involvement with cocaine, crack, or heroin, and they made a conscious decision to avoid similar fates."⁷⁵ Having witnessed the damage wrought on families and individual lives, most individuals chose to abstain from using crack cocaine as a matter of personal choice, and in doing so, the consequences of the drug, rather than scare tactics and punitive sanctions, were what likely resulted in a significant decline in market demand.

Methamphetamine is likely to follow the same path. In those regions where the drug is of higher prevalence, the eventual deterioration of people's lives is certain to serve as a beacon of warning for children reaching adolescence. For those individuals who have not experienced the consequences of methamphetamine directly, it is our national responsibility to use prevention and educational techniques that are honest and portray the consequences of drug use and efficacy of treatment in a realistic fashion. Exaggerating these points only undermines the credibility of the source of information and increases the likelihood that the recipient will discount future warnings.⁷⁶ This may be what is occurring with the Montana Methamphetamine Project, where a graphic campaign intended to scare people from trying the drug by positing life-altering consequences as a result has actually witnessed a *decline* in people's perception of the risks of the drug.

⁷⁴ Ibid.

⁷⁵ Curtis, R. (1998). "The Improbable Transformation of Inner-City Neighborhoods: Crime, Violence, Drugs, and Youth in the 1990s," *The Journal of Criminal Law and Criminology*, Vol. 88, (4), pp. 1233-1276.

⁷⁶ *Supra*, notes 65, 66.

The Promise of Treatment

In addition to media coverage of methamphetamine use that has overstated the prevalence and increase of the drug's consumption, there is also a widely held perception perpetuated by the media that methamphetamine users respond far less effectively to treatment than do users of other substances. *Newsweek* remarked that “[t]he sobering fact is that, like addiction itself, this epidemic can only be arrested, not cured.”⁷⁷ *The New York Times*, in a front-page article, noted that “[t]here is debate among experts about how treatable methamphetamine addiction is. But most specialists believe it is one of the hardest to treat, requiring that a patient stay in treatment for up to two years.”⁷⁸ A more recent piece noted, without presenting empirical foundation, that “rehabilitation for methamphetamine often takes longer than other drugs.”⁷⁹

“[C]laims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and re-incarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an equivalent manner as individuals admitted for other drug abuse problems”

In an open letter to the media, a collection of treatment professionals warned of the dangers of this type of reporting. “[C]laims that methamphetamine users are virtually untreatable with small recovery rates lack foundation in medical research. Analysis of dropout, retention in treatment and re-incarceration rates and other measures of outcome, in several recent studies indicate that methamphetamine users respond in an *equivalent* manner as individuals admitted for other drug abuse problems” [emphasis added].⁸⁰

Despite proclamations to the contrary, outcome measures of treatment protocol and programs in 15 states provide reason to be optimistic.⁸¹ Kermit Dahlen, the CEO of a recovery center in Iowa noted, “[t]here’s a belief out there that people don’t get well. People do get well from meth addiction.”⁸² An overview of state-based responses to methamphetamine by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) reflects positive treatment potential in every

⁷⁷ *Supra*, note 40.

⁷⁸ *Supra*, note 41.

⁷⁹ Kate Zernike (2005, July 11). “A Drug Scourge Creates Its Own Form of Orphan,” *The New York Times*.

⁸⁰ *Supra*, note 67.

⁸¹ See Table 4.

⁸² Lynn Zerschling (2006, April 10). “People Do Get Well from Meth Addiction,” *Sioux City Journal*.

state in which treatment outcomes were evaluated.⁸³ In testimony before a Senate subcommittee on appropriations, Lewis E. Gallant, NASADAD executive director, stated, “people can and do recover from methamphetamine addiction. [S]tudies have shown that clinically appropriate services provided by qualified staff help people with methamphetamine addiction enter into recovery.”⁸⁴

TABLE 4 – STUDIES SHOWING THE EFFICACY OF METHAMPHETAMINE TREATMENT

PROGRAM	FINDINGS
Survey of Methamphetamine Treatment	Survey of methamphetamine treatment studies; reports recovery rates similar to other drug treatment; calls for greater research into methamphetamine-specific treatment protocol.
Comparative Treatment Model Study	Evaluation of different treatment protocol for methamphetamine; reports higher retention (38%) and completion (27%) rates for Matrix Model of treatment versus traditional, out-patient treatment; questions remain about long-term abstinence.
Colorado	Abstinence rates for methamphetamine users higher after discharge (80%) than for people receiving treatment for other substances.
California ⁸⁵	Study of methamphetamine treatment among high-risk population (urban gay and bisexual men); compared three different treatment types and found significant and sustained reduction in use and levels of unprotected sexual activity (reduced by half).
California ⁸⁶	Study of in-patient and out-patient methamphetamine treatment in 13 counties; abstinence rates at 87% nine months after beginning treatment; criminal activity cut by nearly 20%.
Iowa ⁸⁷	Study of methamphetamine treatment outcomes; post-treatment data (six and 12 months) showed high rates of abstinence, higher rates of employment, and a decline in arrests.
Polk County, IA (Drug Court Evaluation)	Evaluation of drug court system; methamphetamine users experienced higher graduation rates than people who were receiving treatment for other substances.

⁸³ National Association of State Alcohol and Drug Abuse Directors. *State Snapshots on Methamphetamine, 2006*.

⁸⁴ Written Testimony Submitted by Lewis E. Gallant, Executive Director, National Association of State Alcohol and Drug Abuse Directors, Hearing on Methamphetamine Abuse, Senate Appropriations Subcommittee on Labor, Health and Human Services (HHS), Education and Related Agencies, April 21, 2005.

⁸⁵ Shoptaw, S., Reback, C.J., Peck, J.A., et al. (2005). “Behavioral Treatment Approaches for Methamphetamine Dependence and HIV-Related Sexual Risk Behaviors Among Urban Gay and Bisexual Men,” *Drug and Alcohol Dependence*, Vol. 78, pp. 125-134.

⁸⁶ Whitten, L. (2006). “Community-Based Treatment Benefits Methamphetamine Abusers,” *NIDA Notes: Research News and Trends from the National Institute on Drug Abuse*, Vol. 20, (5), pp. 4-5.

⁸⁷ Gunter, T.D., Black, D.W., Zwick, J., & Arndt, S. (2004). “Drug and Alcohol Treatment Services for Methamphetamine Abuse,” *Annals of Clinical Psychiatry*, Vol. 16, (4), pp. 195-200.

Iowa	Statewide study of methamphetamine treatment; found significantly reduced recidivism rates for persons having graduated from treatment.
Maine ⁸⁸	Study of methamphetamine treatment discharges in 2005; found about half completed treatment; 93% not arrested during treatment.
Maryland ⁸⁹	Study of methamphetamine treatment in 2005; employment increased 25% at discharge; 60% of methamphetamine users completed treatment, compared with 53% receiving treatment for other drugs.
Michigan ⁹⁰	Study of methamphetamine treatment in 2005; found a 24% decrease in homelessness; 62% decline in arrests, and a 37% increase in employment; drug use at discharge decreased by 64%.
Minnesota ⁹¹	Small sample study of individuals who received treatment between 1993 and 1999; found an abstinence rate of 73% six months after discharge.
Nevada ⁹²	Survey of state non-profit treatment providers; 90% of persons completing treatment were drug-free at discharge.
Oregon ⁹³	Study showed similar retention rate (57.5% methamphetamine, 54.6% other drugs) and completion rate (45.6% methamphetamine, 47.4% other drug) for persons seeking methamphetamine treatment compared with other drugs.
South Carolina ⁹⁴	Study found 98% of persons discharged from treatment still abstaining from use in the last 90 days since discharge; 99% report no arrests and 59% report employment during that same period.
South Dakota ⁹⁵	Small sample study of individuals who received treatment in 2005; found an abstinence rate of 71% at discharge.
Tennessee	Study of methamphetamine treatment; finds significant abstinence rates (65% after six months) for persons completing treatment and positive employment (from 10% full-time employment to 46% full-time) and recidivism (11% re-arrest) outcomes.
Texas ⁹⁶	Study found an abstinence rate of 74% and an employment rate of 56% two months after discharge; 96% report no arrests during this time frame.
Utah ⁹⁷	Study of methamphetamine treatment in 2004 found an abstinence rate of 61% at discharge.
Washington State	Study comparing treatment outcomes for methamphetamine and other substances; concludes no measurable difference, with positive outcomes in abstinence, recidivism, employment, and treatment re-admissions.

⁸⁸ *Supra*, note 83.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

A survey of treatment approaches published in the *Journal of Substance Abuse Treatment* concluded “that clients who report methamphetamine abuse respond favorably to existing treatments.”⁹⁸ The study noted a number of promising treatment options, but concluded that additional research is necessary to construct a specific protocol for methamphetamine, rather than relying on treatment designed for cocaine users. This positive assessment of the receptivity of methamphetamine abuse to treatment was echoed by the author of a study surveying different treatment protocol in **California**. In response to findings demonstrating an abstinence rate of nearly 90% nine months after beginning treatment for “heavy or long-term methamphetamine abuse,” the primary investigator remarked, widely held perceptions notwithstanding, that “recent clinical trials . . . [show] that community-based treatment reduces drug abuse and other problems.”⁹⁹

One treatment approach that has demonstrated encouraging outcome measures is the Matrix Model. This model focuses on an integrated treatment protocol that combines cognitive-behavioral therapy, family education, social support, and individual counseling “using a non-judgmental, non-confrontational style and employ[ing] extensive positive reinforcement by therapists and peers.”¹⁰⁰ In a study of participants drawn from eight western states, researchers found that Matrix participants experienced higher retention rates (38%) and were more likely to complete treatment (27%) than participants undergoing traditional methamphetamine treatment.¹⁰¹ In post-discharge follow-up, about two-thirds of participants from both samples remained methamphetamine free.

A number of studies in different states have also demonstrated encouraging outcome results for methamphetamine treatment. A study of program outcomes for the **Polk County (IA)** adult drug court system revealed graduation rates for methamphetamine users that were significantly higher than for cocaine or marijuana users.¹⁰²

⁹⁸ Cretzmeyer, M., Sarrazin, M.V., Huber, D.L., et al. (2003). “Treatment of Methamphetamine Abuse: Research Findings and Clinical Directions,” *Journal of Substance Abuse Treatment*, Vol. 24, pp. 267-277.

⁹⁹ *Supra*, note 86.

¹⁰⁰ Rawson, R., Marinelli-Casey, P., Anglin, M.D., et al. (2004). A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence,” *Addiction*, Vol. 99, pp. 708-717.

¹⁰¹ *Ibid*.

¹⁰² Stageberg, P. (2001). *Final Report on the Polk County Adult Drug Court*. Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning.

Fifty-eight percent of methamphetamine users successfully graduated the program, compared with 21% of cocaine users, 25% of marijuana users, and 50% of prescription drug users. Another **Iowa** study found 71.2% of people who received treatment for methamphetamine addiction were drug-free after six months, and three-quarters of those persons who remained abstinent for six months were still methamphetamine-free one year later.¹⁰³ An evaluation of recidivism outcomes found that 89% of people who had graduated from methamphetamine treatment had not been arrested within six months of release, compared with 32% in the twelve months prior to treatment.¹⁰⁴

An evaluation by the **Colorado** Department of Human Services of methamphetamine treatment outcomes found that about 80% of patients were abstinent at discharge, which was slightly higher than patients receiving treatment for other substances.¹⁰⁵ NASADAD also reports abstinence rates in **Texas** (88%) and **Utah** (61%) that indicate the potential success of the treatment option.¹⁰⁶

Another Iowa study found 71.2% of people who received treatment for methamphetamine addiction were drug-free after six months, and three-quarters of those persons who remained abstinent for six months were still methamphetamine-free one year later.

In a study in **Washington State** comparing treatment outcomes for different types of drugs, researchers concluded “there were no statistically significant differences across a series of outcomes between clients using methamphetamines and those using other substances.”¹⁰⁷ Similarities in treatment readmission (18.9% for methamphetamine, 20.5% for other drugs), employment (49.2% for methamphetamine, 49% for other drugs), and re-arrest (12.7% for methamphetamine, 11.1% for other drugs) were similar in the year following treatment, while inpatient hospital admissions (6.8% for methamphetamine, 10.7% for other drugs) were *lower* for methamphetamine than for other substances.

¹⁰³ Iowa Department of Public Health, Iowa Adult Methamphetamine Treatment Project, Final Report 2003.

¹⁰⁴ Johnson, A., Arndt, S., & Barber, K. (2005). *Outcomes Monitoring System, Iowa Project: Year Seven Report* (Iowa Department of Public Health, Contract No. 5885NA01). Iowa City, IA: Iowa Consortium for Substance Abuse Research and Evaluation.

¹⁰⁵ Colorado Department of Human Services, Alcohol and Drug Abuse Division. *Methamphetamine in Colorado, FY 05 – Demographics, Use Indicators and Outcomes*.

Available: <http://www.cdhs.state.co.us/ohr/adad/MethDemographicsOutcomesFY05.pdf>; accessed March 24, 2006.

¹⁰⁶ *Supra*, note 83.

¹⁰⁷ Luchansky, B. (2003). Treatment for Methamphetamine Dependency is as Effective as Treatment for Any Other Drug. Olympia, WA: Looking Glass Analytics.

A Tennessee study found 65% of methamphetamine users surveyed six months after the completion of treatment were still not using the drug.

A **Tennessee** study found 65% of methamphetamine users surveyed six months after the completion of treatment were still not using the drug.¹⁰⁸ Employment was also dramatically affected: before treatment, only 9.6% of those surveyed had full-time work. That figure increased to 45.8% after treatment. Only 38% of those in treatment were unemployed in the six months after admission, a decline from more than two-thirds prior to treatment. Only 11.4% reported re-arrest during the six months after admission and 94% reported no further involvement in domestic violence.

In **Montana**, the family drug court system has demonstrated some promising success in dealing with methamphetamine addiction.¹⁰⁹ Montana employs an approach that involves the judge, prosecutor, social worker, substance abuse counselor, and a mental health worker, among others. This integrated approach has been successful, largely due to the team approach as well as the individually tailored recovery plan that each participant receives.

Policy Responses

An overview of the **Nebraska** state response to methamphetamine abuse called for the development of an inter-agency approach and bringing together healthcare and social service providers, as well as law enforcement.

“Ultimately, the recommendations for the State turn not on the prevalence of methamphetamine users in any given justice or social service system, but on the State’s ability to establish the continuum of assessment, treatment and recovery as needed beneath methamphetamine users.”¹¹⁰

The task force warned that for a methamphetamine user entering the system as a result of an arrest, there are frequently delays in being properly diagnosed and often

¹⁰⁸ Kedia, S. (2004). “Methamphetamine Abuse in Tennessee: Trends and Treatment Outcomes,” *The SAT (Substance Abuse in Tennessee) Report*, Vol. 1, No. 3, pp. 1-4. Institute for Substance Abuse Treatment Evaluation (I-SATE), The University of Memphis.

¹⁰⁹ Ed Kemmick (2005, August 25). “Drug Treatment Court: A Glimmer of Hope in the Fight Against Meth,” *Billings Gazette* (MT).

¹¹⁰ Robinson, T.H. (2005). *Moving Past The Era of Good Intentions: Methamphetamine Treatment Study*. Initial Report to the MA Treatment Study Committee of the Nebraska Community Corrections Council.

further delays before a treatment slot can be found in an appropriate program. “It would seem that the solution to the dilemma turns on the State’s ability to quickly develop a cadre of clinicians and treatment specialists to fill these gaps.” The task force called for an expansion of the number of available treatment beds and also to develop additional methamphetamine programs. “To reduce methamphetamine abuse, an infrastructure must be laid which enforces a state-wide response to the problem and channels into a fast-flowing stream of recovery in which it is easier to succumb than escape.”

This model of integration between the different social service agencies that will interact with a client entering treatment through the criminal justice system governed the design of a pilot program in **Anoka County, Minnesota**.¹¹¹ The result of meetings of a Methamphetamine Task Force was the creation of the *Enhanced Treatment Protocol* (ETP), a year-long program targeting women (both with and without children) who have been charged or are awaiting charges for a methamphetamine offense, or women who have been referred to the Child Protection System due to past methamphetamine use. The Task Force identified one of the major weaknesses in the way that methamphetamine use has been addressed in the past as the “lack of extended treatment” options. The critical nature of the time immediately following treatment is supported by research showing that the first few months after treatment are the period when someone is most likely to resume methamphetamine use. In addition, a gap in services was also identified in the period between being sentenced to court-ordered treatment and the location of treatment space. This can frequently extend for more than a month, thus leaving the individual vulnerable to resuming methamphetamine use.

The Task Force, which was comprised of partners from the corrections, courts, social services and mental health, treatment, employment, and income support communities, developed the ETP model to follow the client through five phases. The first phase (one to three months) prepares the individual to enter treatment and works to keep that person drug-free while waiting for an opening in the program. The second phase (one month or more depending on the participant) is treatment in a licensed program focusing on both recovery from addiction as well as on issues

¹¹¹ Information about this program was provided to the author in the form of grant proposal documents.

such as employment, housing, and family reunification. The third phase (three months) provides immediate after-care support, that is gradually reduced with an emphasis on transitioning out of the program in the fourth (three months) and fifth (three months) phase.

Other officials who deal with methamphetamine abuse recognize the promise of treatment and caution against the futility of relying on prison to address methamphetamine abuse. In **Arizona**, Tucson Police Chief Richard Miranda has voiced concern about his city's approach to methamphetamine use, calling for the coordination of the law enforcement and treatment communities.¹¹² Chief Miranda warned that “[w]e can’t arrest the problem away,” while calling for increased investment in treatment, an expansion of treatment options, and a public education campaign about the consequences of methamphetamine abuse. This message has been echoed in **New Mexico**, where a four-point strategy to reducing methamphetamine use in the state noted that enforcement of methamphetamine laws alone will not solve the problem of addiction.¹¹³ “[N]egative consequences from methamphetamine use will still be present in communities unless treatment is widely available for users.” Thus, as a means of reducing use and increasing public safety, the plan calls for enhanced prevention and treatment investment, pointing out that “[s]ubstance abuse treatment has been proven to reduce crime among participants.”

Prison Programming

In **Indiana**, a focus on methamphetamine treatment has been adopted by the Department of Correction. In the spring of 2004, the state correctional department implemented the *Clean Lifestyle is Freedom Forever* (CLIFF) program, which is currently operating in three state facilities. The program admits certain categories of drug offenders who suffer from a history of methamphetamine abuse. Program participants are housed in a separate unit of the facility and work intensively through a three-phase treatment program focusing on education, treatment, and re-entry for

¹¹² Erica Meltzer (2005, September 2). “Tucson Police: Meth Epidemic Spreading, Boosting Crime Rate,” *Arizona Daily Star*.

¹¹³ New Mexico Methamphetamine Working Group, 2005 Statewide Strategy Recommendations: A Comprehensive Plan for New Mexico Communities. September 2005.

six to nine months. The “in-patient” model of treatment, in which people receiving treatment are not simply released to the general population and all the potential pitfalls it offers, is a critical element of the program. Those who complete the program may become eligible for a reduction in sentence of up to six months. The one shortcoming with this program, as with many drug treatment efforts in correctional facilities, is that there is no system of after-care available for these individuals upon release. The program is limited to people serving between 14 and 24 months, so that the range of sentence coupled with the potential six-month reduction means that many of these individuals may be ready for release soon after completion of the CLIFF program. This amplifies the need for the development of an after-care protocol for these graduates upon release from the facility. Other states, including **Montana** and **Illinois**, appear poised to invest in a similar model of intensive methamphetamine treatment in a dedicated facility.¹¹⁴

¹¹⁴ See Associated Press (2006, March 1). “Meth Prison Gets Legal Clearance,” *Billings Gazette*; Tracy Swartz (2006, January 15). “Gov. Wants Prison Units to Treat Meth Offenders,” *Chicago Sun-Times*.

A Rational Methamphetamine Model

The findings in this report are not intended to downplay the seriousness of the consequences of methamphetamine abuse, nor should they be read to suggest that we discount the harmfulness of illicit drug use. However, this report clearly illustrates that the portrayal of methamphetamine in the United States as an epidemic spreading across the country has been grossly overstated. Although use rates are higher than they were ten years ago, they remain far below historic peaks and have been stabilizing in recent years. The confluence of different use measures points to one conclusion: methamphetamine use, while significant in some geographic regions, remains a rare occurrence throughout most of the United States. Criminal arrest data indicate that in areas with higher rates of arrestees testing positive for methamphetamine, a replacement effect may be occurring, as methamphetamine use supplants drugs such as cocaine. For state and local agencies, it is critical that methamphetamine policy respond to the demonstrated needs of the population and not media accounts that frequently misconstrue the nature of the problem. For communities considering solutions that best meet their particular needs, we offer recommendations drawn from success stories across the country.

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Develop a National Prevention Strategy

The most cost-effective and productive way to address the harms of methamphetamine abuse is to prevent people from beginning to use the substance. As noted above, too often the American model of prevention has been fear tactics coupled with disproportionate punishment. This is a failed strategy and the government, along with partners at the state and local-level and private service providers, must reevaluate this national model of drug control prevention.

The Institute of Medicine of the National Academy of Sciences has developed three categories of prevention strategy: universal, selective, and indicated.¹¹⁵ The universal approach targets the country at-large, the selective is aimed toward at-risk populations, and the indicated focuses on at-risk populations that are already exhibiting indicators of drug abuse. Applying this framework to the issue of

¹¹⁵ National Institute of Drug Abuse, *Drug Abuse Prevention: What Works*. 1997.

methamphetamine use in the United States, the data support a blended use of selective and indicated treatment, targeting prevention to at-risk groups (youth, for example) in certain geographic regions while conducting more intensive outreach in communities in which methamphetamine has demonstrated a foothold.

This strategic model is instructive in helping formulate a balanced national education and prevention strategy, making sure to target resources to communities most in need and adjusting the language of the campaign based on the specific challenges facing each locality. A universal approach that ignores the regionalized contours of drug markets runs the risk of overextending resources and jeopardizing national credibility. Most importantly, the prevention campaign must treat the issue of methamphetamine honestly, relying on evidence-based practices rather than resorting to counterproductive scare tactics of dubious efficacy. These outreach programs should be based upon federal, state, and local partnerships and should link education and treatment. A good prevention campaign will also reach people who are currently using methamphetamine. Pathways to recovery through non-criminal justice avenues must be developed, and prevention offers an opportunity to reach a population that is in need but reluctant to ask for help. Otherwise, by relying upon law enforcement to be the primary entry point into treatment, it is far more likely that people will wait to seek treatment, thereby exacerbating the health risks.

Expand and Fund Treatment Programs

The successful outcomes demonstrated across a broad range of states indicate that treatment is a successful response to methamphetamine use, and the prudent decision is to expand the available options. Currently, only a fraction of persons needing treatment are able to find available bed space, and that is usually only after waiting for a month or more until an opening emerges. This scarcity of beds and extended wait time is problematic as it increases the likelihood that people seeking help will return to using methamphetamine, while the window of opportunity to bring about change may be lost. Considering that research indicates both the cost-effectiveness of treatment versus incarceration as well as better long-term outcomes, funding for the expansion of treatment programs is urgently needed.

It is also important that we begin to think more broadly about the concept of using treatment as an alternative to incarceration. In many cases, once the criminal justice system has become involved in the process, it is too late. Waiting to be arrested by the police should not be a necessary predicate to entering a treatment program. In addition, for those who do enter treatment through arrest, the court system needs to revisit the predominant model of drug case processing in which the individual must plead guilty as a condition of placement in a program. This trade of “plea for treatment” may seem appealing in light of the alternative (incarceration), but the mere fact of having a felony criminal record poses obstacles to employment, housing, and other social services. These denials only increase the likelihood of relapse for an individual exiting in-patient treatment.

Programming for Women

Efforts should include not only seeking to expand existing treatment program space, but also investing in innovative programs. One promising option of particular importance to female methamphetamine users is the “family treatment model.” Family-based treatment acknowledges the very common reality that many of the women entering the criminal justice system are single-mothers and primary caregivers of minor children. For those who need substance abuse treatment, the only option in the past has been to surrender custody of the child to a foster family and enter a single adult treatment program. This compounds an already difficult situation in which treatment must come at the expense of the mother-child relationship.

In addition to substance abuse, many mothers have suffered emotional, physical and sexual abuse and may have been diagnosed with co-occurring disorders. The family-treatment model is a holistic approach, allowing the mother and child to be treated together, and making the parental bond a vital component in the treatment process. The mother is not compelled to give up her child and, instead, is given the freedom to work to heal the damage that has been done to their relationship in light of past drug addiction. Empirical evidence supports the efficacy of this approach. A number of evaluations of family-based treatment programs show higher rates of abstinence, better employment outcomes, and reduced recidivism compared with

more traditional single adult treatment programs.¹¹⁶ Unfortunately, family-based treatment programs are woefully underfunded, and as such, bed space is at a premium. As state departments of child and family services frequently highlight the consequences of methamphetamine abuse on families and children, this model appears as a positive option. With the potential for sustainable outcomes, there should be a commitment by federal and state partners to expand upon the family treatment model when addressing methamphetamine addiction.

Integrate Programs

In addition to funding programs, a survey of the national landscape clearly indicates that a successful treatment structure requires the integration of different agencies. Persons enrolled in court-ordered drug treatment will frequently need to deal with a number of different agencies, including the court system, child and family services, housing, income support, and treatment providers. These obligations can be confusing and, in some cases, conflict with one another. A treatment model that brings all of the different acting agencies under one umbrella and coordinates the provision of services, with the client having one point-of-contact who manages the treatment, is a critical need that is a hallmark of some of the successful programs.

Extend Aftercare

Clinical research has consistently shown that drug treatment requires an aftercare strategy before release. With relapse being most common in the first six months after treatment, planning for that period and preparing for the challenges that lay ahead are mandatory if sustainable abstinence is going to be achieved.

¹¹⁶ See The Rebecca Project for Human Rights, Memorandum: Cost Benefit Analysis of Family Treatment, 2006.



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